The Florida Fulcrum

A Cost-Saving Strategy to Pay for Long-Term Care

Presented by

"The Long-Term Care Specialists"
February 23, 1994

Public Release Date: April 21, 1994

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EXECUTIVE SUMMARY

Universal access to top quality care for rich and poor alike across the entire spectrum from home and community-based to nursing home care.

Common Goal

Give me a lever long enough and a fulcrum strong enough and single-handed I can move the world.

Archimedes

Florida is slipping faster and faster into a fiscal sinkhole. The swamp engulfing the state is health care financing. The mire's deepest quicksand is long-term care costs. As Florida's aging demographics forecast America's in 20 years, the whole country is in danger of sinking into the same morass.

Florida's Medicaid nursing home expenditures have been skyrocketing for years, but providers still say the program pays too little. State expenditures for home and community-based services have declined in real dollars, but seniors say they would rather receive care at home than in an institution. Catastrophic long-term care costs are the biggest financial peril elderly people face, but only four percent of them have purchased private insurance against the risk. Something desperately needs to be done before the baby boomers retire, but public policy is gridlocked.

A prosperous state in the world's richest nation should not despair of providing and paying for quality long-term care for all of its citizens. The current long-term care financing

stalemate in Florida contradicts this principle. In nature, however, contradictions do not exist. The best approach to an apparent contradiction is to examine one's premises.

The fundamental premise underlying the long-term care financing system in Florida is that Medicaid is a social safety net which protects middle class people from utter devastation after they have spent down their life savings. Everything follows from this assumption, as I will explain in the text, including budgetary pressures, low reimbursement rates, institutional bias, quality problems, limited access, and discrimination. If the underlying premise is wrong, public policy will have to seek a new locus--a "fulcrum" from which to leverage a solution to these seemingly insoluble problems. That is what this report attempts to provide.

We discovered in this study that, contrary to conventional wisdom, the median elderly individual in Florida who needs nursing home care can qualify easily for Medicaid without spending down. Even people with higher incomes and assets can sometimes obtain public long-term care benefits if they have access to good Medicaid estate planning advice. Until very recently, anyone could give away unlimited assets overnight to qualify for Medicaid in Florida without triggering any penalty. Even now, people can shelter unlimited assets in exempt resources to obtain nursing home benefits immediately. Because Florida does not recover from

recipients' estates, asset shelters are equally as desirable as transfers to achieve eligibility for public assistance: "heirs reap the windfall of Medicaid subsidies."[1] Florida's infamous "income cap" is a major obstacle to Medicaid eligibility for the upper middle class, but it does not save the state as much money as most people believe. Under these circumstances, there should be no surprise that very few people pay privately for long-term care or buy insurance, that Medicaid nursing home census and costs are steadily increasing, and that resources available for other critical state services like education, highways, and crime control are dwindling. If Florida moves aggressively to control asset divestiture and recover from Medicaid recipients' estates, the state can reclaim up to $62 million per year. The state can save an additional $160 million per year by reducing Medicaid nursing home census from 67 to 57 percent. These savings are more than sufficient to pay for a new, "medically needy" eligibility system which senior advocates prefer and most analysts recommend. This goal and these savings are achievable within three to five years by educating and convincing the public that long-term care is a major risk, that Medicaid nursing home care is no longer a grant but a loan, and that paying privately or buying insurance is

[1] Office of Inspector General, Medicaid Estate Recoveries, Office of Analysis and Inspections, OAI-09-86-00078, San Francisco, California, June 1988, pps. 47-48.

preferable to relying on public assistance.

Florida is not spending too little money on long-term care. It is spending too much counterproductively. This report explains the problem and shows how to lift the state's long-term care financing system out of the hole into which it has been slipping. What this analysis requires from the reader is a willingness to entertain a radically new way of looking at the issue.

INTRODUCTION

Last year, the Florida State Legislature mandated that the Agency for Health Care Administration (AHCA) "develop a proposal to limit resource and asset transfers for the specific purpose of obtaining Medicaid eligibility for long-term care services." On November 19, 1993, the Agency's Office of Medicaid Program Analysis issued Request for Proposal #9402 entitled "Development of a Proposal for Limiting Resource and Asset Transfers." The RFP observed that: "Transfer of resources and assets is a growing problem among the nursing home population, where individuals deliberately reduce or transfer assets in order to gain financial eligibility for Medicaid long-term care benefits." The RFP required that the selected contractor research Medicaid estate planning techniques, investigate their economic impact on the State of Florida, compare conditions and corrective actions in other states, review federal laws, regulations and policies, and prepare specific recommendations for controlling asset divestiture and related practices in Florida. The deadline for receipt of proposals was November 29, 1993. The winning bidder was announced December 15, 1993. The contract was officially signed December 22, 1993. The deadline for submission of the final report was extended to February 23, 1994 by mutual agreement.

The winning bidder, LTC, Incorporated, is a private firm

specializing in long-term care financing and insurance. The company markets private home health and nursing home insurance throughout most of the United States. LTC, Incorporated is also active in the public policy debate on long-term care financing and publishes a national newsletter--LTC News & Comment--on these subjects. The company's consulting practice provides advice to state Medicaid programs and nursing home associations on methods to relieve public long-term care financing pressures by diverting future patients to private financing alternatives.

Stephen A. Moses, the project director and author, is Director of Research for LTC, Incorporated. He writes and speaks extensively on the subjects of Medicaid nursing home eligibility, Medicaid estate planning, liens, estate recoveries, and public/private long-term care financing partnerships. He was previously a Medicaid State Representative (9 years) for the federal Health Care Financing Administration (HCFA) and Senior Analyst (2 years) for the Office of Inspector General of the Department of Health and Human Services (IG). Steve Moses directed and authored three national studies for HCFA and the IG on Medicaid estate planning.

The State of Florida assisted in this project by arranging appointments with local experts throughout the state and by facilitating access to key staff and public documents

of the Agency for Health Care Administration, the Department of Health and Rehabilitative Services (DHRS), and the Department of Elder Affairs (DOEA). The State also provided conference space, photo-copy support, and local telephone service. We would like especially to express our appreciation to Susan Ahrendt, the Contract Officer, and Robert Butler who assisted her. Their hard work and ready availability helped to relieve the pressure of extremely tight time frames. We also appreciate the assistance and support of Medicaid Director Marshall E. Kelley and Gary Crayton, Chief of Medicaid Program Analysis (AHCA). Finally, to the respondents and interviewees who provided the information on which this report is based, we reserve special thanks for your time, your expertise, your cooperation, and your encouragement.

To achieve the objectives of this project, LTC, Incorporated staff examined Florida's long-term care eligibility and benefits policies in the context of federal law and regulation; we studied myriad official reports, academic studies, media coverage, program data, and demographic statistics; we polled every state in the country with a questionnaire on policies and corrective action plans concerning Medicaid estate planning, liens and estate recoveries; we spent one week on site in Tallahassee and another week in Miami, St. Petersburg, and elsewhere; we visited three district offices of the DHRS, reviewed Medicaid

nursing home cases, and interviewed eligibility workers; and we conducted 32 roughly two-hour briefing and interview sessions with 70 respondents (see list below) including state management, policy, operational, and eligibility staff as well as interested parties representing public and private sector points of view.

We tried to reach everyone in Florida with a strong interest in and an important impact on long-term care: from senior advocates and elder law attorneys to provider representatives and insurance agents. In sessions with key stakeholders, we presented a conceptual framework for understanding the problems of Medicaid estate planning and long-term care financing from both a national and Florida-specific perspective. Each respondent/interviewee received a packet of information containing articles describing the problem and recommending solutions. We solicited analysis, criticism, and recommendations from every participant in the study.

The following report describes the long-term care financing problem, as exacerbated by Medicaid estate planning, and proposes a solution for Florida. The proposed solution is designed to target scarce public welfare resources to those who need them most while providing a stronger incentive for prosperous seniors and their heirs to plan ahead, take care of themselves, and avoid reliance on public assistance. Given

the brief, two-month duration of this project, the report is necessarily concise and only suggestive.[2] It can point the direction, but a lot of additional work will be necessary to operationalize and implement these recommendations. We attempt throughout the report to provide specific suggestions on promising policy, operational, and research initiatives.

[2] For more detail, see the author's Wisconsin and Montana reports: Stephen A. Moses, The Senior Financial Security Program: A Plan for Long-Term Care Reform in Wisconsin, LTC, Incorporated, Kirkland, Washington, 1992 and Long-Term Care in Montana: A Blueprint for Cost-Effective Reform, LTC, Incorporated, Kirkland, Washington, 1993.

QUESTIONS AND ANSWERS

The contract for this project contains the following directive:

> The Florida Legislature may desire to implement into law one or more of the policies recommended within this proposal at some future point in time. Therefore, the selected provider must report results that can be easily understood by a wide variety of readers; i.e. minimal use of agency acronyms and professional jargon, and speaking directly to results over process.

With deference to this requirement, and in recognition of the complexity and political sensitivity of the topic, we present the body of this report in the form of simple questions and answers. The idea is to approximate the clarity and balance of a legislative hearing in which questioners with differing perspectives query representatives of contrasting interests. We hope that this approach will help to clear up any possible misunderstandings and answer reasonable objections before they crystallize into problems or opposition.

1. What is Medicaid estate planning?

Medicaid is a means-tested public assistance program; it is welfare. As welfare, Medicaid stipulates strict income and asset limits for eligibility. Generally, people with more than $446 of income per month or $2,000 in assets do not qualify. This is why two-thirds of the elderly poor and half of all poor children are not covered by Medicaid, even for

preventive, acute, or emergency care.[3] Medicaid's eligibility criteria for these essential services are very severe indeed.

People who need nursing home care, however, confront much lower barriers to Medicaid eligibility. Most states have no limit on how much income a nursing home patient may have and still qualify for Medicaid as long as total medical and health insurance expenses approximate income. Although Florida and several other states have an "income cap" for nursing home eligibility, the limit ($1,338) is three times the maximum allowed for acute care eligibility. On the resource side, the kinds of assets which nursing home patients are likely to possess are the very ones that Medicaid rules exempt from the $2,000 limit. Exempt assets include a home and all contiguous property, a business, rental property, an automobile, home furnishings, certain kinds of insurance and trusts, etc. There is no limit on the value of most of these exempt assets.

Because of the Medicare Catastrophic Coverage Act of 1988 which thankfully eliminated spousal impoverishment, married people who require long-term care institutionalization enjoy even more generous Medicaid eligibility criteria than single

[3] "The medical 'safety net' that the giant Medicaid program provides to the nation's poor is full of holes, a study commis-sion created by the Kaiser Family Foundation has concluded.... In 1990, 47 percent of the poor under 65 were covered, and only 30 percent of the poor 65 or older." (Spencer Rich, The Washington Post, 11/14/91)

individuals. In Florida, an institutionalized Medicaid recipient may transfer to a spouse in the community the federal maximum allowance of $72,660 in addition to retaining the $2,000 asset limit and all of the aforementioned exempt property. Furthermore, the institutionalized spouse may transfer up to $1,816.50 per month of income to the community spouse although this right is partially moot given Florida's cap of $1,338 on income for purposes of initial eligibility.

Obviously, income and asset limits would be meaningless if people could simply give away their resources to qualify for Medicaid. Therefore, federal and state Medicaid rules provide for a penalty period of ineligibility if an applicant or recipient transfers income or assets for less than fair market value in order to qualify. This penalty period applies only if such assets are transferred within 36 months of applying for assistance (or 60 months if the assets are transferred into a trust). The duration of the penalty is equal in months to the uncompensated value of the income or assets transferred divided by the average monthly cost of a private nursing home. Of course, income or assets converted into exempt resources or transferred into qualified trusts avoid the transfer of assets penalty altogether.

This has been the barest, thumbnail summary of Medicaid nursing home eligibility rules. Nevertheless, no further evidence is required to demonstrate that this subject is

extremely complex and confusing. Distinguished jurists have called Medicaid law "an aggravated assault on the English language, resistant to attempts to understand it" and "so drawn that [Congress has] created a Serbonian bog from which the [state] agencies are unable to extricate themselves."[4] Regrettably, Medicaid's almost impenetrable complexity invites loose interpretations which open gaping loopholes, hamstring strict enforcement, and attract people interested in making or saving money at the government's expense. **Medicaid estate planning is the practice of working within these arcane elastic rules to maximize eligibility for Medicaid benefits by legally divesting or sheltering income and assets.** As this report will explain and document, most people who need nursing home care in Florida qualify for Medicaid within 30 days with or without retaining professional legal advice.

2. Why is Medicaid planning important?

Medicaid is a very expensive program. Nationally, Medicaid costs exploded 13 percent, 19 percent, 27 percent and nearly 30 percent in successive years before moderating somewhat in 1993.[5] It was 10 percent of state budgets in

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

[5] Judith Feder, et al., The Medicaid Cost Explosion: Causes and Consequences, The Kaiser Commission on the Future of Medicaid, Baltimore, Maryland, 1992, p. 4.

1987; it is 17 percent today; and it is expected to exceed 25 percent by 1995.[6] Medicaid has consumed all new state revenues for the past several years. It is encroaching seriously on other government responsibilities. As a percent of total state appropriations in Florida, Medicaid has gone from 7.0 percent in 1982-83 to 17.9 percent in 1992-93. Other state responsibilities, including education, prisons and highways, have gone from 78.0 percent to 68.5 percent in the same period.[7]

Unfortunately, long-term care (especially nursing home care) is one of the biggest and fastest rising Medicaid costs. In Florida, Medicaid nursing home expenditures more than doubled in the past five years from $493.8 million to over $1 billion per year. The state's nursing home program consumes 19.5 percent of total state Medicaid expenditures[8] to provide benefits for only 6.2 percent of Florida's recipients.[9] These fiscal pressures place enormous stress on the state's ability

[6] National Governors' Association, Governors' Bulletin, 4/26/93, p. 2.

[7] Assistant Secretary for Medicaid, Office of Program Analysis, Medicaid Statistics: March 1993, Tallahassee, Florida, May 18, 1993, p. 29.

[8] Agency for Health Care Administration, Nursing Home Reporting System: 1993 Annual Report (draft), Tallahassee, Florida, December 1993, p. 1.

[9] HCFA-2082 data for federal fiscal year 1992 as published by the Health Care Financing Administration of the U.S. Department of Health and Human Services, July 1, 1993.

to finance access to quality care in appropriate institutional and noninstitutional settings. By facilitating access to Medicaid benefits for people who might otherwise have paid or insured privately, Medicaid estate planning exacerbates these problems.

3. What published evidence is there to suggest that Medicaid planning is widespread or seriously impacts State Medicaid budgets?

The literature on Medicaid estate planning is vast and growing rapidly. It began with national studies conducted by the Health Care Financing Administration,[10] the Inspector General of the Department of Health and Human Services[11] and the General Accounting Office[12] in the 1980's. These studies combined some hard, empirical data on Medicaid loopholes with extensive anecdotal evidence on Medicaid estate planning. In 1991[13] and again in 1993,[14] Brian Burwell systematically

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[10] Stephen A. Moses and John Duncan, Medicaid Transfer of Assets, Health Care Financing Administration, Region 10, Seattle, Washington, October 24, 1985.

[11] Stephen A. Moses, Medicaid Estate Recoveries, OAI-09-86-00078, Office of Inspector General, Office of Analysis and Inspections, San Francisco, California, June 1988.

[12] General Accounting Office, Recoveries from Nursing Home Resident's Estates Could Offset Program Costs, GAO/HRD-89-56, March 1989.

[13] Brian O. Burwell, Middle-Class Welfare: Medicaid Estate Planning for Long-Term Care Coverage, Systemetrics/McGraw-Hill, Lexington, MA, September 1991.

[14] Brian O. Burwell, State Responses to Medicaid Estate Planning, Systemetrics, Cambridge, Massachusetts, May 1993.

catalogued and documented dozens of asset divestiture and sheltering techniques and explored possible corrective actions. Recently, numerous studies by state Medicaid programs and legislative research bureaus have found Medicaid estate planning to be a serious problem without exception.[15] On July 20, 1993, the General Accounting Office published a new report on Medicaid estate planning which concluded that "[o]f the 403 applicants in our sample, 54 percent converted some of their countable assets to noncountable assets and 13 percent transferred assets."[16]

Of course, the legal literature on Medicaid estate planning over the past 12 years positively bursts with information on how to qualify for Medicaid without spending down. For quotations from the formal academic writings of Medicaid estate planners including an immense array of creative divestiture and sheltering techniques, see "Appendix A: Representative Quotes" below. The Bibliographies section of this report lists dozens of articles, reports, and monographs on the subject.

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[15] See the "Other State-Specific Citations" in the Bibliographies section of this report.

[16] General Accounting Office, Medicaid Estate Planning, GAO/HRD-93-29R, Washington, D.C., July 20, 1993. Although GAO debunked some of its own findings, its results were actually highly significant as I explained in a monograph: Stephen A. Moses, Medicaid Estate Planning: Analysis of GAO's Massachusetts Report and Senate/House Conference Language, LTC, Incorporated, Kirkland, Washington, 1993.

Clearly, there is no dearth of evidence concerning widespread Medicaid estate planning. What is far more interesting, however, is the complete lack of hard evidence to substantiate extensive catastrophic asset spenddown. Everyone has heard of people who sold their homes, liquidated their stocks and bonds, and spent down their life savings on long-term care before qualifying for Medicaid. But these stories remain purely anecdotal. No serious research confirms that spenddown is the rule rather than the exception. In fact, the data show that 72.9 percent of single people, 85.4 percent of married people, and 77.7 percent of all people are eligible for Medicaid already when they enter a nursing home.[17]

Nevertheless, until very recently, conventional wisdom among pundits, policy-makers, and the public alike proclaimed that most people in nursing homes on Medicaid did not begin poor, but rather spent down their life savings on expensive institutional care to qualify. In the past few years, dozens of studies[18] have shown that "spenddown" affects only 10 to 20 percent of Medicaid nursing home patients instead of the 50 to 75 percent previously thought. Furthermore, none of these new studies distinguished between genuine spenddown (paying for

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[17] Frank A. Sloan and May W. Shayne, "Long-Term Care, Medicaid, and Impoverishment of the Elderly," The Milbank Quarterly, Vol. 71, No. 4, 1993, p. 585.

[18] See the partial list of "Spenddown Studies and Articles" in the Bibliographies section.

one's own care until the money runs out) and artificial impoverishment (taking advantage of elasticities in Medicaid eligibility rules to transfer or shelter assets). So, as low as the newly documented spenddown percentages are, they include the effects of Medicaid estate planning. Genuine spenddown is therefore even lower still.

If people are not spending down their life savings as private payors before they qualify for Medicaid nursing home benefits, then who is paying for their care? In 1991, Medicaid financed 47.4 percent of all nursing home costs nationally. Another approximately 18 percent came from Social Security benefits contributed by Medicaid recipients toward the cost of their own care. Medicare paid 4.4 percent. The Department of Veterans' Affairs and nonpatient nursing home revenues both contributed roughly 2 percent. Thus, according to HCFA: "Third-party payments, including estimated social security benefit payments, are currently financing almost three-fourths...of all nursing home care."[19] Once we add in payments made from private income sources such as pensions, interest on savings, and contributions from friends and relatives, very little remains of total national nursing home

[19] Helen C. Lazenby and Suzanne W. Letsch, "National Health Expenditures, 1989," Health Care Financing Review, Vol. 12, No. 2, Winter 1990, pps. 8-9.

costs to attribute to spenddown of assets.[20]

There are only four possible ways to explain these phenomena. Either (1) people spend down their savings for home care and other expenses before they apply for Medicaid; (2) they hide or dispose of their assets fraudulently; (3) they divest the assets legally before applying for Medicaid; or (4) they retain their assets in exempt, i.e. sheltered form, while receiving Medicaid. There is very little evidence for the first or second propositions, but ample reason to believe that the third and fourth apply liberally in Florida as the remainder of this report will show. In fact, an earlier study of this subject found that: "...anecdotal evidence from several sources suggests that Medicaid estate planning is a relatively common and growing phenomenon in Florida."[21] The current study will put meat on those bones.

4. Is it true that many elderly patients receiving Medicaid long-term care benefits in Florida would not be eligible if their true financial status were known?

A very common misconception about Medicaid estate

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[20] No estimate of the percentage of nursing home costs financed by private income is available, but it is reasonable to suppose that private payers use income first before consuming assets. Also, Medicaid patients are required to contribute their private income, as well as their Social Security payments, toward their cost of care.

[21] Burton D. Dunlop, Max B. Rothman, and John L. Stokesberry, The Context of Long Term Care in Florida: Interrelationships of Medically Needy, Assets Recovery and Long Term Care Insurance Policy Initiatives, Southeast Florida Center on Aging, North Miami Florida, December 1992, p. 23.

planning is that it is illegal or at least unethical. Actually, fraud and abuse is fairly unusual as a means to qualify for Medicaid nursing home benefits. This is not a "welfare Cadillac" issue. Neither are seniors or the attorneys who advise them morally culpable for taking advantage of legal loopholes. The attorney's first responsibility is to individual clients, not to public policy. Seniors would be fools to forgo benefits which the law entitles them to receive. Nevertheless, the net result of Medicaid planning is to divert scarce public resources from the poor to the prosperous and financially savvy. Medicaid planners are not perverse, but the public policy which empowers them is certainly counterproductive.

While fraud may not be the problem, it is a problem. My discussions with eligibility workers in Florida and many other states suggest that one to five percent of active Medicaid nursing home cases may actually be ineligible because of intentional or unintentional misrepresentation of income or assets. Medicaid estate planning attorneys report that their clients often ask whether the state checks on income and assets. The clients wonder what would happen if they failed to mention a resource, an asset transfer, or an uneasily traceable income stream. In fact, the state does not routinely verify statements by applicants who deny owning available resources. For example, only if an eligibility

worker in Florida is suspicious will he contact the Assessor's office to investigate real property ownership or the Recorder's office to search for possibly unreported asset transfers. Overworked eligibility staff, high turnover, and therefore, necessarily loose property verification standards contribute to the sense that some cheating goes undiscerned.

It is not reasonable to expect eligibility staff or even the Quality Control unit to uncover most fraud and abuse. They are required to treat every case equally. Therefore, intensive investigation of all cases is infeasible. The solution is to develop an error-prone profile to help identify high-cost cases that are likely to involve fraud or unintentional misrepresentation. To minimize or eliminate identification and recovery costs, the state could employ a contingency contractor to design the error screen and apply it to the caseload. Pay the contractor a handsome percentage for terminated fraud cases and hard-dollar recoveries; nothing otherwise.

5. How common is divestiture or transfer of assets in Florida?

Another common misconception about Medicaid estate planning is that millionaires all across America are jettisoning fortunes to qualify for welfare. This is not only counter-intuitive it is logically false. In America today, only 6.4 percent of senior households possess assets in excess

of $500,000. Among elderly female householders, who are the most likely to require nursing home care, the proportion of half-millionaires drops to only 3.3 percent.[22] Obviously, our problem is not an epidemic of Medicaid abuse by the super-rich.

To acknowledge this fact, however, is not to say that millionaires cannot qualify for Medicaid or that none do. At a conference of the National Academy of Elder Law Attorneys two years ago, a prominent Medicaid planner explained how couples with $1.2 million in assets could preserve their wealth while achieving eligibility for Medicaid nursing home benefits.[23] Ironically, according to this authority, Medicaid law actually presented few obstacles. The challenge was to achieve eligibility for public assistance without triggering capital gains or estate tax liability. To many public policy makers, the fact that any truly wealthy people can qualify for Medicaid is unacceptable. The principle involved is qualitative, not quantitative.

Until very recently,[24] divestiture of large amounts of

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[22] U.S. Bureau of the Census (T.J. Eller), Current Population Reports, Series P70-34, Household Wealth and Asset Ownership: 1991, U.S. Government Printing Office, Washington, D.C., 1994, Table 4, p. 7.

[23] As referenced in Stephen A. Moses, "Pauper Planners Potpourri," LTC News & Comment, Vol. 2, No. 10, June 1992, pps. 7-8.

[24] The change occurred on August 10, 1993 with the

liquid assets was easier in Florida than in most other states. Federal rules used to permit a joint owner of a Medicaid applicant's bank account to remove unlimited assets without triggering a transfer of assets penalty. Unlike many other states, Florida did not consider the casual addition of a joint owner to a bank account to be a transfer of assets either. Consequently, anyone could, and many did, divest huge amounts of money overnight by adding their names to someone else's account and withdrawing all of the money. Medicaid eligibility workers in Florida gave me numerous examples. One St. Petersburg case divested $884,055.16 in this manner. In Tallahassee, the son of a Medicaid nursing home recipient sold his mother's exempt home, put the $95,000 proceeds of the sale into a joint account with her, and then withdrew the entire amount immediately for his own private use. His mother remained eligible for Medicaid throughout this process and afterward. Eligibility workers told me that similar cases involving divestment of tens of thousands of dollars were commonplace. When asked how prevalent the joint account divestiture technique was overall, workers replied with estimates as low as five percent and as high as 70 percent. According to one: "Our policy was not to explain the joint account loophole unless the applicant brought it up. Anybody

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enactment of the Omnibus Budget Reconciliation Act of 1993; see below for details.

who knew about it would qualify, anyone else would not." Therein lies the benefit of retaining a good Medicaid planner or studying the self-help guides to Medicaid estate planning.

Given that the joint account gambit is no longer legal, why is it important to discuss here? The joint account issue raises three significant questions: (1) Why did Florida permit unlimited asset divestiture by this method, while other states restricted the practice severely without federal objection? (2) Are there other similar techniques toward which the state takes a relatively permissive stance? And, (3) How many Medicaid estate planning techniques that are common in other states, but were absent in Florida because of the ease of joint account divestiture, will show up here now? I think the answer to the first question is two-fold. Florida eligibility policy staff honestly believed, and they make a plausible case for, their liberal interpretation of the law; but, it is also true that tolerance on the joint asset rule relieved a lot of the pain inflicted on elderly Floridians by the "income cap." Many seniors in need of care who could not qualify for Medicaid because their incomes exceeded $1,338 per month were able to qualify easily after they divested their assets and eliminated the interest income therefrom. As we will see repeatedly throughout this report, state staff see themselves as "eligibility workers" not "ineligibility workers." They often interpret the rules

liberally to help applicants in need qualify for Medicaid benefits. There is nothing wrong with this; it is their job. Nevertheless, creative eligibility expansion by state staff has serious consequences for the ability of public policy makers to target scarce public resources to the neediest cases.

In answer to questions (2) and (3) of the preceding paragraph, there are many other planning practices already available or that will likely become available to qualify for Medicaid in Florida without spending down. For example, anyone--regardless of wealth--can qualify for Medicaid nursing home benefits by giving away everything he owns 36 months before applying for assistance.[25] Eligibility workers reported that this technique is already used frequently in Florida. Prospective Medicaid recipients call in to verify the length of the "look-back" period. Then, they call back periodically to double-check as they wait out the three year interval. Such people may or may not be "spending down" while they wait. They may only be anticipating expensive care needs years in the future. Those who do have to pay for care while they wait can employ the "half-a-loaf" strategy. They give away half their assets, incur half the penalty intended by Medicaid law,

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[25] An exception is that some kinds of income are very difficult to give away, such as Social Security or private pension benefits.

and spend down in half the time they would otherwise have been able to pay for their own care. Although they now require a five year planning window, trusts are another vehicle people can and do use to divest assets while qualifying for Medicaid. Even Charitable Remainder Trusts, previously utilized only by the extremely wealthy to avoid capital gains and estate taxes, are now being recommended for Medicaid estate planning by some elder law attorneys. Finally, divorce is an old stand-by frequently mentioned in the Medicaid planning literature that tends to reappear when other loopholes are closed.

None of these techniques has been present at epidemic proportions in Florida in the past. One reason that the Medicaid estate planning bar has been less active with these asset divestiture approaches in Florida than in Massachusetts and California is that it was so easy to "do it yourself" here. Before the joint account strategy was eliminated, the more esoteric approaches to Medicaid planning were completely unnecessary. The challenge to state Medicaid officials now is to watch vigilantly for the appearance of new divestiture techniques and to control the expansion of existing practices.

6. What does it mean to "shelter" assets in order to qualify for public benefits? How common is this practice in Florida?

Another reason why divestiture is less common in Florida than in Massachusetts and California is that those states have

strong estate recovery programs, but Florida does not. In states with estate recovery programs, divestiture of assets is highly desirable. Retained assets, even if they are exempt and do not affect eligibility, are vulnerable to recovery upon the recipient's or the surviving spouse's death. In states without Medicaid estate recovery programs, asset divestiture is almost unnecessary. It is much easier to convert the same resources into exempt property. Because such property passes to heirs unencumbered at death, the objective of diverting wealth from long-term care costs at public expense is achieved much more easily by means of sheltering the assets in this manner than by transferring them. We will discuss estate recoveries further below. The point here is only to underscore the importance of asset sheltering in Florida.

The single biggest asset shelter available to Medicaid nursing home recipients is the home. Recipients may retain a personal residence and all contiguous property regardless of value. Despite some confusion to the contrary, federal rules protect the home even if the Medicaid recipient will never be able medically to return to it. All that is necessary is an expression of intent to return home made either by the recipient or a personal representative. The home is practically an unlimited potential repository of sheltered assets. One can convert nonexempt liquid assets into exempt status easily by paying off a mortgage, purchasing a more

expensive house, or investing in household improvements like a room addition or a new roof. Nationally, 77.3 percent of elderly households own their homes and 82.5 percent of those that own their homes own them free and clear of mortgage debt. The median value of seniors' homes is $70,418 and the mean is $95,175. Net home equity held by people over the age of 65 in America today exceeds $1.5 trillion.[26] Home ownership among Medicaid nursing home recipients is usually much smaller, although it is still highly significant.[27] Unfortunately, we lack data on the home ownership of seniors and Medicaid nursing home recipients in Florida. Possibly the proportion of senior owners is lower than elsewhere if elderly immigrants sell their family homes before retiring in Florida and rent or purchase less expensive residences upon arrival. In any case, the fundamental point remains incontrovertibly true: anyone with excess nonexempt assets can shelter them quickly in an exempt home in order to qualify for Medicaid. In the absence

[26] Personal communication, February 7, 1994, with Bruce Jacobs, Director, Public Policy Analysis Program, University of Rochester, Rochester, New York. Source: American Housing Survey for the United States in 1991, Bureau of the Census.

[27] GAO found that "about 14 percent of Medicaid nursing home recipients own a home" in its study of eight states in 1989: General Accounting Office, Recoveries from Nursing Home Resident's Estates Could Offset Program Costs, GAO/HRD-89-56, March 1989, p. 19. An important, but yet unanswered, question is: what becomes of seniors' homes between the time when they are still living in the community and when they end up in a nursing home on Medicaid?

of an estate recovery program, such assets pass unencumbered to heirs.

Household goods and personal effects are also exempt for purposes of determining Medicaid nursing home eligibility. Technically, there is a limit of $2,000 on net exempt equity in such property. In practice, many eligibility workers follow a policy similar to the military's "don't ask, don't tell, don't pursue." According to one respondent who trains eligibility workers: "The $2,000 limit is rarely used. Even though we know the house is full of antiques, we ignore them." Most workers use "negative interviewing technique" concerning household goods. For example: "You don't have anything of value in your home do you?" This issue may seem insignificant. On the other hand, a popular self-help book on Medicaid estate planning which has sold more than one million copies nationally contains this advice:

> 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....Here's another loophole that a nursing-home resident may want to consider. He or she could buy a brand-new--and expensive--ring right before going into a nursing home. After all, the law doesn't limit this exclusion to rings purchased at the time of a wedding or engagement.[28]

[28] Armond D. Budish, Avoiding the Medicaid Trap: How to Beat the Catastrophic Costs of Nursing-Home Care, Henry Holt, New York, 1989, p. 39.

It is not difficult to imagine how people could shelter large amounts of money in household goods and personal effects in order to avoid spending them for long-term care expenses.

Medicaid policy in Florida exempts one automobile of any value whether or not the recipient is married, although federal law permits a $4,500 limit on an unmarried Medicaid nursing home recipient's personal automobile. Even a second car worth $2,500 or less may be retained by a Medicaid nursing home recipient if it is designated as an asset to pay for burial expenses. Although I found no one who had actually seen it used yet, the "two Mercedes" loophole is wide open in Florida. Because one can own one car of any value and because transferring an exempt asset (other than a home) does not trigger the usual penalty on asset transfers, one could buy an expensive automobile, give it away, buy another, give it away, and so on until any amount of money has been depleted.

One shelter in particular is devastating to Florida's Medicaid budget. It is almost ghoulish to have to mention the state's policy on burial accounts, burial savings, and burial funds; prepaid burial trusts; funeral plans; burial-designated automobiles; life insurance equity exempted for burial; cremation contracts; cemetery plots; and mausoleum vaults. Bottom line: elderly Floridians who need nursing home care can bury virtually unlimited assets in prepaid funeral expenses. Individual cases have protected $10,000, $20,000,

even $35,000 in this manner although workers agree it averages only $4,500 per case. In addition, each recipient can--and most do--designate another $2,500 of resources for burial over and above the $2,000 in otherwise exempt assets mentioned earlier. One worker told me that 65 percent of Medicaid nursing home recipients shelter assets from long-term care expenses by this means; another said 75 percent; a third said 90 percent. Consensus was closer to the higher than the lower estimate. The Medicaid eligible population for FY 1993-94 in Florida's ICP (Institutional Care Program) is 46,489.[29] If only three-fourths of these people have prepaid for burials ($4,500) and set aside resources or an automobile for burial costs ($2,500), then $244,067,250 has been made unavailable to pay for their long-term care costs. Medicaid pays instead.

While no one would begrudge a fellow citizen a decent burial, it is important to realize that this policy often indemnifies upper middle class heirs against the cost of burying their parents. Nor does the state follow up after a recipient's death to be certain that resources sheltered to finance funeral expenses are actually used for that purpose. One eligibility worker even speculated: "I think [families] are making business with the funeral home owners." It is

[29] Agency for Health Care Administration, Summary of Services: Florida Medicaid, Tallahassee, Florida, January 1994, p. 5.

reasonable to ask whether expensive prepaid burial reserves[30] are the best possible use of public funds when genuinely destitute seniors are denied eligibility for prescription drugs in Florida under the MEDS (Medicaid Eligibility Designated by SOBRA [Sixth Omnibus Budget Reconciliation Act of 1986]) program if their income exceeds 90 percent of the poverty level. According to one Medicaid nursing home eligibility policy expert: "That's why we do not have a lot of sympathy for Medicaid planners. This was very upsetting. People are concerned they will die because they cannot get their medicines, while our Medicaid nursing home program exempts thousands of dollars for burial expenses."

Many other Medicaid shelters are available in Florida. One can own a business, or a rental property, or a mortgage. Although the income from such properties is countable, it can often be reduced by ostensible losses like a "write-off" for income tax avoidance purposes. "Unavailable" property is not considered in determining eligibility. The Medicaid recipient may own a gold mine with other investors or purchase a half interest in his children's (themselves quite possibly over age 60) otherwise free-and-clear home. As long as the co-owner

[30] We checked with three funeral homes in Tallahassee, Miami, and St. Petersburg. The average minimum cost for burial was $878; the average for a service and burial was $1,725. Therefore, the prepaid burial allowance permitted by Medicaid is relatively expensive.

refuses to liquidate, the asset remains uncounted for purposes of Medicaid eligibility. Even if there is no co-owner, property listed for sale remains uncounted if it does not sell. According to one Florida eligibility expert: "Most property put up for sale is not sold before the people die. The property just passes to their heirs." A worker told me that since Florida clamped down on joint accounts, irrevocable annuities for community spouses have become "the big thing" for sheltering assets.

I think the point on asset shelters is sufficiently made. They can protect large amounts of assets; they are much easier to arrange than divesting assets; and, in the absence of estate recovery, they are equally as effective as transferring assets. The reader may scan "Appendix A: Representative Quotes" for a more comprehensive list of asset sheltering techniques.

7. How do people find out about asset shelters, resource transfers and other Medicaid estate planning techniques?

Having studied Medicaid estate planning throughout the United States and having read hundreds of articles on the subject by members of most states' bars, my sense is that Medicaid planning is not as widespread or intense in Florida as elsewhere. Yet! Interviewees for this study provided the following quotes:

> Medicaid estate planning is big time. There are attorneys whose whole practice is in circumventing

> rules to become eligible for Medicaid. There are books and estate planning courses on Medicaid eligibility. The attorneys even go to condos in south Florida and give seminars. (Eligibility policy expert)
>
> People contact us because they want to know what the rules are. It is obvious that they are planning to use the rules to see if they can find a way to become eligible. Chances are they tell their attorney and the attorney contacts us too. They have to pay the attorney for what they could have gotten from us for free. (Eligibility worker)
>
> I talk to about two attorneys a week. Multiply this times my four counterparts. That is eight per week and 30 or so per month. They ask about property, trusts, and asset limits. They are real interested in transfer of assets, penalties, length of the look-back period, etc. (Eligibility worker)
>
> We are starting to see quite a bit of Medicaid planning. As a supervisor, I get calls frequently asking what are some of the loopholes, what can we do, what is your opinion? A lot of the attorneys are making quite a profit. A lot of young attorneys are beginning to get good at hiding assets, setting up annuities, and so on. (Eligibility supervisor)
>
> We object to providing benefits for people who could pay their own money while we have to turn away people who are just a little over the income cap. Sometimes, we tell them if they just used the interest on their savings, they could pay privately for care. But, we have to be so careful not to offend. (Eligibility worker)
>
> We have a lot of wealthy attorneys and doctors whose parents are on Medicaid. We had a senator once. I would be embarrassed to admit it. (Eligibility worker)
>
> People who have the savvy to hire a lawyer get the breaks. (Eligibility supervisor)

Private lawyers are not the only professionals who dispense advice on how to use public programs to avoid

spending personal assets for care. Legal services attorneys, hospital discharge planners, social service agencies, nursing home admissions staff and social workers, physicians, financial planners, and geriatric care managers provide the same assistance often free of charge. This is not unethical or inappropriate. It is a valuable public service, although an extremely expensive one in terms of social costs and one that benefits people with assets at the expense of public resources originally intended for the poor.

Sometimes Medicaid estate planning advice is dispensed wholesale. Workers in one Florida district office told me about a guardianship program that helps Medicaid applicants create retroactive debts to consume excess nonexempt assets. "The guardianship program will not lose a hearing. That is a given. They just find judges to sign the orders. This happens frequently." Another example of wholesale Medicaid estate planning is a large religious long-term care facility. "This organization has it down to a science. By the time its residents apply for Medicaid, they have already turned over all their assets to the facility. Their experts keep up on our policy. They make sure the maximum number of assets are transferred including homes. By the time their residents go from the retirement side to the nursing home side, they are eligible for Medicaid." No one knows how widespread wholesale Medicaid planning is in Florida. It behooves the state to

investigate this issue carefully and soon.

The single biggest source of information about Medicaid planning opportunities, however, is the "wheelchair telegraph." As long-term care becomes an issue in people's lives, they read an article, see a television show, or talk to a friend. The word spreads quickly about how to handle the problem. The first step for most people is to call the eligibility workers at the District offices of the Department of Health and Rehabilitative Services.

The Department's policy is to explain Medicaid rules fully, but not to encourage people to transfer or shelter assets. It is routine, for example, to tell all inquirers and applicants that they may retain $2,000 of exempt assets, another $2,500 for burial expenses, a further $2,500 of life insurance equity, a home of any value, a car of any value, a prepaid burial trust of any value, and so on. "Most of us explain the policy, but we do not give a course on how to qualify." In one meeting, however, a worker told me that "we encourage people to set up burial trusts." His supervisor interrupted abruptly with this correction: "we only tell people what they can do, not what they should do." Other workers made similar slips of the tongue frequently during my interviews.

The reality is that Medicaid eligibility workers care deeply about the people they serve and want to help them. One

said: "I always have mixed feelings. I feel sorry for people who saved $200,000. They resent turning it over to a nursing home. They were productive. They paid taxes. They don't mind paying for the poor. But they feel entitled to something too." We have no way of measuring the full cost to the State of Florida and the United States government of the public's routinely maximizing every possible asset exclusion. Nor can we determine whether a given applicant's eligibility or ineligibility depends more on the luck of the draw between eligibility workers than on his economic status. What we can say for certain is that the $2,000 Medicaid asset limit, which is so often mentioned in public policy discourse as a draconian obstacle to care, rarely applies. It is usually replaced by a much higher *de facto* limit. As one eligibility policy expert told me: "We don't believe in penalizing people because the asset limit is $5,000 and they happen to have $10,000." The fundamental point is that Medicaid asset limits are elastic. They depend more on information provided by field staff in private eligibility interviews than on formal public policy established by the state and federal legislatures.

8. Isn't asset sheltering and divesting moot in Florida because of the "income cap" that keeps the well-to-do off Medicaid?

Ineligibility falls like a guillotine in Florida on anyone with income over $1,338 per month. One penny in excess

of that limit disqualifies an applicant for Medicaid nursing home benefits. The fact that private nursing home care averages more than $2,400 per month in Florida makes no difference. People who fall into the "Utah Gap," so named for that state's desert canyon precipices, must depend on friends, relatives, and private charity for their care; or they go without.

The personal tragedy and public policy ramifications of Florida's income cap have been eloquently described by Dr. Jill Quadagno, Mildred and Claude Pepper Eminent Scholar in Social Gerontology at the Florida State University Institute on Gerontology in Tallahassee and her colleagues.[31] Ira Wiesner, a thoughtful private attorney of national prominence and chair of the Elder Law Section of the Florida State Bar, told me that three of his clients have died as a direct result of the income cap. Tess Canja, a board member of the American Association of Retired Persons and chair of the Department of Elder Affairs' State Advisory Counsel speculated that potential estate recoveries could not amount to much in Florida because people who meet the income cap are not likely to possess significant assets. In a recent report, Larry Polivka, Burton Dunlop, and Max Rothman estimated that:

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[31] Jill Quadagno, Madonna Harrington Meyer, and J. Blake Turner, "Falling Into the Medicaid Gap: The Hidden Long Term Care Dilemma," The Gerontologist, Vol. 31, No. 4, 1991, pps. 521-526.

"About 11,000 people now fall into this gap group in Florida, and it would cost about $100 million ($45 million in general revenue) to fund a medically needy program."[32]

Virtually everyone I interviewed for this project attacked the income cap as a great burden on elderly Floridians and a serious public policy mistake. Everyone with an opinion proposed a "medically needy program" as the most sensible solution. (A medically needy income eligibility standard solves the problem by allowing people with excess income to "spend down" on medical and long-term care expenses in order to qualify for Medicaid.) Unfortunately, no one had any practical ideas on how to pay for such a liberalization of eligibility policy and lawmakers in Florida tighten their grip on the public purse strings every time the issue comes up. My experience from consulting with other states is that many more of them are planning to drop medically needy programs in order to save money than are planning to add such programs to serve more seniors.

I believe that Florida can implement a medically needy nursing home eligibility program within the next five years and save money in the process. Before I can make a credible

[32] Larry Polivka, Burton D. Dunlop and Max B. Rothman, Long Term Care in Florida: A Policy Framework for Expanding Community Programs and Increasing Administrative and Service Delivery Efficiency, Florida Policy Exchange, Center on Aging, University of South Florida, Tampa, Florida, 1993, p. 27.

case for that position, however, the reader must understand how the current "income cap" actually works. I will also have to explain why, in combination with other critical public policy initiatives, the income cap can be eliminated without causing a fiscal hemorrhage.

Florida's income cap of $1,338 per month amounts to $16,056 per year. According to the Census Bureau, the median income of elderly men is $14,548 per year; the comparable figure for elderly women is $8,189.[33] In other words, the median senior who needs nursing home care qualifies for Medicaid nursing home benefits even under the income cap. When we consider that older sub-groups of seniors who are more likely to require nursing home institutionalization have even less income, it becomes evident that a very substantial proportion of elderly people are unaffected by the income cap.[34] In fact, one analyst concluded that "...meeting the income test for Medicaid eligibility for nursing home care is usually not too difficult...all but relatively higher income elderly are eligible."[35]

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[33] U.S. Bureau of the Census, Current Population Reports, Series P60-184, Money Income of Households, Families, and Persons in the United States: 1992, U.S. Government Printing Office, Washington, D.C., 1993, Table B-15, p. B-33.

[34] Unfortunately, we were unable to obtain Florida-specific mean and median income and asset data by age. Numerous respondents insisted that such data is not available.

[35] Edward Neuschler, Medicaid Eligibility for the Elderly

Social Security payments average $6,634 per year and 92.6 percent of seniors receive them. Interest on savings average $2,970 per year and 66.7 percent of seniors receive them. Private pensions average $8,278 per year and 33.0 percent of seniors receive them.[36] No other single source of income is available to as many as 20 percent of seniors. If we add up the three primary sources of seniors' income listed above, the total is $17,882. This figure exceeds the income cap of $16,056 by $1,826. Therefore, a senior who received an average measure of all three of the most common sources of seniors' income could reach below the Medicaid income cap by doing no more than divesting or sheltering assets to eliminate interest income. We established above how easy this is to do.

Finally, is it true that "median seniors" lack significant assets for later estate recovery? Among married-couple households over the age of 65, median net worth is $147,904; excluding home equity which is exempt for Medicaid purposes, the figure is $56,080.[37] This amount is below the

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in Need of Long-Term Care," National Governors' Association Center for Policy Research, Washington, D.C., September 1987, pps. 17, 20.

[36] U.S. Bureau of the Census, Current Population Reports, Series P60-184, Money Income of Households, Families, and Persons in the United States: 1992, U.S. Government Printing Office, Washington, D.C., 1993, Table 34, p. 178.

[37] U.S. Bureau of the Census (T.J. Eller), Current Population Reports, Series P70-34, Household Wealth and Asset

$72,660 "community spouse resource allowance" permitted in Florida so Medicaid nursing home eligibility is no problem. For male householders over 65 years of age, median net worth is $64,381 or $17,322 excluding home equity. A new car would shelter the remaining assets. For elderly female householders, median net worth is $59,521 or $12,689 excluding home equity. In this case, a high-end prepaid burial trust would achieve Medicaid nursing home eligibility quite effectively.

The point of the exercise in the preceding paragraphs is to demonstrate that even under an income cap eligibility system, most seniors qualify for Medicaid long-term care benefits without employing sophisticated estate planning advice and that they retain very substantial exempt assets that could be recovered from their estates to help finance an expansion of program benefits to the medically needy.

9. What is Medicaid estate recovery; why is it important; and where does the issue stand in Florida?

Medicaid estate recovery is the practice of recouping benefits paid to a legitimate recipient from the estate of the recipient and/or the estate of a surviving spouse. Medicaid estate recovery has been pursued by at least a handful of

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Ownership: 1991, U.S. Government Printing Office, Washington, D.C., 1994, Table J, p. xv.

states almost since the inception of the program in 1965. The Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 codified Medicaid estate recovery as a voluntary program which states could opt to pursue with the assistance of Federal Financial Participation (FFP). By last year, approximately 28 states were collecting estate recoveries although far fewer states had aggressive programs that included best practices such as liens, central recovery units, and comprehensive training for eligibility workers. The Omnibus Budget Reconciliation Act of 1993 made estate recovery mandatory. As the Asset and Resource Transfer Survey that we conducted for this project demonstrates (see Appendix C), many states are moving expeditiously to implement this new federal requirement.

Over the years, numerous studies of Medicaid estate recovery have been conducted. The Bibliographies section below contains references to them. They include projects by many federal and state investigative agencies as well as private companies and research institutions. Without exception, the comprehensive studies have concluded that estate recoveries are cost effective and that safeguards in federal and state law protect recipients and their dependents from undue hardship. Reporting on the results of one early study, the Inspector General of the U.S. Department of Health and Human Services made these points in a 1988 letter to

Florida's ex-Governor Bob Martinez:

> Many people with median and higher income and resources qualify for expensive nursing home Medicaid benefits while two-thirds of the elderly poor are excluded entirely from Medicaid.
>
> Few States recover effectively from estates so that most recipient assets pass to heirs who did not share in the cost of care instead of going back to the taxpayers who paid the bills.
>
> Effective use of transfer of assets rules, liens, and estate recoveries can save a State 5 percent or more of total nursing home vendor payments. Such savings permit more generous eligibility policies and a far more humane approach to long-term care funding.

The Inspector General observed that Florida recovered $640,941 from the estates of deceased Medicaid recipients in 1985. He estimated that the state's annual recoveries could exceed $18,400,000 "if Florida recovered from estates at the same rate as the most effective state in the country [Oregon]" and that even "if Florida recovered from estates at the same rate as the top ten recovery States in the country, annual recoveries would" still exceed $3,909,000.

Those estimates were based on data from nine years ago when Florida spent $364 million on Medicaid nursing home care. Today, the state spends more than three times that much on the Institutional Care Program,[38] and potential estate

[38] Fiscal Year 1993-94 estimated total nursing home care expenditures were $1,214,125,963 according to the Assistant Secretary for Medicaid, Office of Program Analysis, Medicaid Statistics: March 1993, Tallahassee, Florida, May 18, 1993, p. 12.

recoveries--using the Inspector General's same formula--would equal **$61.6 million** if Florida could achieve at the same rate as the leading estate recovery program in the country. Potential recoveries would be $13.0 million even if Florida could only recover at the lower level of effectiveness of the top ten recovery states.

Instead of developing Medicaid estate recoveries as recommended by the Inspector General, however, Florida allowed collections to dwindle from nearly two-thirds of a million dollars in 1985 to almost nothing last year. One elder law attorney interviewed for this project said that he has tried to pay back Medicaid benefits from a client's estate, but "they won't even tell me where to send the check." Although field eligibility staff still faithfully fill out and send in HRS Form 325, the "Notification of Public Assistance Recipient's Death," which used to initiate the estate recovery process, it remains unclear what use is being made of the form now. The Medicaid Third Party Liability Unit conducted a study of Medicaid estate recoveries several years ago, but no one can find a copy. The study's author recalled, however, that the district legal counsels who collected from estates often resented this duty because it diverted them from more service-oriented issues such as handling elder abuse complaints. Finally, a Florida Supreme Court decision took the steam out of estate recoveries by excluding the

"homestead" from an individual's estate if "any natural person" has a legitimate claim on it.[39] Unfortunately, State staff who are working on how to respond to the new federal mandate on estate recoveries and on how to handle the "homestead" issue were unavailable to contribute to this study given the narrow time constraints.

We have demonstrated above that asset divestiture has been largely unnecessary in Florida because of the absence of an estate recovery program. Sheltering assets is much easier and achieves the same purpose when Medicaid recipients' estates pass unencumbered to heirs. We have also shown that, despite Florida's relatively strict "income cap" eligibility policy, one can reasonably predict that large amounts of sheltered assets are available for estate recovery. It remains only to explain how Florida could achieve estate recoveries on a par with Oregon's model program.[40]

To borrow a currently popular phrase among policy wonks: "this is not rocket science." The key to successful estate

[39] See the discussion of this issue in Burton D. Dunlop, Max B. Rothman, and John L. Stokesberry, The Context of Long Term Care in Florida: Interrelationships of Medically Needy, Assets Recovery and Long Term Care Insurance Policy Initiatives, Southeast Florida Center on Aging, North Miami Florida, December 1992, p. 30. The Florida Supreme Court Ruling is included in that publication as Appendix 13.

[40] For a detailed description of Oregon's estate recovery program, see General Accounting Office, Recoveries from Nursing Home Resident's Estates Could Offset Program Costs, GAO/HRD-89-56, March 1989, pps. 25-39.

recoveries is KISS: "Keep it simple, stupid." The idea is to find estates to recover and to recover them as inexpensively and efficiently as possible. (Liens are merely a sub-category of estate recovery to which the same principles apply.) The first step is to find out quickly when a Medicaid nursing home recipient dies. Years of practical experience have shown that the best source of this information is the local eligibility worker and/or the personal representative of the recipient. The next step is to ascertain whether Medicaid has made sufficient payments on a case to warrant recovery efforts. If not, no further effort is necessary. If so, the final step is to contact the personal representative of the deceased recipient, determine whether or not a recoverable estate exists, and file a claim.

In other words, one begins with a manageable amount of information and proceeds by an orderly process of elimination and prioritization to target staff efforts onto the most recoverable cases. Once this process has been refined and perfected manually, certain elements of it can be automated cost-effectively. The secret, however, is to start small, experiment, adopt procedures that work, drop those that do not, work the best and easiest cases first, measure progress in actual dollars recovered, and add staff and budget proportionately to the program's actual success. For example, for every $100,000 recovered, Florida might give the recovery

program an extra $20,000 to grow and improve until its recovery ratio levels out at 10 or 15 to one with total recoveries approaching five percent of the Medicaid nursing home budget. This is how most private businesses (and nearly all successful ones) begin. Nothing government does is more like a private business than estate recovery. Therefore, Florida would be wise to consider retaining a private contractor to run the estate recovery program on contingency. For little or no up-front investment, the state could generate a major new nontax revenue source.

Several of the reports on Florida's Medicaid program that I read in preparation for this study shared the opinion that the state should pursue estate recoveries aggressively. Nevertheless, I was still surprised to find almost a consensus among our 70 interviewees in favor of collecting from estates in order to generate revenue to finance the lowering of eligibility barriers. To be sure, there are obstacles to implementing an effective estate recovery program in Florida, but only one problem is critical. Seventy percent of the net worth of the median elderly household is in a home,[41] so the homestead exemption issue in Florida must be resolved before the state can maximize estate recoveries. From discussing

[41] U.S. Bureau of the Census (T.J. Eller), Current Population Reports, Series P70-34, Household Wealth and Asset Ownership: 1991, U.S. Government Printing Office, Washington, D.C., 1994, Table E, p. xi.

this issue with an elder law attorney and with LTC, Incorporated's own general counsel, however, I believe that it may be resolvable short of a state constitutional amendment. Nevertheless, this is a complicated matter that is far beyond the scope of the current study and that the State of Florida should address thoroughly post haste.

10. Even if Florida could collect $62 million annually from estates, that would still leave us $38 million per year short of the price tag for a medically needy institutional care program. Where are we supposed to find the rest of the money?

Despite Florida's relatively strict income eligibility criteria, Medicaid pays for about 67 percent of all nursing home patient days in the state. This proportion is roughly equal to the average Medicaid nursing home dependency level in all states.[42] According to Gary L. Crayton, Chief of Medicaid Program Analysis, a reduction in Medicaid nursing home census from 67 percent to 57 percent would save the Medicaid program approximately $160 million per year.[43] In conjunction with savings from aggressive Medicaid estate recoveries, this cost reduction would be more than enough to finance a medically

[42] "Overall, Medicaid paid for a slightly larger share of nursing resident days in 1990 than 1989, 71.6 percent versus 69.5 percent respectively." The Guide to the Nursing Home Industry, 1992, HCIA and Arthur Andersen & Co., Baltimore, Maryland, 1992, p. 15.

[43] This data was provided in a table transmitted by official correspondence on January 31, 1994.

needy institutional care program for the state.[44]

The problem, however, is that Medicaid nursing home census is not going down in Florida. It is going up. Medicaid paid for only 61.6 percent of nursing home patient days in 1987, but financed 67.3 percent in 1992. That is an increase of over one percent per year. Unfortunately, the converse of the potential savings computation in the preceding paragraph is also true. An increase in the Medicaid census from 67 percent to 77 percent would cost the state an extra $160 million annually. Such an increase in Medicaid nursing home expenditures would seriously exacerbate current state budget problems and further obstruct efforts to enhance home and community-based services.

Thus, the key questions that must be answered are: why has Medicaid nursing home census been increasing in Florida and what can be done to reverse the process. I have already explained at length how people can qualify for Medicaid nursing home benefits without spending down in Florida. I have also explained why this alternative is attractive to recipients, their heirs, and their attorneys. There is no need to establish a causal connection between generous

[44] Furthermore, there is no reason to stop at a ten percent reduction in Medicaid nursing home census. I am prepared to make the case that over the long term, using the strategy proposed in this report, Medicaid census in Florida's nursing homes can be reduced to 30 percent or less while improving access to care for rich and poor Floridians alike.

eligibility and the increase in Medicaid nursing home census. The two phenomena belong together like two sides of the same coin.[45]

Having reconceptualized the problem in this way, the ultimate solution practically slaps one in the face. The logical steps to reduce Medicaid nursing home census, save the tax payers hundreds of millions of dollars, and simultaneously, improve access to quality long-term care for all seniors are these:

•. First: **Eliminate asset divestiture altogether.** Seniors who struggled through the Depression, fought World War II, and scrimped and saved to put aside a small estate should not be induced into self-expropriation to obtain long-term care.

•. Second: **Establish generous Medicaid nursing home eligibility income and asset limits.** Let Grandpa and Grandma keep their money. They earned it and they need it. Public policy should not indemnify their heirs for taking the money

[45] It is interesting to note that several experts on this subject have attributed recent increases in Medicaid nursing home eligibility to liberalizations introduced by the Medicare Catastrophic Coverage Act of 1988. For example, Brian O. Burwell, Middle-Class Welfare: Medicaid Estate Planning for Long-Term Care Coverage, Systemetrics/McGraw-Hill, Lexington, MA, September 1991.

away from them prematurely.

•. Third: **Institute the strongest possible Medicaid estate recovery program.** Give middle class seniors back their dignity. Let them repay the Medicaid benefits they receive while alive out of the wealth that remains when their last, surviving, exempt, dependent relative dies. It is not welfare if you pay it back.

•. Fourth: **Educate the public aggressively about the risks of long-term care.** Make sure everyone knows that Medicaid is a loan, not an entitlement for the middle class and that "going bare for long-term care" has serious consequences, i.e. asset spenddown or estate recovery.

•. Fifth: **Encourage high quality, affordable alternatives to Medicaid nursing home care.** Use strict, but reasonable regulation to foster private geriatric care management, home and community-based care, and long-term care insurance.

These action steps are easier said than done. They raise almost as many questions as they answer. We have to respond to these new questions before we can operationalize this proposal with specific recommendations.

11. What are the main objections to closing Medicaid eligibility loopholes and recovering from estates?

Medicaid estate planners often observe that their clients are not rich, but only normal middle class people facing the financial catastrophe of long-term care. I asked one of the

elder law attorneys interviewed for this project what an average client's income and assets might be. She told me "$40,000 per year in income, $100,000 to $200,000 in assets and a modest home owned free and clear." Census data place people with that level of income and assets in the fourth quintile of wealth, far above the median senior.[46] Although it is tragic for anyone to spend down on long-term care, surely the greater tragedy is that most children below the federal poverty level are excluded from Medicaid altogether.

Another common objection is that Medicaid estate planning clients are usually already desperately ill; they have no other choice but Medicaid; it is too late for them to pay privately for home care or purchase long-term care insurance. This point is well-taken, but it begs an important question: why do people end up at the end of their lives unprepared for the single biggest financial risk they face? Most Medicaid planning books, articles and seminars urge people to plan years in advance of illness to arrange trusts, transfers and gifts. As long as they can divest or shelter all of their assets even at the last minute, it should come as no surprise that few people plan ahead to pay for long-term care or

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[46] U.S. Bureau of the Census (T.J. Eller), Current Population Reports, Series P70-34, Household Wealth and Asset Ownership: 1991, U.S. Government Printing Office, Washington, D.C., 1994, p. xi.

purchase insurance against the risk.

One Florida elder law attorney observed to me that he "has acquaintances who have enough annual income to purchase the average small hospital, but when they get an acute illness, they get their care paid for by Medicare, whereas a chronically ill person is wedged into the welfare program." This too is tragically unfair. It raises the question, however, whether America is more likely to provide nursing home benefits to the wealthy in the next few years or to lose Medicare altogether. According to the New York Times on April 7, 1993: "The Clinton Administration warned today that the principal trust fund for Medicare, which finances hospital care for 35 million elderly and disabled people, would run out of money in 1999...The financial condition of Medicare's hospital insurance trust fund has deteriorated since April of last year, when Government actuaries predicted that it would be exhausted in the year 2002."

The biggest fear about closing Medicaid loopholes and requiring estate recoveries is that such a policy will discourage seniors from obtaining needed care. State Medicaid programs that responded to this project's "Asset and Resource Transfer Survey" questionnaire (see Appendix C) raised this concern repeatedly. It is true that many seniors and their families are likely to postpone Medicaid eligibility if they become responsible for paying back the cost of the care out of

the elder's estate and the heirs' inheritance. Demand for any economic good goes down when its price goes up. That fact is one of the main reasons the new policy will save tax payers and the Medicaid program a lot of money. It does not necessarily follow, however that seniors will fail to obtain the long-term care they need. In fact, the policy may encourage families to pull together, take care of their elders at home longer, avail themselves of less expensive private services like adult day care and assisted living, and obtain private insurance in order to postpone or reduce Medicaid estate recovery liability.

Another related point is critical to make. Medicaid estate planning frequently shades into financial abuse of the elderly. For example, where does legitimate asset transferring end and theft of a parent's assets begin? Elder law attorneys have to be extremely careful about who their client is: the adult child who stands to receive an early inheritance by placing a parent on welfare or the infirmed elder whose life savings could purchase red carpet access to top quality care in the best private-pay nursing home? When the state of Oregon suspects that a Medicaid recipient's wealth has been expropriated, it petitions the court to appoint a private attorney as conservator to protect the senior's interests. Such conservators have reversed illegal transfers, relitigated abusive divorce decrees, invaded

improper trusts, and partitioned undivided property. Oregon pays the attorneys on contingency so the state has no cost unless the assets are recovered. Recovered assets are used to indemnify the state for benefits already paid or to allow the Medicaid recipient to pay privately for care in the future. This is a highly creative way to enhance adult protective services while sending the message to the public that long-term care is first and foremost a personal and family responsibility.

12. Didn't the Omnibus Budget Reconciliation Act of 1993 (OBRA '93) solve the asset divestiture and estate recovery problems already?[47]

After years of infuriating anecdotes and irrefutable evidence on widespread Medicaid estate planning, Congress and President Clinton recently laid down the law. The Omnibus Budget Reconciliation Act of 1993[48] closed some eligibility loopholes and required states to pursue recovery from recipients' estates. Specifically, OBRA '93 extended the transfer of assets look-back period from 30 to 36 months (60 months for trusts), eliminated the 2.5-year cap on

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[47] Part of this section is adapted from an article I published in the February 1994 issue of LTC News & Comment entitled "Undaunted Divesters Dig Deeper."

[48] President Clinton signed OBRA '93 on August 10, 1993. Most of its provisions became effective by October 1, 1993. To keep their Medicaid state plans in compliance, states have until one calendar quarter after the next session of their state legislatures to implement necessary statutory changes.

ineligibility penalties for uncompensated asset transfers, ended multiple or pyramid divestment (which Florida did not permit anyway), plugged the joint account divestiture loophole (which had been devastating Florida financially), constricted the use of certain trusts to qualify for Medicaid nursing home benefits, and extended the divestiture penalty to transfers of income (as well as assets) and to noninstitutionalized recipients. OBRA '93 not only required all Medicaid programs to pursue estate recoveries, but it also empowered states to define "estate" more broadly than before in order to encompass assets such as life estates, joint tenancies, living trusts, etc. that previously evaded recovery. On the other hand, the law sets no standards with regard to estate recovery and leaves states wide latitude in how aggressively they pursue this new revenue source.

Most commentators assume that OBRA '93 will succeed in controlling Medicaid estate planning. To its credit, the Florida Medicaid program has moved thoughtfully and expeditiously to implement the new eligibility rules. Early indicators from across the country on OBRA '93's potential effectiveness, however, are not good. It appears that prosperous people with access to the right legal and financial advice will continue to find ways to qualify for Medicaid nursing home benefits without spending down and without estate recovery liability.

Consider these recent quotes from some leading Medicaid planning attorneys: "WE STILL BELIEVE THAT ALMOST ANYONE CAN BECOME MEDICAID ELIGIBLE FOR LONG-TERM CARE BENEFITS EVEN IN CRISIS." (Emphasis in original.) "[OBRA '93] restrictions won't keep middle- and upper-income seniors off Medicaid..." "Numerically, most of the techniques we use are still there." "It is worth trying anything once; then network and tell each other what we got away with." "Now we have more complicated [Medicaid] plans, but we still have plans. We are going to bill more. OBRA '93 was bad for our clients, but good for us."[49]

How can Medicaid planners work around the seemingly severe restrictions of OBRA '93? First, they intend to take full advantage of Medicaid planning techniques that were left untouched by the new rules. These include but are not limited to unrestricted asset transfers three years in advance of application; giving away half the assets or arranging automatic monthly withdrawals and transfers in order to reduce any penalty period by half; purchase of exempt assets such as homes, cars or costly, pre-paid funeral arrangements; giving away an expensive but exempt car, replacing it with another and repeating the process until all countable assets are

[49] Source: the "1993 Elder Law Institute" in St. Louis, November 1993, sponsored by the National Academy of Elder Law Attorneys. None of these quotes are attributable to Florida Medicaid planners.

depleted; paying adult children for their help pursuant to a formal "purchase of services" agreement; gifting or entrusting assets to the community spouse or a minor or disabled child; petitioning for increased resource allowances (sometimes $150,000 or more) without risk of denial; counseling a responsible spouse to refuse to support a dependent spouse and openly defying the state to sue; using divorce to sever marital responsibility altogether; and transferring exempt assets (other than the home) with impunity to avoid estate recovery.

Second, Medicaid planners are devising some ingenious new strategies to work around OBRA '93. These include charitable remainder trusts; family limited partnerships that divert assets into unavailable, and hence exempt, status; purchasing an interest in a third party's (such as an adult child's) home thereby rendering otherwise countable assets unavailable and unlienable; returning transferred assets to the transferor in order to erase the eligibility penalty (as expressly permitted by OBRA '93) and then converting the assets into exempt or unavailable property; taking maximum advantage of new guidelines on hardship waivers that are expected to be much more lenient than in the past; using the new trusts authorized by OBRA '93 for disabled persons under age 65 and/or managed by a non-profit association as part of a trust pool; working around income caps by negotiating with nursing homes, moving

clients to lower levels of care, or exporting infirmed seniors to medically needy states; and carving up real estate interests into non-probate property to avoid estate recovery.

Clearly, OBRA '93 was a good start but it does not complete the job. Congress will have to revisit these issues. In the meantime, state Medicaid programs will need to seek federal waivers in order to implement adequately tight asset control methodologies.

13. Didn't OBRA '93 at least resolve the income cap problem by authorizing irrevocable income trusts?

OBRA '93 contains an ingenious, back-door approach to the income cap problem. To have required that all states adopt medically needy income criteria for their institutional care programs would have raised serious objections as yet another of the infamous "unfunded federal mandates." So Congress mandated "irrevocable income trusts" instead. These trusts permit individuals whose income would otherwise exceed the $1,338 per month cap to divert their income away from consideration in the eligibility process. The only drawback to families is that "the State will receive all amounts remaining in the trust upon the death of such individual up to an amount equal to the total medical assistance paid on behalf of the individual...."[50] At least the principle here is sound:

[50] 42 USC 1396d(4)(B)

give people the care they need now and let them pay back the state later. Some of the practical ramifications of these trusts are less promising though, as will become evident below.

Irrevocable income trusts are a great boon to Florida's seniors. For all practical purposes, they eliminate the income cap. They permit people to qualify for Medicaid who would otherwise have fallen into the "Utah gap." Even more interesting, however, the law places no limit on the amount of income that can be diverted into such a trust. So theoretically, someone who is already paying privately for nursing home care could divert income into a trust, qualify for Medicaid, lock in the program's much lower reimbursement rates, and defer payment of the nursing home bill until death. The irrevocable income trusts might also allow much more income to pass to community spouses. Once eligible, an institutionalized spouse can shift up to $1,816.50 per month to a spouse at home. By eliminating the income cap, these trusts appear to allow families to protect a much larger amount of income from payment for care and from recovery by the state after death.

Therefore, irrevocable income trusts are likely to be a very expensive proposition for Florida's Medicaid program. An economic impact statement prepared by the state Medicaid program estimates that 11,000 individuals currently ineligible

because of income could qualify for Medicaid if they establish trusts. If only half of these people follow through and set up the trusts, Medicaid nursing home costs will increase $4.6 million this year, $3.7 million next year, and $6.5 million the following year. The "Long-Term Care" section of the Florida Health Plan puts the bill even higher: "It is estimated that this new provision will cost the state 13.1 million dollars in 1994-1995, and 19.8 million dollars in 1995-1996 in matching funds to the Medicaid nursing home program."[51] Furthermore, personal income that now goes to offset a recipient's Medicaid cost of care would not be available to reimburse the state until after the recipient's death if it is diverted into a trust. "The possibility of Florida totally recouping its expenditures from these trusts in future years is unclear."[52] Already, the St. Petersburg district office reports a "huge stack of irrevocable income trusts waiting for final approval." Nor will the Medicaid program bear the cost of these new trusts alone. State eligibility policy experts have "heard from members of the public that their attorneys wanted them to sign contacts for $1500 to $2500 to set up income trusts." Ongoing legal

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[51] Agency for Health Care Administration, The Florida Health Security Plan: Healthy Homes 1994, Tallahassee, Florida, December 1993, p. 136.

[52] Ibid.

maintenance fees for this kind of trust are likely to be $500 or more per year.

Florida Medicaid staff have been hustling to resolve the problems with irrevocable income trusts and to implement a sensible policy for the benefit of elderly citizens. In the meantime, however, a federal bureaucratic muddle has derailed the whole process. The Health Care Financing Administration (HCFA) interprets OBRA '93 to require grantors to give up all rights to the income they divert into these trusts. Unfortunately, other federal laws prohibit people from irrevocably alienating their right to Social Security or private pension benefits. In other words, the new policy is gridlocked by a governmental Catch 22. [Postscript as of April 21, 1994: On March 17, 1994, after completion of this manuscript but before its public release, the Medicaid Bureau Director of the Health Care Financing Administration issued a memorandum entitled "Miller-Type Trust Exemption Under OBRA '93--Information" intended to clarify this issue, break the policy deadlock, and authorize limited use of irrevocable income trusts.]

Senior advocates, at least the ones I spoke to during this project, would much rather see Florida move directly into a full-fledged medically needy eligibility system than tinker around with a makeshift contrivance like irrevocable income trusts.

14. How did we get into this mess in the first place where Medicaid pays almost exclusively for nursing home care which seniors would rather avoid while ignoring home and community-based care which most seniors prefer?

Every study I read in preparation for this project (and almost every person I interviewed) said Florida should spend more money on home and community-based care and pay for it by reducing future increases in nursing home costs. That is a little bit like supplementing your food budget by begging the landlord not to increase your rent. In this case, the landlord is an already underfinanced nursing home industry facing an imminent demographic age wave with a capped bed supply. The elementary economics of supply and demand suggest that this situation will get a lot worse before it gets any better unless some underlying conditions and assumptions are changed.

In fact, nursing home costs in Florida increased 83 percent from 1988 to 1992, while funding for community-based programs went up only 15 percent in the same period. In real, inflation-adjusted dollars, expenditures for home care have actually gone down in Florida since 1985.[53] According to the Florida Health Plan: "Expenditures for nursing home care are

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[53] Larry Polivka, Burton D. Dunlop and Max B. Rothman, Long Term Care in Florida: A Policy Framework for Expanding Community Programs and Increasing Administrative and Service Delivery Efficiency, Florida Policy Exchange, Center on Aging, University of South Florida, Tampa, Florida, 1993, p. 13.

eight times the expenditures for community-based care."[54] There are no signs that this relationship will change any time soon. Most state legislators are not convinced that home and community-based care can save enough money to offset the induced demand and moral hazard of providing public financing for services that families, friends, relatives, and charities are now providing for free. Ironically, home care is more cost-effective for many frail and infirmed seniors, but we cannot afford to pay for it publicly.

In one of the best summaries that I found of Florida's elder care malaise, Lou Comer of the State Insurance Department lamented:

> Despite case management, Medicaid waivers, screening, and other cost containment programs, the poor elderly face long waiting lists for community care services--demand consistently exceeds the funding for those programs. Access to residential and nursing home facilities is hindered by low government assistance/reimbursement rates. The inherently negative effects of institutionalization are exacerbated by chronic nurse shortages and patient neglect and abuse in some facilities. Welfare (Medicaid) patients and residents particularly, are often robbed of their dignity and self-respect, along with their autonomy, by the [long-term care] system. Although the number is unknown, many people must be 'suffering silently' because they are unable to accept 'welfare' or are not eligible for assistance or do not know how to access services.[55]

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[54] Agency for Health Care Administration, The Florida Health Security Plan: Healthy Homes 1994, Tallahassee, Florida, December 1993, p. 135.

[55] Louis J. Comer, Long-Term Care: A Florida and National

We cannot expect to change this disastrous situation until we understand why it exists.

When Florida joined the Medicaid program in 1970, long-term care was not yet a big issue, but it was on its way to becoming one. People were already living longer and dying slower often at great inconvenience and expense to their families. That was the time when a strong, private home and community-based care industry could have developed. Spending out-of-pocket, families would have opted for the least expensive level of care appropriate to meet an impaired elder's needs: first a home health aide, then adult day care, followed by assisted living, with expensive nursing home care only as a last resort. Instead, with every good intention, Medicaid made them an offer they could not refuse: free long-term care for as long as Grandma lived if, and only if, they would put her in a nursing home. No federal transfer of assets restrictions detracted from this opportunity in the beginning. Anyone could give away everything and Medicaid would pay. This policy suppressed the development of home and community-based care and private long-term care insurance for many years: "You can't sell apples on one side of the street when they are giving them away on the other."

Crisis, Florida Department of Insurance, Office of the Treasurer and Insurance Commissioner, Tallahassee, Florida, June 3, 1991, p.3.

So, what exactly did happen? Form followed funding and the rest is history. Home and community-based care languished for lack of financial oxygen. Families had no incentive to pay for home care when the government offered the confidence and safety of professional institutional care for free. Nursing homes sprang up on every corner to take advantage of the big new funding source. "Roemer's Law" (a built bed is a filled bed) applied with a vengeance, because there was no market discipline, i.e. no price limit on demand. Of course, Medicaid costs skyrocketed quickly out of control. Therefore, in the mid-1970's, government implemented CON (Certificate of Need) programs on the principle that "we can't pay for a bed that does not exist." Capping supply only drives up prices, however. So the government had to cap prices also. Thus began the differential between Medicaid and private pay nursing home rates. With Medicaid rates artificially reduced, nursing homes had to charge private patients more. But the more expensive private nursing home care became, the bigger incentive people had to qualify for Medicaid. Eligibility bracket creep made it easier and easier to qualify for Medicaid as politicians sought to deliver relief against catastrophic long-term care costs. In time, so many nursing home residents were receiving Medicaid at reimbursement rates less than the cost of providing the care[56] that quality of care

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[56] "Because Medicaid pays nursing homes less than the cost

became a major problem. You should not expect to get high quality care when nurses' aides can make more money working in fresh vegetables and soda pop at the local Taco Bell than Medicaid will pay them for working in blood and feces at the nursing home. Thus, Congress interceded again with the Omnibus Budget Reconciliation Act of 1987 which compelled nursing homes to hire more nurses' aides, train them better, and generally provide higher quality care. Unfortunately, OBRA '87 provided no extra money to cover these added expenses. With no other choice remaining but ultimate insolvency, nursing home associations started suing their state Medicaid programs under the Boren Amendment (a federal law that guarantees at least minimal Medicaid reimbursement levels). State Medicaid programs have tried to save money by diverting frail seniors from nursing homes to assisted living facilities by means of home and community-based services waivers. Regrettably, government does not have enough money even to pay the nursing homes adequately much less to retrofit a new home and community-based care system this late in the process. So we have ended up in a war of all against all, fighting over need vs. expense, home care vs. institutional care, and public vs. private financing. Policy makers, senior

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to provide the service, many nursing homes are reluctant to accept Medicaid patients." United Seniors Health Cooperative, Long-Term Care: A Dollar and Sense Guide, Washington, D.C., 1988, p. 32.

advocates, providers and insurors are frustrated, angry, discouraged, cynical, and broke.

The solution is clear. Stop discouraging people from buying home and community-based care and private insurance by providing them free nursing home care. Obviously, to achieve this goal, we should not eliminate all of the Medicaid exemptions and force people to impoverish themselves. That would be morally callous and politically disastrous. Instead, again: eliminate asset divestiture; establish generous Medicaid eligibility criteria; recover from estates; educate the public about the risks of long-term care; and encourage high quality, affordable alternatives to Medicaid such as geriatric care management, home and community-based care, and long-term care insurance. When the choice is pay now for home care and private insurance or pay later anyway in estate recoveries after dying in a nursing home on welfare, the public will choose wisely.

15. What is the status of long-term care insurance in Florida today?

Elaborate proposals to expand long-term care services abound in Florida. They all recommend centralized planning and coordination, a full continuum of care, patient self-determination, and local case management. The one thing each

plan lacks, however, is a way to pay for these services. Designing a long-term care system without considering financing is like building a moonship without considering gravity. Neither one is going to get off the ground.

There are only two sources of financing for long-term care: public funds or private funds. Public funds are scarce for reasons explained above and probably will remain so. Private funds tend not to move into long-term care, because of the relatively easy availability of Medicaid. If Florida adopts the policies recommended in this report and makes public long-term care financing harder (because of closing loopholes) and/or less desirable (because of estate recovery) to obtain, it behooves the state to be sure that Floridians have access to a high quality, affordable, private financing alternative.

In today's marketplace, private long-term care insurance is the primary alternative to paying out of pocket for home health or nursing home care. Unfortunately, many of the respondents to this study had a very negative opinion of private long-term care insurance. They claimed that it is too expensive for most seniors, often lacks important product features, and is subject to marketing abuses. On the other hand, many other respondents believed that the problems with long-term care insurance can be solved and that this product could play an important role in a long-term care financing

system less oriented toward public financing. Tess Canja of the American Association of Retired Persons (which markets its own policy) opined that the products have greatly improved in the last few years. Margaret Lynn Duggar, a highly-respected long-term care expert and former state official, said she recommends long-term care insurance to certain clients. Two of the three elder law attorneys that I interviewed for this project mentioned that they recommend private long-term care insurance whenever clients can qualify for it medically and financially. Lou Comer of the Insurance Department has written: "insuring for [long-term care] makes economic sense for those with assets they want to protect or for those in the Medicaid gap who do not qualify for public financial assistance."[57] An eligibility worker in St. Petersburg said: "I've been getting calls about private long-term care insurance. People have money to buy insurance, but cannot find anyone to sell it."

Florida has a reputation for strong regulation of private long-term care insurance. A major study of these products in the mid-1980's showed the way. The 1988 Florida Long-Term Care Insurance Act standardized benefits and provided consumer protection. Florida is in "near compliance" with the National

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[57] Louis J. Comer, Long-Term Care: A Florida and National Crisis, Florida Department of Insurance, Office of the Treasurer and Insurance Commissioner, Tallahassee, Florida, June 3, 1991, p. 66.

Association of Insurance Commissioners' model standards.[58] The Insurance Department employs ten staff members including an actuary to regulate long-term care insurance products.[59] The Department also publishes an excellent "Consumer's Guide" that explains how to evaluate various products and their features.[60] Florida's SHINE (Serving Health Insurance Needs of the Elderly) program engages seniors themselves in helping their peers to make wise insurance choices. Clearly, Florida is well-positioned to encourage the availability of quality private long-term care insurance as an alternative to widespread Medicaid dependency.

People who sell long-term care insurance, however, often say that Florida discourages private coverage. They point to eligibility loopholes and suggest that Medicaid planning is like being able to buy fire insurance after the house is in flames; why buy it before? They complain about state threats to mandate inflation coverage and nonforfeiture benefits,[61]

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[58] Robyn I. Stone, et al., State Variation in the Regulation of Long-Term Care Insurance Products, American Association of Retired Persons, Washington, D.C., January 1992, p. 14. See Appendix B entitled "Compliance with National Association of Insurance Commissioners' (NAIC) Guidelines."

[59] Ibid., p. 26.

[60] Tom Gallagher, (State Treasurer & Insurance Commissioner), 1993 Long-Term Care Insurance Consumer's Guide, Florida Department of Insurance, Tallahassee, Florida, 1992.

[61] Inflation protection assures that insurance benefits go

because this would be like requiring everyone to drive a limousine in order to improve automobile safety: all the cars on the road would be safe, but most of us could only afford bicycles. They worry that Florida's requirement that policies include at least half as much home care as nursing home care drives up premiums and discourages people from purchasing any coverage. They are concerned that new regulations under consideration to cap commissions, stabilize premium rates, and even to eliminate medical underwriting could destroy the financial viability of private long-term care insurance. They note that state officials and publicly financed reports often criticize long-term care insurance, but rarely point out ongoing improvements in and positive aspects of the products.

Some middle ground needs to be found. Regulators do not want to destroy the private long-term care insurance market in the absence of adequate public financing. Responsible insurors do not object to strong, but reasonable regulations that establish a level playing field. Given Florida's long-term care financing emergency, the state should encourage communication, reconciliation, and cooperation between the Insurance Department and the insurance industry.

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up to counteract increases in the cost of care. Nonforfeiture benefits provide a return of some kind even if a policy is lapsed.

16. What about the Robert Wood Johnson Foundation public/private partnership approach to encouraging long-term care insurance?

The Robert Wood Johnson (RWJ) plan encourages people to buy private long-term care insurance by offsetting or eliminating Medicaid asset spenddown requirements. The idea is to make long-term care insurance more attractive and affordable to lower income people by protecting a higher level of assets. OBRA '93 discouraged new RWJ plans by refusing to exempt them from the Medicaid estate recovery requirement. Florida decided not to pursue this kind of public/private partnership.

The RWJ approach has several problems. Most people would not buy insurance to avoid a spenddown liability years in the future (that may not even happen) if they can wait to see if they need nursing home care, hire an attorney, and get Medicaid to pay the bill anyway. Thus, the Robert Wood Johnson partnership will only succeed once the transfer of assets problem is resolved. But after Florida controls Medicaid estate planning, it will no longer need to exempt people from the spenddown liability to get them to buy insurance. They will buy private long-term care insurance to avoid estate recovery.

Controlling Medicaid planning and recovering from estates will also enhance the affordability of private insurance, another objective of the RWJ approach. With their

inheritances at stake, heirs will be more likely to help parents purchase policies to protect the estate. They will also consider long-term care insurance to protect their own estates, because the premiums are so much lower at younger ages. Seniors themselves will be more likely to consider home equity conversion to generate the additional income needed to afford a policy. Research shows that 57 percent of homeowners can afford long-term care insurance from the proceeds of a reverse annuity mortgage.[62]

Another problem with the RWJ approach is that it uses public welfare resources to aid the middle class. This feature elicited strong opposition from the American Association of Retired Persons.[63] Finally, insurors worry about what may happen to their insureds if Medicaid nursing home costs continue to escalate. Will Medicaid be able to pay for comparable quality care as people use up their limited private benefits under the partnership and phase onto public assistance?

One aspect of the Robert Wood Johnson partnership idea

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[62] Aldo A. Benejam, "Home Equity Conversions as Alternatives to Health Care Financing," Medicine and Law, Vol. 6, No. 4, May 1987, pps. 329-348. Home equity conversion allows a homeowner to generate a limited cash stream from home equity with no requirement to repay the loan until after death.

[63] Jane Tilly, "Linking Medicaid Eligibility to the Purchase of Private Long-Term Care Insurance," AARP Public Policy Institute Policy Brief, Washington, D.C., 1989.

has been highly praised universally and remains a strong tool for states to use even after OBRA '93. That aspect is to engage the state Insurance Department in evaluating long-term care insurance policies, identifying the better products, and encouraging the public to consider purchasing them. Florida could adopt this part of the RWJ plan without incurring future unfunded liabilities for the state's Medicaid nursing home program.

17. How do Florida's unique demographics affect the state's long-term care financing options?

Florida is definitely unique demographically. Some people think that the state's unusually large and transient senior population bodes ill for the economic future. An equally good case can be made, however, that Florida's burgeoning population of "old-old"[64] can be a boon to the state financially as newly retired senior immigrants have been in the past. Inasmuch as "Florida's current age structure foreshadows the future age structure of the United States..."[65] in approximately 20 years, it is very important to make that positive case.

During this project, I compiled the following list of

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[64] People over age 85 who are the population cohort most vulnerable to long-term care institutionalization.

[65] Leon F. Bouvier and Bob Weller, Florida in the 21st Century: The Challenge of Population Growth, Center for Immigration Studies, Washington, D.C., 1992, p. 31.

Florida's unique or unusual demographic characteristics.

- Florida has the highest proportion of elderly in its population among the United States.
- Florida's seniors come disproportionately from out of state.
- Florida has lenient estate taxes and no income tax, which makes moving here lucrative financially.
- Florida also has a very attractive constitutional homestead protection.
- Florida's snowbirds and immigrants bring a fortune into the state.
- Florida has a contingent liability from encouraging people to retire here but then having to take care of them when they become incapacitated.
- Partially counterbalancing this is a trend that some seniors move back to their home states when they need long-term care to be closer to their relatives.
- Florida's seniors tend not to live as close to their families as seniors elsewhere in the country.
- Florida's old are younger on the whole.
- Florida's seniors are healthier than seniors elsewhere.
- Florida has the lowest ratio of nursing home beds per 1,000 people over the age of 65 of any state.
- Florida's seniors are more highly educated than seniors elsewhere.
- Florida has relatively low senior poverty rates.

"One thing is certain. Florida will continue to be a haven for elderly retirees from all over the United States as well as from Ontario and Quebec. Florida will remain the nation's oldest state in terms of its share of elderly residents. In this sense, Florida will remain 'different' from all other

states."[66]

If one projects Florida's current long-term care financing system into the future, these demographic characteristics portend disaster. More and more seniors will move into the state. As they become older, frail and incapacitated, the demand for long-term care will increase. More and more nursing homes will have to be built. Pressure on the Medicaid program will escalate. Home and community-based care will be harder and harder to finance publicly. The lack of adequate long-term care financing will exacerbate access and quality problems. More and more public resources will be drawn out of education, highways, crime control, prisons and other necessary programs. In time, Florida will no longer be the haven its citizens dearly wish to preserve.

Now imagine a different scenario. What if Florida implements the recommendations in this report? If it does, each of the characteristics listed above could become a positive instead of a negative factor. To avoid estate recoveries, seniors and families will pull together to take care of their loved ones at home longer, pay privately for community-based care as long as possible and buy long-term care insurance against the nursing home risk while they are

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[66] Leon F. Bouvier and Bob Weller, Florida in the 21st Century: The Challenge of Population Growth, Center for Immigration Studies, Washington, D.C., 1992, p. 93.

still young enough and healthy enough to afford it. Taxpayers will be relieved of the need to support so many people on Medicaid. Long-term care will once again become a profitable, tax paying, private business for providers and insurors instead of a public utility. In time, Florida could become "America's assisted living facility" and generate a net economic gain from long-term care. Under these circumstances, senior immigration into Florida would remain a great economic benefit and the state would still want to attract as many retirees as possible. This paragraph may seem a flight of fancy, but it is plausible if considered in the context of the logic of the whole report.

18. Will President Clinton's health reform plan solve the long-term care problem and make all these issues moot?

The President and Mrs. Clinton have been forthright in acknowledging that the long-term care portion of their health reform plan is not a solution. They call it "just a start." Unfortunately, when Dan Rather talks for two or three minutes about the Health Security Act on the evening news, his last sentence is likely to be: "And the President's plan covers long-term care."

Actually, President Clinton's plan provides for no long-term nursing home care (which is the biggest financial risk seniors face). The plan offers only extended home care. To qualify, individuals must be severely disabled: either

deficient in three of five activities of daily living or suffering from severe cognitive impairment. People who are this impaired probably already need 24-hour-a-day attendants or nursing home care. With $56.7 billion to cover an anticipated average of 2.8 million seniors for the first five years, the plan would only be able to spend $4,193 annually per beneficiary. Even adding in a small state match of five to 22 percent and co-insurance of up to 40 percent, this is not the level of funding for home care that is needed to substitute for institutionalization. When the money is gone, it is really gone; the next applicant in line gets nothing; this will be a "capped entitlement."

The portion of the President's plan called "Medicaid nursing home liberalization" calls for mandatory medically needy programs, $50 personal needs allowances instead of $30, and an increase in the asset limit for unmarried nursing home recipients from $2,000 to $12,000. In other words, the plan hastens Medicaid spenddown and therefore adds significantly to state welfare rolls and Medicaid nursing home costs. There is nothing wrong with this outcome *per se*. These proposals are perfectly in line with the thrust of this report. The difference is that this report also provides a means to pay for the added benefits, an aspect of program implementation that federal mandates often neglect.

Ironically, having sent the message in OBRA '93 that (1)

Medicaid nursing home benefits will be harder to obtain, (2) that all benefits received will be recovered from estates, and (3) that people should plan ahead with long-term care insurance to avoid Medicaid dependency, the administration has offered a long-term care plan that inadvertently implies a promise of publicly financed security in the future. Many people are using the unfounded hope that President Clinton's health plan will protect them against catastrophic long-term care costs as an excuse to avoid exploring private insurance protection. This could prove tragic for them and their heirs someday when they confront the new, stricter Medicaid nursing home eligibility rules and mandatory estate recoveries.

19. Wouldn't it make a lot more sense to have a national social insurance program to support long-term care?

Of all the health care reform proposals currently under consideration in Congress, only one attempts to address long-term care comprehensively. Congressman McDermott and Senator Wellstone have proposed a "single payer" system. Their system requires everyone to contribute according to financial ability, and allows everyone to withdraw benefits according to medical need. They call this approach social insurance and compare it to Social Security. Many people across America believe that this is the right way to solve the long-term care problem.

Leaving aside issues of philosophy and ideology, the main

difficulty with social insurance is financing. America has a $4.4 trillion national debt. Congress recently raised the ceiling on the debt to $4.9 trillion. That is almost $20,000 for every man, woman, and child in the country.

Interest on the national debt exceeded defense as the biggest item in the federal budget during fiscal year 1992. The federal deficit was much lower this year and last because interest rates declined. This is a mixed blessing and an ominous portent, however, because government has refinanced the national debt at the lowest possible short-term interest rates (one to three years) instead of locking in slightly higher rates for thirty years. When interest rates trend back up, as they inevitably do, the country will face almost immediate fiscal duress.

Under these circumstances, we are unlikely to see a big new entitlement for health care, much less one that covers long-term care. In fact, we may be unable to save the entitlement programs we already have. Over half of a representative sample of unretired Americans said they do not believe Social Security will have the money to pay benefits to them when they retire.[67] As mentioned earlier, Medicare's own

[67] "When respondents who are not receiving Social Security benefits were asked whether they agree or disagree with the statement: 'Social Security will have the money to pay benefits to me when I retire,' a majority (51 percent) disagree...46 percent say their confidence has gotten worse [over the past 5 years]." (1991 Advisory Council on Social

actuaries report that it will run out of money in 1999. The disability trust fund will be gone in 1995. Private companies are retrenching on retiree health benefits all across the country. Unfunded public and private pension liabilities are staggering.

It looks like we may not be able to depend with certainty on a beneficent government or a paternalistic corporation to take care of us in the future. Quite possibly, we will take care of ourselves or face dire consequences. In terms of public policy, this may not be all bad. According to Reverend Ike: "The best way to help the poor is not to become one of them."

Security)

THE SENIOR FINANCIAL SECURITY PROGRAM[68]

The politics of aging is changing in America (and in Florida). Today, we are in the latter stage of "third rail" politics. To criticize a senior benefit can still bring instantaneous political death--like touching the middle rail on the subway. But things are beginning to change. The 1989 repeal of the Medicare Catastrophic Coverage Act was the watershed that brought us into the first phase of "greedy geezer" politics. One can already foresee the time when (no matter how inaccurate, unfair, and over-simplified the charge) some politician will lose an election for lavishing one more benefit on "wealthy" seniors at the expense of the long-suffering middle class. The latest furor over Generational Accounting[69] is only an early skirmish in the on-coming

[68] This section is borrowed in principal part from earlier reports on Wisconsin and Montana by the author. It articulates the goals to be achieved by the recommendations in the following section. I found no significant differences in the needs and preferences of the key interest groups in Florida.

[69] Laurence J. Kotlikoff, Generational Accounting, The Free Press, New York, 1992. According to Kotlikoff: "...the baby boom generation has inherited tremendous fiscal liabilities. Yet the fiscal obligations confronting the boomers' children and grandchildren are even larger. Unless generational policy is adjusted and adjusted soon, future Americans will pay at least 21 percent more, even after adjusting for real income growth, than those who have just been born. This 21 percent figure is based on an optimistic scenario concerning prospective government health care expenditures. Ten more years of excessive growth in health care spending could, by itself, more than double the extra payments required of future Americans." (P. 218)

intergenerational war. The only way to avoid the inevitable carnage in our public benefits programs is to bring all the interested parties to the bargaining table now and begin the diplomacy and negotiation. We have to give something to everybody without undercutting anybody.

Who are the main parties to the long-term care financing debate and what do they want? **Seniors** want access and quality in home or institutional care without impoverishment or welfare. **Taxpayers**, and their stewards in government, want limits on Medicaid's explosive growth. **Nursing homes and home care providers** want more private patients at full-pay, non-Medicaid rates. **Long-term care insurers** want a level playing field without the competition of free public benefits for the upper middle class. **Younger and future generations** want to inherit more than a huge public debt. Today, these constituencies are pulling in opposite directions, drawing and quartering the broader public interest. What could harness their energies in a common purpose?

First, we must establish in principle a moral high ground on which everyone can stand with pride and agreement. This is the common philosophy that I found in Florida:

> **We have very limited dollars available for public assistance; we must take care of the truly poor and disadvantaged first; 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 Medicaid 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 and purchase quality private long-term care insurance if it is available and affordable.

Next, we must imagine a program structure that achieves everyone's goals without violating these principles. Such a program would have to do six things:

(1) Maximize income and asset protections for single and married seniors who need long-term care.

(2) Eliminate divestiture and estate recovery avoidance.

(3) Secure property in a beneficiary's possession as a condition of eligibility for publicly financed care.

(4) Recover publicly financed benefits from estates when dependents no longer need the assets.

(5) Encourage the sale of long-term care insurance as an alternative to public benefits and estate recovery.

(6) Educate the public on the advantages of avoiding Medicaid dependency and paying privately for care.

Finally, we must show how this program delivers the key values that each constituency wants to achieve. By maximizing income and asset protections, the program eliminates catastrophic spend-down for **seniors**. By requiring a pay-back from estates, it removes the stigma of welfare. By making people pay their own way (pay me now or pay me later), the program creates an incentive (now nonexistent) for people to purchase **private insurance**. By empowering people to pay privately for care with insurance, it diverts families away from dependency on **Medicaid**. By sending the **home care and**

nursing facilities more full-pay private patients, the program enhances the providers' commercial viability and reduces their reliance on public financing. By infusing new money into long-term care, it enhances the industry's ability to provide good access to quality care for all patients, private-pay and Medicaid alike. By making people spend their own money, i.e. their insurance benefits, on care, the program encourages a wide continuum of cost-effective home, community-based, and institutional options. By stimulating **heirs** to plan ahead for their own long-term care needs and to protect their parent's estates (i.e. their own inheritances), the program ameliorates the biggest danger we face as a nation from the aging of the baby boom generation.

RECOMMENDATIONS: THE FLORIDA FULCRUM

The objective of these recommendations is to reduce Medicaid nursing home utilization from 67 percent of all bed days to 57 percent over a period of three to five years. This is a conservatively achievable goal and could save the state of Florida $160 million per year or 13.3 percent of the Medicaid nursing home budget. Given aggressive implementation of these recommendations, savings within the first year of full implementation could reach $12 to $60 million from a combination of estate recoveries ($12 to $30 million) and cost avoidance ($12 to $30 million). If the state does nothing and Medicaid utilization continues to creep up to 77 percent[70], Florida will need to spend an extra $160 million per year for nursing home care not counting inflation adjustments.

The following recommendations do not stand alone. They must be read in the context of the entire report. Neither are these recommendations comprehensive. They only suggest the magnitude, range, and general direction of the task at hand.

1. Hire a contractor on contingency to design the necessary programs and implement these recommendations. Compensate the contractor with a percentage of the savings from reducing

[70] Medicaid nursing home utilization is already 82 percent in the state of Maine.

Medicaid nursing home census and increasing estate recoveries.

2. Obtain "section 1115" streamlined waivers (as announced by USDHHS Secretary Donna Shalala on August 18, 1993) to implement any of the following recommendations that are not otherwise achievable by changes in state law, regulation or policy.

3. Mobilize a task force of headquarters and field eligibility and legal staff to build on the findings of this study, identify any additional loopholes or unclarities in Medicaid eligibility regulations and policies, recommend corrective actions, and supervise the contingency contractor.

4. Continue efforts already well underway to operationalize, implement, and train field staff on the new OBRA '93 authorities including the extension of the eligibility look-back period to 36 months, the elimination of the 30-month limit on the penalty period, the addition of a "transfer of income" penalty, etc.

5. Track the new OBRA '93 trust and annuity rules closely as they are interpreted by private Medicaid planners and implemented by the Health Care Financing Administration; review Florida law, regulations, and policy in this new

context; and ensure that the new authorities are reflected as quickly as possible in state policy.

6. Verify and track real property and transfers on all Medicaid applicants and recipients through county assessor's and recorder's offices. Use field staff to do these verifications using time saved by delegating all complicated income and asset cases to the paralegal staff of the centralized Medicaid estate recovery unit suggested below.

7. Cap prepaid burial trusts at the minimal cost of a decent burial and monitor larger existing trusts for recovery of excess funds.

8. Discourage excessive purchase of exempt assets (such as automobiles and household goods) to qualify for Medicaid nursing home eligibility by advising eligibility workers not to suggest this practice; by identifying, tracking, and recovering high-value personal property; and by enforcing limits on personal property values that may be exempted.

9. Eliminate the "half-a-loaf" strategy by requiring that the transfer of assets penalty begin when an applicant would have been eligible otherwise if the transfer had not occurred.

10. Having already closed the joint account loophole, act now to rein in abuse of "account rebuttals" whereby relatives claim that assets in joint accounts did not really belong to the elderly Medicaid recipient.

11. Watch vigilantly for the appearance of new divestiture techniques now that the joint account strategy is gone and control the expansion of existing practices.

12. Develop an error-prone profile to identify and terminate fraud and abuse cases.

13. Develop stricter policy and stronger enforcement to control the use of claims by relatives that assets taken from Medicaid recipients should be exempted to compensate them for providing care or services provided before Medicaid eligibility began.

14. Investigate "wholesale" Medicaid estate planning, the practice by public legal assistance programs or private non-profit providers of advising and assisting clients or members to transfer, shelter or encumber assets to qualify for benefits.

15. Establish safeguards to assure that seniors get the care

they need despite stricter eligibility criteria. Adopt the Oregon program described in the text whereby private attorneys retained on contingency represent expropriated seniors to get their resources back from financial abusers.

16. Use the same method to discourage the theft of recipients' income by "protective payees" which creates a problem for nursing homes because it deprives them of the patient's contribution to cost of care.

17. Refer all inquiries from the public and especially Medicaid estate planning attorneys on Medicaid eligibility rules to a central toll-free telephone number in order to save time, discourage eligibility bracket creep and assure that everyone receives exactly the same information.

18. Similarly, refer all complicated long-term care income and resource eligibility cases to a new, headquarters unit highly trained and specialized to enforce uniform statewide eligibility verification rules stringently. Field staff should continue to handle all routine cases and to implement all eligibility decisions reached by the new specialty unit (located within the Medicaid estate recovery program).

19. Take full advantage of the legal interpretation that

Medicaid estate planning may violate the common law of fraudulent conveyances. In other words, a transfer in contemplation of avoiding a future possible creditor, i.e. Medicaid, may be a fraudulent conveyance even if it otherwise complies with Medicaid rules (see the quotation in Appendix C on this subject).

20. Draft an executive proclamation for Governor Chiles to deliver at a press conference declaring that Medicaid in Florida is for the genuinely needy, that measures are being taken to discourage Medicaid estate planning, that restrictions on divestiture of assets are being tightened, that a strong estate recovery program is on the drawing board, and that seniors and heirs should carefully examine private long-term care insurance options.

21. Draft a similar statement as a "Sense of the Legislature Resolution" for introduction in the state House and Senate.

22. Mount a campaign to educate the media, the public, attorneys, judges, eligibility workers, hearings officers, seniors and their advocates, nursing homes, home health agencies, insurance agents and other long-term care interest groups concerning the issues explained in and the public policy changes recommended by this report.

23. Prepare, propose and pass a strong Medicaid lien law as authorized by Section 1917(a) of the Social Security Act. Maryland and Wisconsin have excellent models.

24. Establish a strong Medicaid estate recovery program with a centralized unit of specialists. Oregon, New Hampshire, Massachusetts, Wisconsin and California are good models. An extensive literature on best practices is readily available.

25. Immediately research and implement a solution to the constitutional homestead exemption issue. Protect homesteads, not welfare windfalls.

26. Seek state statutory authority to require nursing homes and financial institutions to remit small "personal needs" and other accounts to the Medicaid estate recovery program automatically upon the death of a recipient. See Oregon's program for example.

27. Require field eligibility staff to notify the Medicaid estate recovery unit immediately upon the death of a recipient. Authorize the estate recovery unit to request and obtain timely income and resource data on deceased recipients from the field.

28. Seek state statutory authority to require attorneys or personal representatives of Medicaid recipients and nursing homes to inform the state when a recipient dies. This requirement impresses the importance of the lien and estate recovery program on attorneys, personal representatives, and judges. It also supplements reports from field staff or clipping services. See Wisconsin's and Massachusetts' programs.

29. Use graphs and charts to measure and display recoveries. Encourage competition among collectors. Give incentive awards to outstanding recovery specialists.

30. Prioritize all estate recovery cases. Work the biggest, most promising cases first. Do not waste the tax payers' money on universal, shotgun approaches.

31. Track real estate ownership even when it is exempt for eligibility purposes. The home is 70 percent of the net worth of the median elderly household and supplies most of the recoverable value in estates.

32. Make use of accounts receivable so recipients or their heirs can pay back the state over time. Expand the use of

"open-ended" mortgages as a way to help people keep the family home by paying back Medicaid benefits with interest over extended periods after a recipient's death.

33. Collect personal property as well as real estate and have a fiduciary maintain and auction the proceeds, e.g. jewelry, paintings, Persian rugs, cars, etc.

34. Extend recovery to benefits received before age 65 to the expanded extent allowed by OBRA '93.

35. Implement spousal recoveries, i.e. recovery from the estates of spouses and other exempt dependents who are predeceased by Medicaid recipients. Federal law prohibits recovery from recipients' estates while a spouse remains alive.

36. Close the joint tenancy with right of survivorship loophole as authorized by OBRA '93. It allows anyone with an attorney to avoid estate recovery.

37. Adopt the strongest possible definition of "estate" to include such assets as life estates, joint tenancies, living trusts, etc. as permitted by OBRA '93.

38. Require the ill spouse's share of the "snapshot" split to go toward cost of care as intended by Congress.

39. Impress upon the Insurance Department the enormous expense to the state of Florida of Medicaid nursing home expenditures, the imminent need to curtail such costs, and the urgency of offering citizens a viable, affordable private insurance alternative.

40. Work with the Insurance Department to resolve regulatory issues (such as the question of whether or not to mandate nonforfeiture benefits) in such a way as to assure access to quality products without driving up premium costs beyond the average Floridian's ability to pay.

41. Coordinate with the Insurance Department to enlist the SHINE program to advise seniors statewide about Medicaid nursing home eligibility changes, liens, estate recoveries and related private long-term care insurance issues.

42. Explore ways to enhance the affordability of private long-term care insurance by (1) encouraging seniors to use home equity conversion (i.e. reverse annuity mortgages) to help finance premiums, and (2) advising adult children to purchase policies for their parents to protect the heirs'

inheritances from private nursing home costs and/or Medicaid estate recoveries.

43. Adopt a mini-version of the Robert Wood Johnson public/private partnership idea: evaluate private long-term care insurance policies, put the state's stamp of approval on the best ones, and encourage people to buy them, but do not promise exemption from Medicaid spenddown liability.

44. Use the savings from these measures to implement a medically needy nursing home eligibility system, but demand the savings first before committing to the extra costs of the new system. That will compel all of the interest groups to work together toward a mutually beneficial goal.

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APPENDIX A: REPRESENTATIVE QUOTES

The following quotations have been culled from over a decade of tracking Medicaid estate planning books, articles, conferences, seminars, and training films. They provide an intense and comprehensive insight into the techniques and rationale of this unusual legal specialization. Full bibliographic citations are located in the Bibliographies section of this paper.

Quotes in favor of Medicaid estate planning (pre-OBRA '93):

"It is true, almost to the point of being a cliche, that benefit programs, whether public or private, are bonanzas for lawyers." (Frolik and Barnes, 1991, p. 715)

"A key element in Medicaid planning is to render property unreachable by the state either during the client's lifetime or after the client's death." (Barreira, 10/90, p. 1)

"The most common problem put to the elderlaw practitioner is how to keep an older person's assets within the family and yet allow the person to qualify for Medicaid." (Regan, 1990, pps. 275-6)

"Planning for Medicaid qualification is not viewed my many commentators on health care for the elderly as immoral, unethical, or fraudulent. Today many middle-class Americans view Medicaid as an entitlement program designed (whether or not intended) to preserve assets to provide for either the support of the community spouse or an inheritance for children...This presents an opportunity for law firms to provide pro bono services to those needing such assistance and unable to pay for it. In addition, an effort should be made to provide low-cost services in this area so that middle-class individuals will be able to obtain the services of qualified advisors at a reasonable fee." (Mezzulo, 1991, pps. 12, 16)

"Just as there is no illegality or fraud involved in taking maximum legitimate tax deductions, there is not illegality or fraud in maximizing governmental benefits. For example, giving away property to qualify for Medicaid benefits easily can be analogized to making gifts in contemplation of death to reduce estate tax. Neither is an ethical question necessarily raised by taking steps, short of illegality, to maximize benefits. The comprehensive literature on the subject rarely raises the issue of the appropriateness of this type of planning." (Herman, 1990, p. 152)

"...it is clear that a substantial portion of the middle class views Medicaid as a legitimate entitlement that may be employed to preserve assets for spousal enjoyment and ultimate inheritance by the family. Congress, in liberalizing the rules applicable when one spouse enters a nursing home and the other remains in the community and the rules relating to assets transfers, and in failing to close apparent loopholes, has knowingly or unknowingly strengthened the perception that opportunities for assistance under the Medicaid system are appropriate estate and financial planning tools." (Donaldson, 1993, p. 95)

"It is important to emphasize to the older client, who may be reluctant to utilize Medicaid because of pride or possible stigma, that participation in Medicaid is not a gratuity but an entitlement like use of a public library or a public park." (Regan, 1991, p. 2-44)

"Careful planning even under adverse state law will still be able to achieve the goal of excluding an applicant's resources for purposes of determining Medicaid eligibility." (Talis, 1981, p. 94)

"There continue to be a number of ways that a single person can structure his or her ownership of assets so that assets can be shifted to other people on relatively short notice to achieve Medicaid eligibility." (Young, 1990, pps. 226-7)

"This article discusses the criteria for, and planning to achieve, eligibility for Medicaid, as the alternative to private pay longterm care, and approaches to maintaining an individual's assets for family use while Medicaid-eligible....Disinheriting the Medicaid applicant is a simple and effective option for the estate plan of an applicant's spouse, parent or child...." (Longenecker, 1990, pps. 131, 138)

"Another asset preservation strategy is for a community spouse to 'just say no' to paying for the other spouse's nursing home care. Say Mrs. Jones holds more money than the state allows for her husband to qualify for Medicaid coverage. If it can be shown that she simply refuses to spend her money on her husband's care, Medicaid coverage will be allowed for Mr. Jones if other easily met requirements are satisfied. This approach has been particularly successful in New York." (Gilfix, 1993, p.38)

"...assets can be reduced by consecutive transfers much more rapidly than by one single transfer." (Gilfix and Woolpert,

1990, p. 56) The authors explain how "Generous George" can qualify for Medicaid, while disposing of $80,000, in 8 months instead of 19 months, as intended by federal law, by giving away his assets in small monthly increments instead of all at once.

"By helping clients plan before the occurrence of disability, by advising clients to make permissible transfers of assets, and by making them aware of relevant administrative regulations on deeming, lawyers can aid in preserving funds to the greatest extent possible." (Oriol, 1985, p. 216)

"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." (Deford, 1984, p. 139)

"Once Medicaid eligibility is established, the community spouse may acquire unlimited assets in her own name. Such assets might be received by gift, inheritance, or by selling the home and, thereby, converting an exempt asset into a non-exempt asset (cash) with impunity." (Gilfix, 1990, p. 45)

"A potential planning technique would be for the community spouse to reallocate his or her assets into forms that pay less income. For example, money market funds could be used to buy zero coupon bonds, gold, or growth stocks, all of which pay no income at all. The community spouse could then legitimately argue that he or she requires a larger allocation of income up to the Monthly Maintenance Needs Allowance." (Wilcox, 3/91, p. 12)

"The careful practitioner asks if an institutionalized spouse or unmarried institutionalized person may inherit any assets, since such inheritance could cause a loss of [Medicaid] and other forms of public benefits eligibility." (Gilfix and Woolpert, 1990, p. 65)

"Many people assume that a family's resources must be virtually exhausted before any help will be available through the Medicaid program. In fact, people in Washington who need nursing home care can benefit from medicaid without devastating their families." (Greenfield and Isenhour, 1986, p. 29)

"Perhaps the best advice under current law is simply to transfer all assets to, and alter the estate plan of, the community spouse. This maneuver would not cause any disqualification period for the institutionalized spouse....Of

course, it would be foolhardy for someone to leave an inheritance (by will, trust, or the laws of intestacy) to the institutionalized spouse after the date of a Medicaid application, for the inheritance could end up being spent for nursing home care that would otherwise have been paid for by the state Medicaid program....For couples who are concerned about nursing home costs and wish to take preventive action well in advance of any need for nursing home care, you may be able to suggest transfers that will preserve a large amount of their assets for their future use or for eventual inheritance by their heirs." (Barreira, 1990, pps. 90-91, see pps. 91 ff. for pre- and post-institutionalization Medicaid sheltering techniques)

"The Medicare Catastrophic Coverage Act of 1988 (MCCA) limited the Medicaid penalty for transferring assets to those applicants who are institutionalized. As a result, those applicants living in the community may freely transfer resources away in order to achieve Medicaid eligibility. This exception also applies to most hospital residents, including long-term patients in chronic hospitals." (The ElderLaw Report, 11/92, p. 8)

"One way to transfer assets prior to institutionalization and still retain the use of the assets is to transfer the assets to a trust. An increasing number of people are using discretionary trusts to insulate non-exempt assets from Medicaid eligibility requirements." (Brent Mitchell, 1991, p. 94)

"...many individuals find it desirable to shelter their income and assets in order to remain eligible for public assistance. A trust is often recommended to achieve such a shelter....Trust mechanisms have been and will continue to be an important aspect of planning for Medicaid eligibility." (Martin, 1987, pps. 185, 208)

"Changes in the Medicaid program enacted by MCCA suggest that spouses concerned about the possibility of an extended stay in a nursing home take action as soon as possible to preserve their accumulated wealth....The estate planner may be serving the best interests of the couple and their children by suggesting the use of a Medicaid trust well in advance of its perceived need." (Barreira, 1989, pps. 109-10)

"Where current law permits, the client may also be able to retain an income interest as a beneficiary of the trust without causing the trust principal to be a Medicaid qualifying asset." (Barreira, January/February 1990, p. 45)

"Recent judicial and administrative agency glosses on the federal regulation on the treatment of trusts appear to have created a legal planning tool which removes virtually all restrictions upon familial wealth retention....Planned impoverishment has been collapsed into a last minute pit stop at an attorney's office to erect a trust shield around assets." (Bagge, 1992, p. 16)

"A trust may be created to insulate personal injury proceeds so that the fund is not available for consideration by the public agency providing for an injured person's support. For example, under the Medicaid statute, such a trust would not disqualify a party from the right to receive that program's benefits." (Kruse, 1990, p. 2187)

"Transferring a principal residence to a trust may be desirable for Medicaid or estate tax planning. This article shows how a trust can be used without sacrificing the tax benefits from the sale of a principal residence." (Bowe, 1991, p. 276)

"By paying off a mortgage, they can magically change assets like cash, which would be lost to a nursing home, into assets that can't be touched....Since there's no limit on the value of a house that they can buy, they may be able to hide most or all of their assets with this one simple technique. This is a giant loophole, which they should feel free to take advantage of." (Budish, 1989, p. 38)

"If a couple has a second vacation home, consider having the couple rent that home and then claim the rental income as necessary for maintaining the community spouse's minimum monthly maintenance needs allowance. If the vacation home is considered necessary for this purpose, it is no longer a countable resource." (Regan, 1993, p. 10-68)

"Whenever an aging person requires a period of nursing home care, all of that person's assets are at risk of loss. Unless one of the safe harbors or loopholes contained in MCCA is exploited, however, chances are that last-minute planning will not succeed and that the home will be lost. Many clients therefore should be persuaded to transfer their homes earlier than they would otherwise have wished." (Barreira, March/April, 1990, p. 107)

"If the person is married, household goods, a car and personal effects are protected <u>without regard to their value!</u>....For example, oriental rugs or paintings that appreciate in value may be worthwhile investments that add beauty and hide assets at the same time." (Budish, 1989, p. 39)

"Here's another loophole that a nursing-home resident may want to consider. He or she could buy a brand-new--and expensive--ring right before going into a nursing home. After all, the law doesn't limit this exclusion to rings purchased at the time of a wedding or engagement." (Budish, 1989, p. 39)

"In regard to assets owned by the welfare recipient, the estate planner needs to be familiar with the number of exemptions and exclusions available under the various federal and state public benefit programs which will shelter assets or income and continue the eligibility of the recipient...Converting assets into exempt assets is a primary goal in planning the estate of the public benefit recipient." (Palmer, 1988, p. 44)

"An alternative to resource gifting and conversion is the purchase of an annuity....the Medicaid estate can usually be reduced by the amount of countable assets used to purchase an annuity." (Forster, 1991, p. 2)

"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." (Hales and Shandrick, 1992, p. 15)

"The new amendment to the Social Security Act (Pub. L. No. 101-239, 103 Stat. 2465, amending 42 U.S.C. 1382b(a)(3)) allows for the exemption of all income-producing property used in a trade or business....In other words, there is now an unlimited exemption for such property....Property used in a trade or business is excluded regardless of its value or rate of return....Critical provisions for advocates to note are that liquid resources used in the trade or business may be excluded from countable resources, and that no limit is placed on such resources (POMS SI 01130.501C.5). Thus, advocates may exclude large amounts of cash in business operating accounts, trust accounts, and the like, that are necessary for use in the business...Ultimately, Medicaid recipients will want to transfer their property to avoid the imposition of a lien and recovery from the estate for Medicaid expenditures. Since

business, farms, and ranches in current use are exempt property, they can theoretically be transferred without penalty. No restrictions are placed on the transfer of this exempt property, unlike the transfer of a home (42 U.S.C. 1396(c))." (Shandrick, 1992, pps. 1-4, emphasis in the original)

"In some states a limited form of life estate retaining lifetime rights of use and occupancy to a family residence transferred to the next generation will protect the property from being considered available for purposes of Medicaid eligibility." (Dench, 1993, pps. 1-3)

"While the public policy issues raised by such a suggestion are obvious, divorce may offer the community spouse more economic protection than do the supposedly protective terms of MCCA." (Gilfix, 1990, p. 46)

"Extreme though the strategy may be, for some couples divorce may be preferable to depleting the estate... particularly if the nursing home resident spouse is beyond comprehending the circumstances." (Young, 1990, p. 227)

"...a common misconception among applicants is that excess resources must be spent only on doctors, hospitals, nurses, medication, and nursing homes. Nowhere in the law is this indicated. Quite literally, an applicant could spend all of his or her assets on something 'frivolous,' such as a 90th birthday celebration of Ziegfield Follies proportion and this should not be cause for denial of Medicaid, because the applicant received 'value' for his or her money." (Schneider and Huber, 1989, p. 142)

"While there are rules against giving away most assets, there are no prohibitions against simply spending money... options might include travel to visit relatives or see the world, or one last tour of Reno's finest establishments." (Gilfix and Woolpert, 1990, p. 42)

"...while the Department of Public Welfare may seek recovery for payments made on behalf of elderly recipients from their estates, careful planning can lawfully defeat the Department's ability to obtain indemnification." (Talis, 1981, p. 90)

"It is substantially easier to obtain placement of a patient in a well regarded nursing home if the patient is or appears to be able to pay privately for six months to a year, than if a patient is unable to do so. Therefore, the goal of financial planning may be to leave the potential patient with adequate funds to pay privately for at least six months."

(Delbaum, 1984, p. 373)

"While a number of asset preservation strategies have been already suggested, numerous others exist and will undoubtedly be developed in the creative practice of elder law." (Gilfix, 1990, p. 46)

"It's common...for people to have undocumented and untraceable assets, such as cash and bearer bonds. If these items were to be surreptitiously transferred, their existence would probably not become known to the authorities. No doubt it is improper to tell clients to make such transfers, but the temptation to hint at them, or to scrupulously avoid finding out if the client has a safe deposit box or undocumented assets, however reprehensible, is strong." (Strauss, Wolf, Shilling, 1990, p. 16)

"The Transfer of Assets procedure to prevent spousal impoverishment has been clearly endorsed as public policy in the United States, based on both federal and state law. Individuals and families should not hesitate to draw upon this public policy to prevent hardship and to serve the wishes of those involved." (Mitchell and Mitchell, 1991, p. 109)

"We have committed an act of piracy--we have broken into the Fort Knox of Government benefits and uncovered the best legal strategies available to you for claiming your share of the gold from the Government's treasure chest....We'll explain how you can 'strike gold' in the Social Security [including SSI], Medicare, and Medicaid programs....With this book we are handing you the treasure map, deciphered from a mine of unintelligible government rules and regulations." (Budish and Budish, 1993, p. xiii)

"...if the individual happens to have about $82 million lying around, he or she could even buy a painting by Renoir to hang on the walls of the house, Black said, adding that he calls this strategy 'burying money in the treasure chest of the house.'" (Schroeder, p. 19)

"Be it ever so humble, or ever so grand, the person's home -- and any amount of acreage contiguous to it -- will not affect her ability to obtain Medicaid....The Medicaid applicant can, as a practical matter, own one vehicle of any value....An additional exclusion applies to property that is considered 'unavailable' because it is a nonliquid asset that cannot for some reason be converted to cash." (Bonnyman, 1990, p. 18)

"So is there any practical way to juggle assets to qualify for Medicaid--before losing everything? The answer is yes! By

following the tips on these pages, an older person or couple can save most or all of their savings, despite our lawmaker's best efforts. Here are the best options: Hide money in exempt assets. Transfer assets directly to children tax-free. Pay children for their help. Juggle assets between spouses. Pass assets to children through a spouse. Transfer a home while retaining a life estate. Change wills and title to property. Write a durable power of attorney. Set up a Medicaid Trust. Get a divorce." (Budish, 1989, p. 34)

Quotes in opposition to Medicaid estate planning (pre-OBRA '93):

"A new breed of legal specialist is advising elderly people how to protect their financial assets, maximize eligibility for Medicaid and avoid being impoverished by the high cost of health care, especially nursing homes." (N.Y. Times, 11/26/87)

"Because of the extraordinarily high cost of nursing home care, even middle-class Americans must face the prospect that they will eventually come to rely on the Medicaid program. Indeed, a cottage industry of consultants has sprung up to advise the elderly on how they can hide or convey their assets so as to meet this welfare program's strict means test." (Longman, 1987, p. 104)

"At least one judge was offended...by divestment. In dissent he indicated that anyone who transfers assets for less than full value and then applies for Medicaid lacks even a 'modicum of decency' and has sunk to 'immoral depths.'" (Dobris, 1989, p. 16)

"The objective of Medicaid estate planning is to avoid using private wealth to pay for nursing home care, and letting taxpayers pay for it instead...State Medicaid officials believe Medicaid estate planning is growing rapidly and has become a serious policy problem. Many attorneys are developing specialty practices in 'elder law' to provide counsel on how the elderly can protect their wealth and still qualify for Medicaid... Medicaid laws which prohibit persons from divesting of their assets for the sole purpose of qualifying for Medicaid have limited impact on actually preventing this practice...Medicaid estate planning creates severe inequities in the distribution of Medicaid benefits. Middle and upper class elderly, and their heirs, are receiving

public benefits, while many truly poor elderly, families and children in the community do not have access to Medicaid because States can't afford to extend coverage to them." (Burwell, 1991, p. 1)

"Nationally syndicated financial columnist Jane Bryant Quinn called the attorney's artificial impoverishment techniques 'immoral, outrageous, unprincipled, but...legal.' Henry Waxman (C-CA), whose House subcommittee has jurisdiction over the Medicaid program, said the legalistic 'charade' of Medicaid planning short-changes the program's intended clientele: the poor of all ages, pregnant women, children, and the mentally retarded. Nursing home experts described how low reimbursement for a growing number of ersatz public patients forces private patients to pay much higher rates." (Summary of Frontline national TV special "Who Pays for Mom and Dad?," which aired April 30, 1991: LTC News & Comment, June 1991)

"We all know that an entire industry has sprung up to advise older people on how to shelter their assets so they can go onto Medicaid if they need nursing home care. Most of this activity is perfectly legal; there are many apparent loopholes in Medicaid policy that permit even some wealthy people to qualify for Medicaid by divesting their assets....We must ask ourselves whether it is just to use scarce resources to subsidize people who can afford to pay their own way or buy insurance to protect their assets. My answer is that it may be legal but it is wrong. Too many Americans lack access to basic health care; I do not think we can afford to drain the nation's health care program for the poor, in order to support those who can protect themselves." (DHHS Secretary Louis W. Sullivan speaking at the 23rd Annual Legislative Conference of the American Health Care Association, Washington, D.C., June 11, 1991, p. 8 of speech)

"Medicaid planning to me is shameful. I suspect one of the areas we will investigate is Medicaid planning and will seek to put a stop to it." (Senator Cohen, R-ME, AHCA Legislative Conference in D.C., June 11, 1991)

"[HCFA Administrator Gail] Wilensky sent a strong message to middle-class seniors who try to hide their assets so Medicaid will pay their nursing-home costs. 'The issue of trying to protect assets is going to have much less sympathy in the future,' she said. 'If it is outside the law, we need to be more vigilant in prosecuting it.' She also hinted she may favor tightening laws that now allow people to shelter assets. 'When there are things that are being done that are within the law, then if you don't like it, you go change the law,'

she said." (Ebert, September 1991, p. 8)

Msgr. Charles J. Fahey, President of the American Society on Aging and a senior associate at Fordham University's Third Age Center refers to "the inappropriate practice now widespread among nonpoor older persons of giving away or sheltering their wealth in order to qualify for Medicaid." (Aging Today, Jan./Feb. 1993, p. 3)

"I am offended by wealthy individuals--with the aid of lawyers like Mr. [name deleted]--taking advantage of the Medicaid program for the poor to finance the transmission of wealth to their heirs at federal and state taxpayer expense. I believe we need to stop this abuse...." (Congressman Henry Waxman quoted in The ElderLaw Report, 10/93, p. 3)

"We are currently in a mileau [sic] that does not aggressively pursue lawyers who actively and materially participate in Medicaid planning for clients. This environment may not continue. We need to be aware that public policy may be read to not only void the systems currently used to qualify our elder clients for Medicaid, but which may implicate us for our participatory involvement - for our making it unlawfully possible to avoid or to impede the recovery rights the state enjoys as obliging creditor ....With some tremor, the author has undertaken the preparation of this paper. The work suggests that in our zeal, as lawyers, seeking to benefit our elder clients in securing medical benefits for them, we may be overlooking responses legally available to those who would be our adversaries.... Fraudulent conveyance laws, in place in every state...appear somewhat obtrusively...to apply to behavior that contemplates avoiding the rights of the state as a creditor. In the context of public benefit planning, we may be wrongly assuming that following the letter of the federal law, the state is pre-empted from applying its statutory or common law equitable remedies for recovery of benefits correctly paid under the federal regulations." (Kruse, 1993, p. CBK-47)

"One of America's great financial shell games is played, unseen, in the offices of lawyers and accountants who counsel the elderly. One minute you see a pile of money. Zip, zip, zip, the next minute it's gone." (Jane Bryant Quinn, 1988)

"As distasteful as the mere idea of pleading poverty 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." (Dunn, 1985, p. 123)

"On the matter of nursing-home costs, the law is quite clear. The bills are your responsibility as long as your money lasts. When you run out, you're rescued by the Medicaid program.... Thousands of older people resent that arrangement. They'd rather get support from the taxpayer right from the start. In this low endeavor, they're counseled by an army of "poverty makers"--law firms, accounting firms, legal-aid offices, social-service centers, nursing homes, even some Medicaid offices." (Jane Bryant Quinn, 1989)

"Manor Care Inc. is the nation's premier provider of long-term care, and its chief executive Stewart Bainum Jr. says the big fiscal threat is not the growing population of the very old, but the number of lawyers specializing in passing the burden of care from well-off families to the taxpayers." (WSJ, 4/7/92, p. A17)

How much money do Medicaid planners earn for artificially impoverishing their clients? "Hourly rates for elder law work range from $85 [per hour] charged by a practitioner in the rural South to $275 [per hour] asked by a Manhattan attorney." "Practitioners say the cost of planning for Medicaid eligibility is difficult to predict. 'In the past year,' Westerman [a Medicaid estate planner] notes, 'the price for the package has ranged from $700 to $1,100.' 'I will almost never charge under $2,000 on a Medicaid plan any more,' says Kuhn [another Medicaid planner]." "Net income ranged from $15,000 in the case of a sole practitioner who recently set up a practice in the rural South, to $240,000 (in a good year) for a principal in a six-person firm in the West." (Coughlin, 12/93, p. 4)

Quotes from Medicaid estate planners and others since the passage of OBRA '93:

"Now we have more complicated plans, but we have plans. We are going to bill more. OBRA '93 was bad for our clients, but good for us.... Numerically, most of the techniques we use are still there....It is worth trying anything once; then network and tell each other what we got away with... Most of my clients get eligible quickly just from thoughtful spending." [Examples: fix the roof or buy a Persian rug.] (Robert Fleming, NAELA Institute speech, 11/21/93)

"The new provisions [OBRA '93] 'will result in a tremendous amount of malpractice' among lawyers who are unaware of the new requirements, predicts Brian Barreira of Plymouth, Massachusetts, who chairs an ABA elder law committee."

(<u>Lawyers Weekly</u>, 9/27/93)

"I think it is very dangerous for a general practitioner to step in without a thorough knowledge of the act and how it is being implemented on a national, state and local level." (Kennedy, 1994, p. 20)

"Most of our clients can still use Medicaid...Take $45,000 and buy a 45 percent interest in kids' house. This makes the resources unavailable. It works in Colorado." (Baird Brown, NAELA Institute speech, 11/21/93)

"Most of the basic planning options that seem to exist today will survive; but many of the more unique, aggressive tactics may or may not survive [p. 1]...WE STILL BELIEVE THAT ALMOST ANYONE CAN BECOME MEDICAID ELIGIBLE FOR LONG-TERM CARE BENEFITS EVEN IN CRISIS...[p. 11] [Emphasis in original.] It is still possible to transfer non-exempt assets (countable) into exempt assets (non-countable) for purposes of obtaining eligibility. The catch will be planning around the estate recovery program...[p. 14] For instance, the conversion of cash into an interest in a third person's residence is a way to shelter cash assets as part of the spend-down amount. The interest in the residence would then be transferred into a limited partnership. This limited partnership interest is not real property and is, therefore, not subject to having a lien placed against it...[p. 16] Carve up the real property interest into non-probate property to avoid estate recovery. This is the life estate interest. Consider having a parent purchase for value, based on actuarial tables, a life estate interest in an adult child's residence that would create an asset that would not have to be liquidated. This seems to avoid estate recovery." [p. 29] (Brown and Fleming, 1993)

"There is nothing immoral, evil or wrong with undertaking [Medicaid] planning so long as it does not violate any rule, regulation or statute." (Brown and Fleming, 1993, p. 1)

"'These restrictions won't keep middle-and upper-income seniors off Medicaid,' says Jeanne Finberg, an attorney with the Los Angeles office of the National Senior Citizens Law Center." (<u>Secure Retirement</u>, Nov.-Dec./93 pps. 14-15.)

"**Old Tactics That are Still Good: Give Assets Away.** Giving assets away [three years in advance] is still the simplest and easiest way to deal with the problem, although it leaves the elderly client totally dependent upon the good faith of their children or others. **Spend Assets on Exempt Items.** Another tactic is to spend the assets on property that won't count for Medicaid purposes...[such as] a home...a new car...household

goods...funeral expenses...and...a burial plot...A client can also reduce his net worth by spending money on travel, which many elderly people enjoy. **Pay Children for Their Help.** Be sure that any payments to children for their services are pursuant to a written agreement, so it's clear that they are not just gifts. **Give Assets to the Other Spouse, a Minor Child, or a Child Who is Disabled.** [Such gifts] will not be penalized. **The Other Spouse Can Petition for an Increased Asset Allowance.** The other spouse can argue that additional assets are needed to generate income...[thereby sheltering in one example an additional] $200,000. **The Other Spouse Can Refuse to Support the Applicant**...In New York, this tactic can be successful even if the spouse's refusal is completely artificial; it is used in that state frequently. **Divorce**...The idea is for the spouse to be given a larger portion of the couple's assets, with little or no support awarded to the applicant. **Sign a Durable Power of Attorney.** All clients should sign a durable power of attorney so that if they become incapacitated, someone else can shelter their assets." (Lawyers Weekly, 9/27/93)

"**Some New Tactics That May Work. Hardship Waivers...Trusts for the Disabled...Trusts Created by Courts.**" (Lawyers Weekly, 9/27/93)

"With a CRT [charitable remainder trust], together with a wealth replacement trust (if needed), the clients can have their cake and eat it too. They can sell their assets, take big income tax deductions, avoid the capital gains, achieve a higher standard of living, avoid or eliminate much of their estate tax problem, and preserve their children's inheritance." (Lawrence Davidow, ElderLaw Report, 11/93, p. 4)

"In general, Medicaid planners see OBRA '93 as a considerable nuisance, but not an impenetrable obstacle to free, taxpayer-financed nursing home care. Their strategy is multi-fold: (1) warn general practitioners that OBRA '93 "will result in a tremendous amount of malpractice" and take over the entire Medicaid planning industry by specializing in ever-more-arcane and expensive techniques; (2) move upscale into acronym trusts (GRITs, GRATs, and GRUTs), charitable remainder trusts, and family limited partnerships in order to attract a wealthier clientele that can afford more complicated estate planning; (3) mobilize politically at the state and federal administrative and legislative levels to "agitate for protections" that soften or repeal OBRA '93 provisions on transfers, trusts, annuities, hardship waivers, and estate recoveries; (4) and branch out increasingly into guardianships

and nursing home litigation through which they can earn fees by suing nursing homes on behalf of underfinanced Medicaid residents." (Steve Moses, LTCN&C, 2/94)

APPENDIX B: COMPLIANCE WITH NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS' (NAIC) GUIDELINES

The following summary explains the degree to which Florida's statute complies with provisions of the NAIC's model long-term care insurance regulation act. Copies of the model act are available from the National Association of Insurance Commissioners or the state Insurance Department.

Source: Health Insurance Association of America, Legislative Bulletin, General No. 3-94, February 11, 1994, distributed as Section 7 of the Proceedings of the 9th Annual Private Long Term Care Insurance Conference, Baltimore, Maryland, February 9-11, 1994.

FLORIDA

1. **LTC Insurance Defined:** Meets most of NAIC language. Requires coverage for at least 24 months. Does not mention that definition includes annuities and life riders or that it also includes policies which provide for payments based on a cognitive impairment or a loss of functional capacity, nor does it mention that insurance may be issued by insurers, fraternal benefit societies, nonprofit corporations, prepaid health plans, and HMOs.

2. **Skilled Care Not Limited:** Meets NAIC language.

3. **ADC/HHC Minimum Standards:** Meets some of NAIC language. However, does not include the following restrictions: 1) requirement that insured need care in a skilled nursing facility if HHC services are not provided, 2) require that the provision of home health care services be at a level of certification or licensure greater than that required by the eligible service, 3) requiring that the insured have an acute condition before home health care services are covered, 4) limiting benefits to services provided by Medicare-certified agencies or providers, and 5) exclusion of ADC services. In addition, omits the following provisions: policies providing home health or community care services shall provide total home health or community care coverage that is a dollar amount equivalent to at least one-half of one year's coverage available for nursing home benefits under the policy (doesn't apply to CCRC's), and HHC coverage may be applied to the non-home health care benefits

provided in the policy or certificate when determining maximum coverage under the terms of the policy.

4. **Preexisting Conditions:** Meets NAIC language.

5. **No Prior Institutionalization:** Meets NAIC language.

6. **30-Day Free Look:** Meets NAIC language.

7. **Outline of Coverage:** Meets some of NAIC language. There is no mention of continuation or conversion.

8. **Shopper's Guide:** Contains no language.

9. **Extraterritorial Jurisdiction:** Meets NAIC language.

10. **Mental Conditions and Alzheimer's Disease:** Meets NAIC language.

11. **Guaranteed Renewable and Noncancelable:** No ltc policy may be canceled, non-renewed or terminated on the grounds of age or the deterioration of the mental or physical health of the insured.

12. **Continuation and Conversion:** Meets NAIC language.

13. **Unintentional Lapse:** Contains no language.

14. **Prohibition Against Post-Claims Underwriting:** Contains no language.

15. **No Attained Age Rating:** Contains no language.

16. **Replacement Notice:** Contains some language. Only requires "a question" to elicit information as to whether the applicant has another ltc policy or whether policy intended to replaced any other accident and sickness or ltc policies in force. Does not require agents to list other insurance policies that they have sold to the applicant and whether they are still in force.

17. **Inflation Protection:** Meets the majority of the NAIC language, but the following are not included: the requirement that inflation protection continue without regard to an insured's age, claim status or claim history, or the length of time the person has been insured. No mention of not being required of life insurance policies. Where policy is issued to a group, the required offer shall be made tot he group

policyholder.

18. **Inflation Rejection:** Contains no language.

19. **Loss Ratio:** Meets NAIC language.

20. **Standards for Marketing:** Contains no language.

21. **Incontestability Period:** Contains no language.

22. **Licensing:** Contains no language.

23. **Reporting Lapses and Rescissions:** Contains no language.

24. **Appropriateness of Recommended Purchase:** Contains no language.

25. **Penalties:** Contains no language.

26. **Nonforfeiture Benefits:** Requires the mandated offer of nonforfeiture provisions.

27. **Agent Compensation:** Contains no language.

APPENDIX C: ASSET AND RESOURCE TRANSFER SURVEY

Pursuant to RFP #94-02, LTC, Incorporated sent a questionnaire to all 50 states and the District of Columbia. The purpose of this survey was to enlist each state's assistance in collecting information on initiatives to control Medicaid estate planning and to implement the provisions of OBRA '93. Only approximately half of the polled states replied. Nevertheless, their answers give an excellent sense of the current status of these issues across the country. Directly below are the names and phone numbers of persons to contact if the reader would like additional information. Then we provide the text of each question and states' responses.

AR: Contact: Richard Dahlgren, Office of Chief Counsel 501-682-8934 or Carol McKnight, Medicaid Eligibility Unit 501-682-8259.

CA: Contact: Gerald B. Rohlfes, Third Party Liability Branch 916-445-0416.

CO: Contact: Colleen Bryan, manager, Third Party Resource Section 303-866-2232.

DE: Contact: Catherine C. McMillan, Chief Administrator, Division of Social Services/Medicaid 302-577-4905.

GA: Contact: Gary Ries, Manager, Third Party Administration 404-657-9502.

IL: Contact: Jim Haertel 217-782-1239.

IN: Contact: Michael Staresnick, Family and Social Services Administration 317-232-2121.

IA: Contact: P.C. Keen 515-281-8782.

KS: Contact: Dennis Priest 913-296-3349.

KY: Contact: Carrie Banahan 502-564-5020

MD: Contact: Lawrence P. Triplett, Director, Medical Care Finance and Compliance Administration (or someone in his office) 410-225-5204.

MI: Contact: Patricia E. Anderson, Section Manager 517-335-0002.

MN: Contact: Lisa Knazan 612-297-5628.

MO: Contact: Linda Ray-McKenna, Attorney at Law 314-751-2505

MT: Contact: Terry Frisch, TPL Manager, 406-444-4162

NE: Contact: George C. Kahlandt, Administrator, Public Assistance 402-471-9267.

NM: Contact: F. Richard Atkinson, Director, Third Party Liability 505-827-4322.

NY: Contact: Barbara Barnes 518-473-5500.

ND: Contact: Betty L. Strecker 701-224-2321.

PA: Contact: Patty Shepherd 717-772-7821.

SC: Contact: Barbara Longshore 803-253-6128.

UT: Contact: Michael Diely, Director, Bureau of Eligibility Services 801-538-6492.

VT: Contact: Linn Taylor, Medicaid Program Consultant 802-241-2819

WA: Contact: Tim Roth 206-753-7463.

WI: Contact: Gene Kussart 608-266-9622

Survey Questions

1. Has a study of Medicaid estate planning (e.g., transfers, trusts, purchase of exempt assets, joint accounts, annuities, etc.) and/or liens and estate recoveries been done in your state? If yes, please send copies of reports or executive summaries and key recommendations as appropriate.

AR: No.

CA: No.

CO: In October 1989 Colorado studied the feasibility of implementing an estate recovery program. Legislation subsequently passed in October 1991 to establish the estate recovery and the lien programs. Both programs became effective 07-01-92. Colorado issued a fixed fee

contract to Health Management Systems, Inc. in October 1992 for administration of estate recovery and lien activities.

DE: No.

GA: No.

IL: Yes, please find attached a copy of the program audit titled "Enforcement of Property Transfer Laws".

Excerpt: To better track property and increase collections, the General Assembly may wish to consider granting IDPA the authority to: 1) file liens on property owned by Medicaid recipients; 2) recover the cost of medical assistance provided to a permanently institutionalized individual before age 65; and recover assistance from the estate of the recipient's community spouse, upon the death of the community spouse.

IN: A study of Medicaid estate planning and estate recovery was conducted in 1992. A copy of the study is enclosed.

Excerpt: MCCA has spawned "Medicaid estate planning" as a new service industry comprised of attorneys and financial advisors who specialize in assisting elderly individuals to qualify for Medicaid by taking advantage of the loopholes in MCCA. By doing so, many elderly are able to accelerate qualification for Medicaid benefits, while retaining or sheltering significant assets.

IA: No.

KS: No.

KY: No.

MD: No.

MI: No.

MN: No.

MO: No.

MT: See Stephen A. Moses, Long-Term Care in Montana: A Blueprint for Cost-Effective Reform, LTC, Incorporated, Kirkland, Washington, September 24, 1993, 86 pages.

NE: No.

NM: No.

NY: While New York State has not specifically researched the extent of Medicaid estate planning, it has participated in the work of Brian Burwell of Systemetrics. We refer you to Mr. Burwell for copies of his findings.

Medicaid estate recovery programs in New York State are operated by local jurisdictions (58 counties and department of Health, the Office of Mental Retardation and Developmental Disabilities and the Office of Mental Health). Prior to the passage of OBRA '93, pursuit of estate recoveries was optional. Since it has become a requirement, we developed a survey (Attachment A) to determine what the actual experience was in this area in the local jurisdictions. The survey was mailed in October '93 and as of this writing, we have responses from two thirds of the mailings. Information received from the survey to date is summarized on Attachment B. Since the survey is not yet complete and we are in the process of analyzing data, we cannot provide an executive summary at this time.

ND: No.

PA: No.

SC: No.

UT: A study of Medicaid estate planning, liens and estate recoveries has been done. A copy of recommendations sent to the Department Director is attached. The recommendations, with minor exceptions, were turned down by Utah's Medicaid Care Advisory Committee (MCAC). This decision made by the MCAC resulted in large part from the State's previous experience with liens. There was a strong feeling that liens had resulted in medically needy individuals, who were otherwise eligible, refusing services and going without vital medical care. This was supported by anecdotal evidence that individuals had recently refused Medicaid coverage through the home and community based aging waiver for fear the State would be reinstituting liens.

The committee which made the original recommendations continued to study problems associated with transfer of assets and trusts. It was in the process of developing recommended changes in State laws and Medicaid regulations when OBRA '93 passed. With the passage of

OBRA '93, we released the committee with the belief [sic] that OBRA '93 either resolved the specific problems being addressed or made it impossible to solve the problem through State law changes.

VT: A phone survey was completed in June of 1993 to determine the impact of:

1. Changing the permissible resource transfer to a community spouse from the maximum to the minimum permitted under federal law;

2. Changing the date of transfer from the date another individual's name is added to the resource to the date the new owner actually takes sole ownership of any portion of the resource;

3. Changing the treatment of a purchase of an annuity from an assumption the client received fair (FMV) market value to a calculation of FMV based on life expectancy; and

4. Changing state law from permitting an individual to renounce an inheritance to counting the inheritance as a resource or treating the renunciation as a transfer.

Of the 1036 clients in long term care reviewed for the survey, 83 (8%) would have been impacted by the first change, 53 (5%) by the second change, 1 (.1%) by the third change and 4 (.4%) by the fourth change in policy.

WA: No.

WI: Wisconsin's reply to this survey refers the reader to Stephen A. Moses, The Senior Financial Security Program: A Plan for Long-Term Care Reform in Wisconsin, LTC, Incorporated, Kirkland, Washington, June 26, 1992, 76 pages.

2. Has your state taken action already to control Medicaid estate planning, to close unintended eligibility loopholes or to encourage private financing alternatives for long-term care? Please explain and provide relevant reports and memoranda; statutory, regulatory or policy language.

AR: Arkansas has enacted legislation to address the issues raised in this inquiry. (1) Ark. Code Ann. 28-69-102 (Act 1228 of 1993) voids any portion of a trust or similar legal device which limits the availability of or

suspends, terminates or diverts interest in a trust. (2) Ark. Code Ann. 20-76-436, 28-40-111 and 2804-101 have been amended (Act 415 of 1993) to allow the Arkansas Department of Human Services to recover benefits from the estates of recipients.

CA: Yes. California has recently enacted legislation to require the filing of TEFRA liens and the filing of liens against real property assets of surviving spouses, as well as restricting statutory exemptions to the proportionate share of the estate of the exempt person (copies of Welfare and Institutions Code Sections 14006.7 and 14009.5 enclosed). In addition, California has a Federally approved Long Term Care Partnership Program that permits a disregard of certain assets, for eligibility purposes, for individuals who have approved long-term care insurance.

CO: To date, there has been no systematic strategic attempt in Colorado to control Medicaid estate planning. In fact, many features of estate planning are substantially supported in relevant provisions of the federal Social Security Act (Title 19) and pertinent federal regulations, particularly prior to passage of OBRA '93.

Colorado has taken a number of steps over the years to curb eligibility expansion and encourage private financing alternatives. For example, in 1990 the Miller decision in a federal court asserted that income trusts were legitimate means to qualify individuals for Medicaid nursing home care, despite the state's categorically needy Medicaid Program. The decision itself established no income ceiling, and did not stipulate a standard of competence or need to justify use of the income trust mechanism. In state legislation passed in 1991, Colorado confined the use of income trusts to people whose income was not sufficient to purchase private care, who met the Medicaid nursing home level of care screen, and required that the remainder of the trust be used to reimburse Medicaid costs on the death of the client. This last feature was adopted as a characteristic of the trusts defined in OBRA '93.

During the fall of 1993, pursuant to authorizing state legislation (SB 93-163), a Colorado task force studied the feasibility of implementing a "private-public partnership" for financing long-term care, patterned on the model which was developed in four states with the help of grants from he Robert Wood Johnson Foundation. The task force concluded that the intriguing "resource

exemption" feature of such a program was not feasible after reviewing the language of OBRA '93. However, the task force recommended that improved certification standards be developed for Long Term Care insurance policies, and a public awareness/information strategy be used to market insurance policies containing such standards. A copy of the report is enclosed.

DE: No.

GA: No.

IL: Yes, please find attached a copy of the Policy Memorandum dated 12/15/93. This memorandum implemented recommendations from the program audit referenced in response #1.

Excerpt: The Auditor General examined the issue of persons transferring assets to qualify for Medicaid and the Department's policies that pertain to transfers and long term care. We received several recommendations to strengthen Department policy and help assure that persons with assets use them for their care. We support these recommendations.

IN: Prior to the enactment of OBRA '93, Indiana initiated administrative actions to close the multiple transfer loophole that allowed individuals to reduce the period of ineligibility by spreading transfers over a period of time.

In addition, Indiana is one of four states participating in the Robert Wood Johnson Foundation initiative for the promotion of private financing for long term care. Enclosed is a copy of the state's enabling legislation (Senate Bill 466) and other relevant materials describing Indiana's program.

IA: The 1993 Iowa legislative session enacted a statute relating to the establishment of a long-term care asset preservation program. The long-term care asset preservation program requires the Department to implement the long-term care asset preservation program to provide incentives for a person to insure against the costs of providing for the person's own long-term care needs and to assist in alleviating the financial burden on the state's Medicaid program by encouraging the pursuit of private long-term care payment initiatives. The legislation directs the Department of Human Services to provide an asset disregard for persons 65 years old or

older, who are the beneficiary of an approved long term care policy. The statute also requires the Division of Insurance to develop methods to increase accessibility and affordability of a long-term care health insurance policy. The long-term care asset preservation program is similar to the programs implemented in Connecticut and Indiana in that when determining resource eligibility for Medicaid nursing facility care the department disregards one dollar in client assets for each dollar paid out by the approved long-germ care insurance program. A copy of the legislation and the draft Iowa Administrative Code is attached.

KS: Certain loopholes were closed in regards to the State's transfer of property rules over past year. These included treating transfers of assets into irrevocable trusts as transfers for less than fair market value and viewing multiple transfers over several months as one single transfer. These issues have now been incorporated in the OBRA provisions. A copy of the State's current transfer provisions is attached.

KY: Prior to the enactment of the Omnibus Budget Reconciliation Act (OBRA) of 1993, we had planned to close Medicaid eligibility loopholes concerning trust agreements, annuities and income producing property and were also seriously contemplating a 60-month look back period for transferred resources. We were advised by the Health Care Financing Administration that we could not consider the purchase of an annuity to be a transfer of resources and adopted the trust provisions and the 36/60 month look back period regarding transfers pursuant to OBRA 93 guidelines. Additionally, we changed our policy with regard to income producing property and now consider income providing property to be an available resource rather than excluded resource. See Attachment 1 for detailed information.

MD: Yes. In May, 1992 regulations were implemented [COMAR 10.09.24.08 (J)] to attribute all funds in a joint account to the Medical Assistance applicant. In addition, the new regulatory provisions applied a penalty to the Medical Assistance applicant for withdrawals of funds by the non-applicant account owner.

We no longer permit the concurrent running of penalty periods. The penalty periods may now run consecutively [COMAR 10,09.24.08 (R)].

MI: Michigan has taken action to implement the mandated

estate recovery program by the Federal Government. We had pending legislation prior to this mandate but it has not passed.

MN: Yes. Minnesota has already taken action to control Medicaid estate planning by passage of statutory authority to seek federal approval through waivers and state plan amendments of provisions representing the largest loopholes. A copy of our legislation, waiver request, and state plan request are attached for your information marked as attachments number 1, 2, and 3. The State of Minnesota has also set up a commission to study long term care, which is also examining these issues in the course of its study.

Excerpt: The Minnesota Legislature and the Department believe that the vast increase in the incidence of asset sheltering in recent years is due mainly to two factors--the publicity resulting from the enactment and subsequent repeal of MCCA, and the growth in the field of elder law and financial advising to the elderly.

MO: No.

MT: See Stephen A. Moses, Long-Term Care in Montana: A Blueprint for Cost-Effective Reform, LTC, Incorporated, Kirkland, Washington, September 24, 1993, 86 pages.

NE: Yes. We have enacted State Legislation regarding the use of Trusts, (see attached LB 800).

NM: No.

NY: To circumvent the provisions of the Medicaid-qualifying trust, many estate planners in New York State were drafting trusts which terminated the trustee's discretion to make distributions to the individual immediately prior to the time when the individual was expected to apply for Medicaid. For instance, many trusts were written so that the individual who created the trust received income from the trust as long as she or he remained at home, but if the individual entered a nursing home, all the income was diverted to someone else. In order to address this loophole, Chapter 41 of the Laws of 1992 added Section 7-3.1(c) to the Estates, Powers and Trusts Law, to state that a provision in any trust, other than a testamentary trust, which provides directly or indirectly for the suspension, termination, or diversion of principal, income, or beneficial interest of the creator or creator's spouse in event that the creator or creator's

spouse should apply for Medicaid or require medical care shall be void, without regard to the irrevocability of the trust or the purpose for which the trust was created. (See Attachments C, D and E.)

New York State addressed the "multiple transfer loophole" in Chapter 41 of the Laws of 1992, by amending Section 366.5 of the Social Services Law. (See Attachments F, G, and H.)

New York State also implemented the Partnership for Long Term Care Program. The NYS Partnership is a unique program to finance long term care based on the concept of a public-private partnership, linking private insurance to Medicaid. (See Attachments I-O.)

ND: No.

PA: Yes, insofar as tighter regulation of the resource "burial reserves" as an eligibility loophole; otherwise, no.

SC: South Carolina follows the federal requirements. There are no state laws to address estate planning.

UT: The State has an active estate recovery program. Additionally, we have applied current laws as stringently as possible and successfully defended challenges to our asset transfer and trust policies. (See attached policy.)

VT: Attached are the current policies regarding transfers of assets with relevant portions highlighted. No statutory changes have been proposed.

WA: Each policy has provisions to control Medicaid estate planning and close eligibility loopholes. Primarily, the policies call for a determination of whether:

a. Adequate compensation was received by the client when an asset was transferred.

b. The transfer of assets was made with an intent to qualify for Medicaid.

c. The transfer of assets occurred within a specified lookback period.

WI: Wisconsin's reply to this survey refers the reader to Stephen A. Moses, The Senior Financial Security Program:

<u>A Plan for Long-Term Care Reform in Wisconsin</u>, LTC, Incorporated, Kirkland, Washington, June 26, 1992, 76 pages.

3. How does your state plan to respond to OBRA '93? Will new state legislation be required? Please provide copies of implementation plans and/or draft statutory language.

AR: Amendments may be necessary, but not drafted yet.

CA: California is in compliance with all OBRA 93 requirements, with the exception of filing estate claims for Medicaid services paid after a recipient's 55th birthday. Legislation has been drafted to make this change (copy of proposed legislation enclosed).

CO: OBRA '93 requires some significant changes to Colorado laws and regulations which affect Medicaid estate planning, particularly in the areas of (a) transfers for less than fair market value, (b) the consideration of trusts established by an individual who is applying for Medicaid, and (c) estate recovery. During the winter and spring of 1994, the Colorado legislature will consider proposed legislation particularly affecting (b) and (c). The OBRA '93 requirements concerning (a) will primarily be implemented through changes to relevant state regulations. The proposed statutory changes have not yet been formally introduced before the state legislature, so draft language is not yet available.

DE: The State of Delaware will be enacting legislation to meet the mandates of OBRA '93. I am not able to send you a copy of the pending legislation as it is still being reviewed by our attorneys.

GA: A copy of the state's legislation is attached. The state intends to issue a Request for Proposal (RFP) seeking bidders to pursue estate recoveries. We do not have a schedule for implementation since this will be determined by contract provisions.

IL: OBRA '93 is under review. It is anticipated that changes to state law will be required for implementing the 36 month "look back" period and for the trust provisions.

IN: The majority of the mandated provisions in OBRA '93 will be implemented through the state medicaid agency's existing authority and will not require additional legislation. However, the state's statute authorizing estate recovery will need to be amended so that it

explicitly applies to individuals age 55 and over (currently the statute applies to individuals age 65 and over). In addition, the state will need legislation to authorize the use of liens, to broaden the definition of an estate for Medicaid recovery purposes, and to authorize recovery from the estates of surviving spouses.

IA: We are currently working to update the state plan in accordance with OBRA 93 changes.

Iowa Administrative Code, the Department's rules of operation and procedure and implementation of the OBRA changes regarding the look-back, penalty periods, trust regulations and trust exclusions is completed.

Legislation to implement the Estate Recovery program and to close loopholes in the OBRA legislation is attached. We feel that OBRA 93 was not specific enough in how income disbursement from Miller/Income trusts was addressed. We also had concerns regarding the use of special needs trusts, our proposed legislation is needed to limit the trusts to their intended purpose.

Excerpt: An act relating to establishing a debt due for medical assistance resulting from a transfer of assets, and to allowable claims against a conservatorship for the cost of medical care or services provided to a recipient of medical assistance.

KS: The State has implemented the OBRA provisions through administrative regulations. A copy of the implementation material is attached.

KY: We implemented the OBRA 93 provisions on October 1, 1993, with the exception of estate recovery. However, we are in the process of developing policy concerning estate recovery which we plan to implement in the near future. See attachment 2, 3 and 4.

MD: The Program has drafted regulations and policy materials. They are presently under review for legal sufficiency. No state legislation is required with reference to asset and resource transfer.

MI: Michigan has responded to the OBRA 93 mandate by implementing a recovery process with existing laws. We will review our program and may request legislation to enhance our recovery program.

MN: We have issued a policy bulletin to local agencies and

the public implementing OBRA '93. A copy is attached as attachment number 4. We are currently working on drafting legislation to implement options permissible under OBRA '93. drafts are not available at this time.

MO: Missouri is in the process of implementing OBRA '93. New state legislation regulations and policies will be required.

MT: See Stephen A. Moses, Long-Term Care in Montana: A Blueprint for Cost-Effective Reform, LTC, Incorporated, Kirkland, Washington, September 24, 1993, 86 pages.

NE: State Legislation is necessary to implement the Mandatory Estate Recovery provision. The provisions regarding trusts and the look-back period were implemented October 1, 1993. The Estate Recovery Legislation has not yet been introduced in the Nebraska Unicameral.

NM: The New Mexico Human Services Department has determined that legislation is required to effectively implement estate recovery. Legislation has been drafted to implement estate recovery and amend the New Mexico Probate Code.

NY: Enabling State legislation is needed to implement the OBRA '93 transfer, trust and Medicaid recovery provisions. The proposed legislation is currently being drafted. Upon enactment of enabling State legislation, implementation plans will be developed to include promulgation of regulations, development of administrative directives to be issued to the local jurisdictions and appropriate systems support. With respect to Medicaid estate recoveries and liens, enclosed is the existing directive (Attachment P) which leaves pursuit of estate recoveries as an option rather than requirement for individuals 65 years of age or older rather than 55. These are the two areas that require revision but with few other modifications, the general procedures set forth in that directive will be continued.

ND: No legislation is required.

PA: Yes. Legislation is required in respect to estate recovery.

SC: State legislation will be required to implement the estate recovery provisions of OBRA 93. No legislation required to implement transfer of assets.

UT: See attached State rules and proposed law changes. We will be making some revisions to policies on asset transfers to or from a trust and defining "for the sole benefit of" in the near future. We will be implementing narrow undue hardship provisions at the same time.

VT: Attached are the policies which implement OBRA '93. New state legislation was not required.

WA: The Office of Financial Recovery (OFR) had previously introduced draft legislation to update our state law to coincide with the Omnibus Budget Reconciliation Act of 1993 (OBRA '93). Currently, that legislation is being reviewed by the DSHS Secretary's office. Please contact the DSHS Secretary's office if you need the most recent version of the draft legislation.

WI: Wisconsin's reply to this survey refers the reader to Stephen A. Moses, The Senior Financial Security Program: A Plan for Long-Term Care Reform in Wisconsin, LTC, Incorporated, Kirkland, Washington, June 26, 1992, 76 pages.

4. Is there a strong Medicaid estate planning bar in your state? Are seminars on how to qualify for nursing home benefits without spending down advertised? Do attorneys call Medicaid eligibility workers frequently seeking information on exclusions and exemptions? Elaborate.

AR: The estate planning bar in Arkansas has become more active in recent years and has offered professional seminars on this subject. Recently, estate planning specialists have offered seminars to the public.

CA: Yes, to all three questions. The National Academy of Elder Law Attorneys (NAELA) is very active in California and at least two local chapters hold regular meetings. Other attorneys advertise in newspapers and hold seminars in order to enlist clients. Many attorneys telephone eligibility workers, as well as estate recovery staff, in order to seek loopholes in existing statutory codes.

CO: The answer to all three questions is yes. Attorneys involved in Medicaid estate planning seem to approach Medicaid eligibility in the same manner as tax attorneys, i.e., that there is nothing unethical or illegal about minimizing their clients' liability to the government, or, stated differently, hastening their clients' financial eligibility for health care benefits which many people believe should be a government entitlement anyway.

DE: There are attorneys who work with Medicaid estate planning in Delaware, although the cadre seems small. To my knowledge, there has been one seminar for attorneys devoted exclusively to this topic. Attorney occasionally call administrators and supervisors, never workers. They sometimes request a copy of the Delaware Medicaid Manual.

GA: Seminars are advertised and attorneys call to determine if various strategies will affect eligibility.

IL: Yes to all of the questions. Please find attached information from the National Academy of Elder Law Attorneys regarding planning options under OBRA '93.

IN: There is an Elder Law committee under the auspices of the Probate, Trust and Real Property Section of the Indiana State Bar Association. Each year the Indiana continuing Legal Education Forum conducts a seminar on Elder Law issues. As part of this seminar there are presentations on "Medicaid Estate Planning" topics. Some of attorneys do advertise their services in assisting individuals to qualify for Medicaid, through it appears that advertising is generally more subtle that this. Eligibility case workers routinely receive calls from attorneys, as well as financial planners, insurance agents and senior advocates, concerning eligibility rules and the use of certain loopholes. During the past year, there has been an increase in the number of calls concerning Indiana's treatment of annuities.

IA: Some Iowa attorneys advertise and offer seminars on Medicaid estate planning. We are not aware of a strong Medicaid estate planning bar in the state. The Department, at the county, region, and central office levels, receive inquiries regarding exclusion and exemption information. The information requested in the calls indicate that the attorneys are unsure of the current rules regarding Medicaid resource policies and would rather have complete information before advising their clients to take action.

KS: Only moderate activity has been seen although there have been several seminars presented in past year. Calls from attorneys seeking estate planning advice have been referred to Central Office Legal Division in most instances. Staff have been instructed to provide no advice or counseling on the issue.

KY: No; No; Yes. Attorneys in Kentucky routinely call

eligibility workers as well as central office policy staff in an effort to obtain information regarding Medicaid eligibility requirements, exclusions, exemptions and loopholes.

MD: Yes, there is a strong Medicaid estate planning bar in Maryland. Seminars are advertised and held. Attorneys frequently call the Medicaid Program's Division of Eligibility seeking information.

MI: Yes there are informational seminars advertised on how to qualify for Medicaid without spend down and especially nursing home coverage. Various staff, both eligibility and policy workers, receive inquiries on how to get around Medicaid eligibility requirements and spend down.

MN: Yes. There is a strong Medicaid estate planning bar with seminars also offered to the public on estate planning. Attorneys are required to submit their questions regarding Medicaid to the State in writing which they do so frequently. We assume they also contact local agencies with questions frequently.

MO: There appears to be a strong state planning bar in Missouri Attorneys frequently call the Division of Legal Services within the Department of Social services seeking information on the solutions and exemptions. Most of these calls appear to relate to the forming of trusts.

MT: See Stephen A. Moses, Long-Term Care in Montana: A Blueprint for Cost-Effective Reform, LTC, Incorporated, Kirkland, Washington, September 24, 1993, 86 pages.

NE: Yes, Yes, Yes. Attorneys contact the Eligibility Workers, Program Specialists and our agency attorneys in an attempt to find ways to shelter resources.

NM: There is a small but vocal estate planning bar in New Mexico. Seminars on how to qualify for nursing home benefits without spending down have been held in New Mexico and Medicaid eligibility workers and state office staff are routinely called by attorneys for policy information.

NY: Medicaid estate planning as represented by elder law attorneys is extensive and strong in New York. Such attorneys, however, only constitute a portion of those providing the public with estate planning information. Certified financial planners offer consumers advice via seminars and adult education classes that is less

expensive and, therefore, more accessible to more people. Anecdotal evidence from local district offices (see Burwell's report) suggests that Medicaid personnel are often contacted by attorneys and planners. State Department of Social Services Medicaid eligibility program and legal staff are also often contacted by attorneys and planners.

ND: No, Yes, Yes.

PA: Yes. Yes. No, as to contact with eligibility workers.

SC: It is unknown if there is a strong estate planning bar in the state. We are aware of a few seminars which have been held in our state on how to qualify for nursing home benefits. We are aware of a small group of elder law attorneys in our state. Attorneys frequently call to inquire about specific cases on which they may be working.

UT: Yes to almost all of the questions posed. Most inquiries from attorneys are fielded by our staff attorney or State eligibility specialists. The one area where we have not had a problem is seminars on how to qualify for nursing home benefits without spending down. However, Utah is a medically needy State covering long-term care. We have also taken the position that diversions of income cause total ineligibility due to failure to apply for (and receive) all benefits for which the individual is entitled. The one challenge to this policy was settled favorably.

VT: There is a strong Medicaid estate planning bar in Vermont. The Vermont Bar Association, Life Insurance providers, financial planners and state supported advocacy groups such as Vermont Legal Aid and the Department of Aging and Disabilities conduct seminars and assist clients in qualifying for nursing home benefits by following the rules of the Medicaid program and identifying gaps and loopholes in these rules. Attorneys are referred to the Medicaid Program Consultant and to the Assistant Attorney General's Office by the eligibility workers. Many attorneys "subscribe" to the policy manual and the updates and call for interpretation of policy.

WA: There is a strong Medicaid estate planning bar in the state of Washington. We are aware of a variety of estate planning seminars provided in this state. Many are also provided by representatives of the insurance industry.

The American Association of Retired Persons advertises some of these seminars in its newsletter.

Attorneys often call program managers in our office regarding Medicaid eligibility requirements related to estate planning.

WI: Wisconsin's reply to this survey refers the reader to Stephen A. Moses, The Senior Financial Security Program: A Plan for Long-Term Care Reform in Wisconsin, LTC, Incorporated, Kirkland, Washington, June 26, 1992, 76 pages.

5. What are the most commonly used artificial impoverishment techniques in your state? How common are these practices? If you had to guess, what percentage of Medicaid nursing home eligibility cases involve some form of divestiture or sheltering? Elaborate.

AR: Prior to enactment of OBRA of 1993, there was a significant number of Medicaid Qualifying Trusts created. Other methods of impoverishment used are transfer of liquid assets to others (often detected by IEVS matching reports) and continuous monthly transfers of assets (to shorten the period of ineligibility). No data is available to provide the percentage of nursing home Medicaid recipients which involves divestiture or sheltering.

CA: As stated above, a study of state planning and transfers of assets has not been done in California. Probably the most common practice has been to transfer real property into joint tenancy or other form of ownership that allows transfer by survivorship. This form of asset transfer to avoid recovery from a recipient's estate has effectively been stopped with the passage of OBRA 93. No additional legislation is required in California since existing state statutes permit recovery from property that transfers through survivorship. As far as the percentage of nursing home eligibility cases that involve some form of divestiture, because of the large volume of cases, it is not possible to give any kind of reasonable guess.

CO: Principal place of residence, jointly owned property used as a residence by one of the co-owners (frequently an adult child or sibling of prospective recipient), property used trade or business (frequently a business operated by other family members), unrestricted right of spouses to transfer resources between themselves, transfers for less than fair market value, and burial

funds are all common. In the area of spousal protection, we regularly see moves to compute high monthly income allowances or move additional resources to the community spouses based on assertion of exceptional circumstances.

The state does not collect data on the property which Colorado Medicaid clients hold in joint tenancy or life estates at this time. However, our eligibility sources estimate that between 10-15% of persons living at home, and between 20-25% of Medicaid nursing home residents use one of these mechanisms. Our eligibility staff caution that property held by Medicaid clients in one of these forms represent a disproportionately large share of all property in which Medicaid clients have legal interest. Simply stated: Most people who have property have found a way under current law to protect it. Such estate planning is more common under the generous resource provisions available to many married couples given spousal protection guidelines.

DE: The most commonly used artificial impoverishment techniques used in Delaware are transferring assets prior to the 30 month "look back" period and transferring assets to different sources in the same period so that the amount transferred was never too great. About 10 to 15% of cases involve some form of attempted divestiture or sheltering.

GA: Trusts are fairly common. We do not keep statistics on this area but, probably 20% of applicants have either transferred property or established trusts. Very few have purchased private insurance.

IL: One of the most commonly used techniques is for adult children to claim services were provided over a number of years in order to justify a transfer to them. The department strengthened policy in this area, with the implementation of the attached Policy Memorandum dated 12/15/93, which will help assure that persons with assets use them for their care. We do not choose to guess and the Department does not maintain summary information regarding the percentage of cases involving transfers of assets.

IN: The state does not have data on which techniques are most commonly used to shelter assets. However, probably the most commonly used method to divest assets in order qualify for medicaid long term care benefits is the establishment of an irrevocable burial trust. Another fairly common technique has been the use of multiple

transfers. The state does not have data on the number of persons utilizing divestiture and sheltering techniques. However, a guess would place the use of these loopholes in the neighborhood of 10% - 30%.

IA: The most common form of artificial impoverishment technique is divestment of assets for less than fair market value. Federal regulations require the department determine a period of ineligibility for nonpayment of nursing facility care and HCBW services when a transfer for less than fair market value occurs. The Department of Management recommended additional action as all other Medicaid services are payable for persons who have divested themselves of resources. With currently enacted legislation the Department will establish a claim against the transferee of such transactions up to the uncompensated value of the asset transferred. A copy of the legislation and Iowa Administrative Code is attached.

It is unknown how common the practice of divestment to qualify for Medicaid is practiced as the transferor usually transfers assets while retaining enough assets so an application for medical assistance is unnecessary until after the look-back period has expired.

KS: Most techniques seen have either been complete transfers of property occurring beyond the look-back period or sheltering assets in irrevocable trusts. New OBRA provisions will allow greater leeway to consider such trusts. It is estimated that between 10% and 20% of nursing home cases involve some form of estate planning.

KY: Prior to the enactment of OBRA 93, the establishment of a trust agreement was one of the most common techniques of impoverishment. We estimate that approximately 10% of all nursing facility admissions divested their resources in this manner.

Currently, the purchase of annuities and burial reserves with an irrevocable assignment of rights clause, home improvements or repairs, purchase of a new home and purchase of household goods and personal effects are the most common techniques of impoverishment. We estimate that approximately 25% of all nursing facility admissions divest their resources in this manner.

MD: The most commonly used artificial impoverishment techniques used are trusts and annuities. The practice is very common. The percentage of Medicaid eligibility nursing home eligible cases involving divestiture or

sheltering is unknown.

MI: Since we have not done a study this is just a guess, the most commonly used impoverishment technique is with the excludable assets. Such as purchasing excludable assets (new or fancy automobiles or funeral arrangements) or spend money on the homestead. I have no idea how much of this occurs.

MN: The most commonly used artificial impoverishment techniques are purchasing annuities and the making of outright cash gifts, timed so that they occur outside the look-back period or will result in some return to the donor during their lifetime. Pre-OBRA '93 transfers frequently made use of concurrently running penalty periods. We assume that artificial impoverishment is a fairly common practice, but we are unable to estimate the percentage of occurrences. Rather, we have acquired anecdotal evidence of this practice. We wish we had a better method of quantifying this practice.

MO: The most commonly used artificial impoverishment techniques in Missouri are trusts. Two significant Missouri cases have addressed this issue. Tidrow v. Mo. State Div. of Fam. Serv., 688 S.W.2d 9 (Mo.App. 1985). Missouri Div. of Family Serv. v. Wilson, 849 S.W.2d 104 (Mo.App.W.D. 1993). According to the division of Family Services, a fairly significant percentage of Medicaid nursing home eligibility cases involve some form of divestiture or sheltering.

MT: See Stephen A. Moses, Long-Term Care in Montana: A Blueprint for Cost-Effective Reform, LTC, Incorporated, Kirkland, Washington, September 24, 1993, 86 pages.

NE: The use of Trusts had been the most common artificial impoverishment technique. It will take sometime to determine if others will develop.

NM: The most commonly used artificial impoverishment techniques used in New Mexico are income diversion trusts and asset transfers. Our guess is that 20% of nursing home eligibility involves some form of divestiture or sheltering.

NY: Commonly used artificial impoverishment techniques include transfers, purchase of exempt assets, establishing joint accounts and annuities. It is not possible to determine which divestiture method is most used, but we believe that transfer of assets to children

is probably the most common technique.

In regard to the percentage of individuals on Medicaid who may have transferred assets, we can only guess based on certain indications.

a) Unlike other states, New York State's Medicaid program offers an extensive network of available home care services. This gives Medicaid recipients a rich and expansive home care system that reaches patients well below the nursing home disability level. Unfortunately, while the availability of these services provides the care needed by many poor elderly to survive at home even where informal support systems are missing, federal Medicaid law (prior to OBRA '93), did not permit the application of transfer penalty periods to those receiving non-waivered home care benefits. In New York, therefore, it was possible for persons to transfer with impunity and still receive extensive long term care services. An informal survey of the extent of such transfers indicated that a conservative estimate of gross Medicaid costs for home care transfer cases was $20,000,000 annually.

b) A study of fiscal lengths of stay in New York nursing homes showed that approximately 55% of patients were Medicaid-eligible at admission. A similar study in Connecticut showed an entry rate of 30%. As income/asset levels are comparable between the two states, we must assume that divestiture is more common in New York.

c) Nursing home rates in New York are high. The average private rate statewide is around $60,000/year with the New York metropolitan region exceeding $70,000 annually. If these rates are multiplied by the average length of stay, the definition of a person at-risk for Medicaid (spenddown) is roughly anyone with less than a quarter of a million dollars. Logically, where the potential of spenddown reaches so high an asset bracket, the incentive and the means (access to/familiarity with lawyers, accountants, investment advisors) of divestiture is increased.

ND: No data available.

PA: On a guess basis, Medicaid qualifying trusts.

SC: Unknown.

UT: In the past, transfer of assets has been the most

prevalent artificial impoverishment technique, particularly when combined with trust fund creation. Our best estimate of the cases involving divestiture is less than 5%.

VT: The survey (see Question #1) found a total of 14 percent of the 1036 clients used any of 7 identified "artificial impoverishment techniques". Since the survey was based on staff memory of each client's situation rather than a record search, a guess might be that 20 percent of the cases involve some form of sheltering. A further guess is that more individuals would seek to shelter assets if the community spouse resource allocation were reduced from the current $72,660. Since a home is not counted as long as the individual's spouse is in the home, the protection of an additional $72,660 in countable resources covers many Vermont couples without the couple taking actions to shelter their assets.

WA: The most common artificial impoverishment technique in this state has traditionally been the establishment of trusts and annuities. Other techniques may soon come to the forefront, depending upon the effectiveness of transfer of asset and trust limitations enacted nationally under OBRA '93 last October.

We would estimate less than 20% of our Medicaid nursing home eligibility cases involve some form of divestiture or sheltering. The vast majority of our clients are already active on Medicaid prior to entering a nursing facility; thus their assets are very limited due to a prior Medicaid eligibility determination.

WI: Wisconsin's reply to this survey refers the reader to Stephen A. Moses, The Senior Financial Security Program: A Plan for Long-Term Care Reform in Wisconsin, LTC, Incorporated, Kirkland, Washington, June 26, 1992, 76 pages.

6. Are divestiture control, liens and estate recoveries politically sensitive issues in your state? Are there concerns about whether vulnerable seniors will fail to seek needed care if Medicaid is more restrictive? Please explain and provide examples.

AR: No data.

CA: Yes, the Estate Recovery Program, together with involuntary liens, is a very sensitive issue in California. Enclosed is a copy of a memo from the

Director of this Department to the Secretary of the California Health and Welfare Agency alerting her to what may happen when liens begin to be filed in early 1994. Also, long term care advocates, such as the California Advocates for Nursing Home Reform and other organizations, have been very critical of recent state legislation (see Welfare and Institutions Code Sections 14006.7 and 14009.5 enclosed) and OBRA 93.

CO: Yes, these issues are politically sensitive. There is a significant percentage of persons who believe that long-term care should be provided by government regardless of a person's financial resources. Many people believe that an elderly person should be permitted to leave his/her estate to his/her heirs, regardless of the need for expensive long-term care. This value system conflicts with another sentiment that is broadly held by coloradans that taxes should be tightly controlled and that the tax bite on the populace is already too large.

DE: Yes, divestiture control, liens, and estate recoveries are politically sensitive issues. There are concerns that vulnerable seniors will fail to seek needed care if Medicaid is more restrictive. Our seniors are very concerned about leaving a legacy for their adult children.

GA: The main issue is more closely related to the family's desire to assure protection of inheritance; children do not wish to lose out. The other issue is the emotional dependence by the nursing home resident on the homeplace.

IL: Yes to both questions.

IN: A bill was introduced in the 1993 session of the Indiana General Assembly that would have authorized the use of liens, expanded recovery to include a spouse's estate and restrict the use of trusts to shelter and divest assets. The bill had bi-partisan support and slightly different versions were passed in both houses during the regular session. However, the bill failed to be enacted as a result of a budget stalemate and was not considered during the subsequent special session of the General Assembly.

IA: The Department does not currently have an estate recovery program. Legislation has been proposed that allows the Department to comply with the OBRA 93 directive of a mandatory estate recovery program. We do not feel that seniors will choose not to seek and receive needed care

because of the estate recovery program.

KS: These have not been considered politically sensitive at this point.

KY: Yes; Yes.

MD: No. Maryland's estate recovery statute (Article Health-General, Section 15-121 of the Annotated Code of Maryland) incorporates the protections set out in Title XIX. No recovery is permitted if there is a surviving spouse, blind or totally disabled child, or child under the age of twenty-one. Also, no claim will be made where undue hardship will accrue.

Maryland's real property lien regulations grant continuous long term care to its residents without the necessity of selling the applicant's residence. Liens are restricted in certain instances and are dissolved upon the return of the long term care recipient to his residence.

MI: Yes, estate recovery is a politically sensitive issue in Michigan. We have had pending legislation on this issue since 1991. The concern seems to be in the public response to "taking grandma's house from the children" and seniors being hesitant to accept Medicaid payment with the potential for recovery.

MN: Yes. The issue of divestiture control, liens, and estate recoveries are politically sensitive issues in this state, but we have successfully passed tightened transfer, estate recovery, and lien legislation nevertheless. We have not heard much in the way of comments about vulnerable seniors hurt by a restrictive Medicaid Program.

MO: Yes, divestiture control, liens, and estate recoveries are politically sensitive issues in Missouri. The power of the "silver haired" legislature is significant. The most sensitive issue appears to involve the Estate Recovery Program. Citizens tend to view the receipt of Medicaid benefits as an unalienable right and not as a public assistance program.

MT: See Stephen A. Moses, Long-Term Care in Montana: A Blueprint for Cost-Effective Reform, LTC, Incorporated, Kirkland, Washington, September 24, 1993, 86 pages.

NE: No. No, these topics are not politically sensitive

topics.

NM: Liens and estate recovery are politically sensitive issues in New Mexico. An estate recovery bill was drafted for introduction in the 1993 Legislature but a sponsor could not be found.

NY: It would be difficult to imagine any state of federal program that didn't carry a high level of political sensitivity; especially when, like Medicaid, the program provides life sustaining care to a vulnerable population. In the case of long term care, it is safe to say that the desire to control Medicaid expenditures is consistently weighed against the impact of service denial to the frail elderly. Anecdotal evidence, however, seems to indicate that adult children of seniors are more concerned than their parents with the OBRA '93 provisions relating to divestiture control, liens and estate recoveries.

ND: North Dakota has had an active estate recovery program in place since the program began.

PA: Yes, as to the use of any realty lien.

SC: Yes and there are concerns about whether vulnerable seniors will fail to seek needed care if Medicaid is more restrictive.

UT: Yes, these are politically sensitive issues. (See response to question 1.)

VT: Estate recoveries are politically sensitive issues in Vermont. The widespread concern about vulnerable seniors caused the Department to abandon its renewed efforts (in 1992) to recover from estates. Vermont does not place liens against property because of a statute prohibiting liens. Any attempt to change the stature would be likely to cause widespread concern.

WA: Divestiture control, liens, and estate recoveries have traditionally been politically sensitive issues in this state; yet most estate recovery is still directed at nursing facility clients. There are concerns of placing an undue hardship on nursing facility clients by pursuing estate recovery.

There is always some concern vulnerable seniors will fail to seek needed care if Medicaid is more restrictive. Recently, there has been a decrease in the number of

nursing facility and waivered program clients. (Waivered programs provide a nursing facility level of care outside a nursing facility, e.g. at home or in an alternative facility.) It is not yet clear whether this decreasing trend will continue.

WI: Wisconsin's reply to this survey refers the reader to Stephen A. Moses, The Senior Financial Security Program: A Plan for Long-Term Care Reform in Wisconsin, LTC, Incorporated, Kirkland, Washington, June 26, 1992, 76 pages.

7. Do you already have a Medicaid lien program? If yes, please describe its effectiveness, i.e. cost vs. revenue generated for the past three fiscal years. If no, do you intend to implement one? Why?

AR: Implementing now.

CA: California is just now implementing a lien program. Some liens have been filed against surviving spouses, but there is no data available as yet due to the newness of this program. The program is being implemented to comply with mandatory state legislation.

CO: The lien program was established in July 1992, and applied to only those costs incurred on services rendered from that date forward. Recoveries began in July 1993. Since the assertion of a lien does not immediately translate into quick recovery, the program is too new to project meaningful statistics on annual recoveries or to assess it's overall effectiveness. However, liens satisfied between July and December 1993 totalled $46,621.22; another $1,172,702 in liens were asserted by December.

DE: No, Delaware does not already have a Medicaid lien program. Yes, we do plan to implement one per the terms of OBRA '93.

GA: No.

IL: Yes, effective 1/1/94.

IN: Indiana does not currently have a lien program. Legislation authorizing a lien program may be introduced in the 1994 session of the Indiana General Assembly. The rationale for a lien program is to establish the priority of the state's claim, and enhance Medicaid's ability to recover for medial assistance payments.

IA: The Department does not have a Medicaid lien program. Due to past experience with liens and an estate recovery program the proposed legislation is not requesting that liens be attached with the estate recovery program.

KS: No lien program exists or is being considered. The process would be administratively cumbersome and costly to operate.

KY No; No. This a politically sensitive issue which state legislatures' and the public have generally not favored. In the early 50's, Governor Chandler was elected partly as a result of promising to eliminate a lien program.

MD: Yes. The Tax Equity and Fiscal Responsibility Act of 1982 granted state Medicaid Programs authority to place growing liens on the real estate of long term care residents under certain circumstances. Maryland's "TEFRA" lien program commenced in May, 1986.

Maryland was the first state to establish a real property lien program and is now one of seven states to have such a mechanism for permitting long term care recipients to secure necessary medical care while protecting the government's interest. Recoveries in fiscal Year ending 6/30/92 exceeded one million dollars. Recoveries for Fiscal Year ending 6/30/93 were slightly greater that $1.5 million. The Division of Medical Assistance Recoveries anticipates lien reimbursements to exceed $2 million in fiscal year 1994.

MI: No, we do not have a lien program. We plan on implementing a lien program because it appears to be an efficient means of recovery. The placement of a lien ensures recovery at the time of estate settlement or when the property is sold.

MN: Yes. We have a Medicaid lien program that was just passed in our 1993 legislative session. It is just getting off the ground, so we have no revenue/cost data available at this time.

MO: The statutory basis for the lien program was enacted in 1993. 208.215(a), RSMo (Supp. 1993). Missouri is currently in the process of drafting implementation regulations.

MT: See Stephen A. Moses, Long-Term Care in Montana: A Blueprint for Cost-Effective Reform, LTC, Incorporated,

Kirkland, Washington, September 24, 1993, 86 pages.

NE: No. We require that the client liquidates the home within the first year that they enter a facility and it is determined that they will not return home. We think this process is cost effective.

NM: New Mexico does not currently have a lien program. Lien provisions are included in our draft legislation.

NY: We do have a lien program. Attachment B displays the number of liens filed by those districts who have already responded to the survey, and Attachment P explains the procedures. Although local jurisdictions report their recoveries to the State on a quarterly basis, estate recoveries are often combined with "other refunds" so we are unable to provide you with the amount actually recovered or with the cost of recovery.

ND: We do not have a lien program; not at this time.

PA: No.

SC: The South Carolina Medicaid Program does not have a lien program. The South Carolina General Assembly will decide if there will be a lien program during the current legislative session.

UT: Utah does not have a Medicaid lien program. (See response to question 1.)

VT: Vermont has a statute which prohibits the Department from placing liens on property.

WA: The state of Washington does not currently have a Medicaid lien program. No decision has been made regarding the introduction of one as a result of OBRA '93. The current interpretation is that it is an optional program.

WI: Wisconsin's reply to this survey refers the reader to Stephen A. Moses, The Senior Financial Security Program: A Plan for Long-Term Care Reform in Wisconsin, LTC, Incorporated, Kirkland, Washington, June 26, 1992, 76 pages.

8. Do you already have a Medicaid estate recovery program? If yes, what were your costs of recovery and total state and federal funds recovered for the past three fiscal years? If no, what do you expect to be able to achieve under the OBRA

'93 estate recovery mandate?

AR: Arkansas' estate recovery program became effective in August, 1993, and neither data nor estimates are available.

CA: California has had an estate recovery program since 1982. Total recoveries and costs for the last three fiscal years were:

	RECOVERIES	COSTS
1990/91	$20,900,000	$1,550,000
1991/92	$21,700,000	$1,800,000
1992/93	$21,900,000	$1,825,000

CO: The Colorado Medical Assistance Estate Recovery program was established in July 1992 and recoveries began in November 1992. Two major reasons accounted for a slow accumulation of recoveries following the 2/93 implementation date:

(1) Decision not to recover funds for services delivered prior to 7/92: The Social Security Act clearly permitted the states to recover historical costs from clients' estates. However, for decades, eligibility workers in Colorado had assured prospective clients that their homeplaces would not be vulnerable if they applied for Medicaid. In deference to fairness issues raised by advocates, the department agreed to recover costs only from July 1, 1992 forward. It was recognized at the time that this agreement significantly slows the accumulation of recoverable claims and thereby slows the rate of estate recovery. During its first year of operation, Colorado's estate recovery program recovered 80% of claim amounts on cases where recoveries were made. This percentage is expected to fall dramatically as the program moves further away from the 7/92 start date, and the rate at which claims accumulate climbs faster than the rate at which estate values increase.

(2) An underlying premise of Colorado's program was that it would not be allowed to drive work onto an already overburdened county eligibility staff. This was a central reason for the state's choice to operate the estate recovery program as a contract function rather than a state function.

Further, Colorado's probate and tax assessment systems do not maintain centralized databases. Consequently, the contractor experienced significant start-up delays as it

struggled to locate essential data elements, i.e. the community address of the client, property of decedents, etc. Resolutions to these database issues have been partially resolved at this date.

The Estate Recovery program is too new to project meaningful statistics on annual recoveries or to assess it's long-range effectiveness. However, the total amount recovered throughout the estate recovery program between July 1992 and December 1993 totalled $48,792.60.

Final estimates of how OBRA '93 changes will affect the recoveries for this program are not yet complete. The preliminary estimate of the FY95 impact that will result from lowering the recoverable age to 55 is $145,646. The legislature has not yet determined whether it will pursue the expanded definition of "estate" which OBRA permits. Certainly, a decision to proceed would spark considerable opposition among the elder law community.

DE: No, we do not have a Medicaid estate recovery program. We do plan to have one, however, and hope to recover the amount of Medicaid monies that we expend for Medicaid eligible long-term care patients.

GA: The Department expects to release an RFP which will implement the mandatory estate recovery sections of OBRA '93.

IL: Yes, recovery information and our best estimate of associated costs for the past three fiscal years are as follows:

	FY '91	FY '92	FY'93
Recovery	$3,285,776	$4,251,591	$6,243,521
Costs	$ 90,004	$ 297,611	$ 437,046

IN: Indiana currently has an estate recovery program that is described in the enclosed study. The amounts recovered during the past three years were $989,000, $942,000 and $1,343,000. However, due to some misreporting by the counties, these figures probably understate the actual amounts recovered. Due to the fact that recovery is administered at the county level and recovery is not a separately identifiable program, the cost associated with recovery cannot be determined. These costs are incorporated into each county's administrative expenses.

IA: The Department does not have an estate recovery program.

We have projected a savings of $85,821 in FY 95 and $298,206 in FY 96.

KS: An estate recovery program was implemented effective July 1, 1992. Attached are the statistics on the program in the first fiscal year (7-1-92 to 6-30-93). It is expected recoveries will increase to $500,000-$600,000 in the current fiscal year.

KY: No, we do not yet have a Medicaid estate recovery program. We expect to save approximately $300,000 to $500,000 in program funds.

MD: Yes. The Maryland General Assembly enacted Article Health-General, Section 15-121 in July, 1976 granting the Department of Health and Mental Hygiene the authority to make claim against the estates of deceased Medicaid patients.

The Medicaid Program's Division of Medical Assistance Recoveries has had the cooperation of Maryland's Registers of Wills who forward bi-weekly listings of estates opened in their counties. The Department is then able to file timely claims.

The Program has also had the benefit of staff counsel who engages in litigation to protect and secure the state's claims and who seeks Letters of Administration as a personal representative (executor) of the estate when no family member is able or desires to act in that capacity.

The cost/benefit ratio is approximately ten to one ($10 collected for $1 cost). Recoveries during the ten year period for Fiscal Year 1982-91 averaged approximately $1.3 -1.4 million annually. Estate Recoveries for Fiscal Year ending 6/30/93 were $1,162,480. The reduction is a result of the sale of real property subject to liens that no longer become part of the decedent's estate.

MI: No, we did not have an estate recovery program prior to OBRA 93. We are projecting revenues in fiscal 94-95 at $35 million. That estimate is currently being revised downward due to over estimations on actual recoveries in that fiscal period.

MN: Yes. We have a Medicaid estate recovery program. Estate recovery is handled on a county basis, so we do not have cost of recovery figures at the State level. However, the total state and federal funds recovered are available, and are as follows:

State FY90	$6,214,088,68
State FY91	$5,156,182.75
State FY92	$8,869.679.70
State FY93	$6,751,987.37

MO: Missouri already has a Medicaid Estate Recovery Program. For the fiscal year of 1991, $769,061.95 was recovered. For fiscal year 1992, $1,004,742.16 was recovered. In fiscal year 1993, $1,274,875.75 was recovered.

The costs for the program were most completely recorded in fiscal year 1992. In fiscal year 1992, the costs of the program were $74,228.00

MT: See Stephen A. Moses, Long-Term Care in Montana: A Blueprint for Cost-Effective Reform, LTC, Incorporated, Kirkland, Washington, September 24, 1993, 86 pages.

NE: No. We estimate that it will result in recoveries in the range of $250,000 to $300,000 annually in Federal and State funds.

NM: New Mexico does not currently have an estate recovery program. Because of the OBRA 93 mandate, we expect to pass estate recovery legislation.

NY: See the response to question 7.

ND: Yes. The cost of recovery for fiscal year 1993 was less than $45,000 and the recovery amount was $806,241.49

PA: No.

SC: No.

UT: Utah does have an estate recovery program.

	Collections
FY '91	$141,288
FY '92	$161,173
FY '93	$414,383
First 6 mths of FY '94	$396,000

The cost is approximately $30,000 per year.

VT: The policy regarding estate recovery went into effect January 1, 1994. The savings from estate recovery, once fully developed, is estimated to be $250,000 gross

dollars annually. No savings are expected in SFY '94 (i.e., before July 1, 1994).

WA: Attached (Attachment #2) is a handout regarding OFR's recovery under the estate recovery program. We do not have the exact cost figures at this time; but we could retrieve them at a later date if you find you need them.

Excerpt: The recovered expenditures support both the current Aging Services and medical Assistance Program costs. Listed below are fiscal year recoveries since Washington implemented the Estate Recovery.

FY	$ Recovered
7/87 - 6/88	$ 1,825
7/88 - 6/89	20,456
7/89 - 6/90	344,668
7/90 - 6/91	475,622
7/91 - 6/92	982,606
7/92 - 6/93	1,306,160

Effective July 24, 1993, State law removed a prior exemption where there was a surviving adult child. The prior exemption limited recovery to 35% of any estate value over $50,000 but not to exceed total Medicaid costs. Recent Federal Legislation changes the program from permissive to mandatory, and requires changes to Washington's laws, which are being reviewed at this time. Changes to the State law will be introduced to the 1994 legislature for enactment.

WI: Wisconsin's reply to this survey refers the reader to Stephen A. Moses, The Senior Financial Security Program: A Plan for Long-Term Care Reform in Wisconsin, LTC, Incorporated, Kirkland, Washington, June 26, 1992, 76 pages.

9. If Medicaid nursing home eligibility becomes harder to obtain and less desirable because of OBRA '93's requirements, do citizens of your state have cost-effective alternatives, such as home and community-based care, assisted living facilities and high quality private long-term care insurance for advanced planning? Explain.

AR: The Department of Human Services has a program of home and community based services for the elderly, but the eligibility requirements and the penalties for transfers of assets are the same as those for long term care Medicaid recipients. There are also assisted living

facilities and long term care insurance available, although it is not known whether they are "cost effective".

CA: Yes, California has a federally approved in-home supportive services program, as well as a federally approved long-term care partnership program.

CO: Citizens of Colorado have cost-effective alternatives such as home and community based waivered services, assisted living facilities (including adult foster care and alternative care facilities to deliver more intensive and structured services), as well as a current demonstration project based on the On-Lok model that delivers total long term care services in the Denver area. Availability is much better in the urban than in rural areas, but general access is maintained throughout the state. However, the costs of these alternatives is disproportionately borne by the Medicaid program. The cost of these services through the private sector frequently exceeds what the consumer is willing or able to pay. The SB93-163 task force (referenced in the response to question 2) recommended that the state proceed with the implementation of a State Certified Private Long-Term Care Insurance product as a means to deal with this problem.

DE: Delaware does have home and community based care, assisted living facilities, high quality private long-term care insurance, and Adult Foster Care. We are also piloting what we term Adult Foster Care II which will serve more medically involved clients and have an RFP out to investigate increased assisted living options.

GA: The state has a Community Care Services Program, but, the same rules apply. Personal care homes are not covered by Medicaid, but, are available.

IL: Yes.

IN: As mentioned above, Indiana's Long Term Care Program promotes private financing of long term care through the purchase of long term care insurance. Home and community based services are available through the state's IN HOME Services Program, as well as through private home and community based care agencies.

IA: We do not expect persons who are in need of nursing facility care to experience difficulties when applying for Medicaid payment as a result of OBRA 93.

If a person chooses to remain at home rather than entering a nursing facility, and the person needs an intermediate level of nursing care, Iowa currently participates in four Home and Community Based Waiver programs. The Department offers coverage, for eligible persons, under the Ill and Handicap Waiver, the MR-OBRA Waiver, the HIV/AIDS Waiver and the Elderly Waiver.

KS: A number of alternatives exist including several 1115 home based waivers and state funded alternative care programs. Renewed emphasis is being placed on expanding these programs further over the next several years.

KY: Kentucky has a home and community based care program for the aged, disabled and mentally retarded. We do not have assisted living facilities and are unsure regarding the availability of high quality private long-term care insurance for advance planning.

MD: Yes. Private long term care insurance is readily available in Maryland. Maryland also has home and community based care and assisted living facilities.

MI: Michigan is currently participating in a home and community based waiver program to keep people within their homes as long as possible. But these services will also be a part of the recovery program. We are reviewing assisted living facilities, we have not made any decisions on this type of arrangement.

MN: Minnesota has a variety of alternatives to nursing home care. The use of alternatives is predicated on individuals needing a nursing home level of care. This means if a person does not qualify for a nursing home level of care, he/she will not qualify for the alternatives either. Currently, the State does not have a high quality long term care insurance program.

MO: Yes, residents of Missouri have cost-effective alternatives. Among these alternatives are the home community-based programs where in-patients are housed in their own homes instead of a state-run hospital. Long-term care insurance is still excluded as resources.

MT: See Stephen A. Moses, Long-Term Care in Montana: A Blueprint for Cost-Effective Reform, LTC, Incorporated, Kirkland, Washington, September 24, 1993, 86 pages.

NE: Yes, many of these alternatives are available in Nebraska.

NM: New Mexico does not have adequate home & community based care programs to meet current demand. We are currently exploring the area of assisted living facilities.

NY: As indicated in the response to question 5, New York State offers an extensive network of available home care services under its Medicaid program. (See Attachment Q, pages 19-31, for information about all of New York State's long term care community-based programs, including the Assisted Living Program on page 24.)

OBRA '93 provides, at State option, that a transfer penalty period be imposed when a noninstitutionalized individual or the individual's spouse transfers assets within 36 months (60 months for trusts) of applying for Medicaid as a noninstitutionalized individual or transfers assets while on Medicaid. During the penalty period, the noninstitution-alized individual would not be eligible for Medicaid coverage of home health care, personal care, home and community care services for the functionally disabled elderly individuals as described in Section 1929 of the Act, and other long term care services the State may opt to include. Currently, an individual may make a prohibited transfer of assets, thus divesting resources to qualify for Medicaid coverage of noninstitutionalized long term care while waiting out the penalty period for nursing facility services. Failure to apply the transfer penalty period to noninstitutional long term care can also result in individuals divesting assets to prevent recovery of Medicaid correctly paid on their behalf. Enactment of this State option will help the State contain medicaid expenditures for home care by addressing this loophole.

As indicated in the response to question 2, New York State has already implemented the Partnership for Long Term Care Program.

ND: OBRA 93 affects HCBC the same as LTC and if an individual did not plan ahead to secure nursing home insurance in advance, it is too late.

PA: If cost-effective means equal to, or less, than Medicaid reimbursement in Pennsylvania for nursing facility care in Pennsylvania--no. Pennsylvania has personal care homes, domiciliary care homes, other assisted living facilities, and several community based service waivers

which receive Title XIX federal reimbursement. Other non-Title XIX funded alternatives are available to citizens of Pennsylvania including private long-term care insurance.

SC: Currently, South Carolina provides home and community based services to eligible individuals; however, the eligibility requirements are the same as those for individuals in nursing facilities.

UT: Utah has a home and community based waiver for those age 65 and older. Currently, it is limited to 100 recipients per year. Utah plans to increase the number of waiver slots as soon as possible.

VT: Vermont has developed alternatives to nursing homes (see attached booklet on "programs for Attendant Services"). The state has high quality private long-term care insurance available to individuals. The state does not sponsor any long-term care insurance.

WA: The state of Washington has a variety of home and community-based care programs, referred to as waivered programs. They provide SSI-Related and/or developmentally disabled clients an alternative to placement in a nursing facility. The state also has contracted for a number of assisted living facility beds. All have been determined to be cost-effective alternatives.

WI: Wisconsin's reply to this survey refers the reader to Stephen A. Moses, The Senior Financial Security Program: A Plan for Long-Term Care Reform in Wisconsin, LTC, Incorporated, Kirkland, Washington, June 26, 1992, 76 pages.

10. Has Medicaid resident census (as compared to private pay census) in your state's nursing homes increased in the past 10 years? If so, from what to what percent approximately? Can this be attributed to eligibility bracket creep and/or Medicaid estate planning? What has been the impact on (1) the state Medicaid budget and (2) nursing home reimbursement levels. Explain.

AR: No increase in absolute number of Medicaid nursing home recipients.

CA: The average census of Medicaid vs. private pay patients in California over the past 10 years has remained fairly stable; at or near 60 percent of nursing home residents

are Medicaid eligible. A subtle change in the total nursing home census in the last three or four years finds the average occupancy rate down from 97 percent to approximately 87 percent. This has resulted in a higher per patient day cost and higher per patient day expenditure by the Medicaid program.

CO: The average monthly nursing home census in Colorado increased by less than 1% overall during the past nine years. The low growth in nursing home census overall is attributed largely to use of home and community based services and alternative care facilities. However, we have seen a marked redistribution in pay source. Medicaid census is up significantly, while the census of private pay clients actually dropped. Medicaid is paying for an increasing share of nursing home stays--up to 71% of all nursing home clients from 67% in 1985.

Colorado Medicaid expenditures for nursing home clients nearly doubled over the same period, rising from $107 million in 1985 to an estimated $213 million in 1993. A good share of this increase is attributable to higher rates: The Medicaid weighted average daily rate rose sharply and consistently during that time--increasing by 96%, from $37.04/day in 1985 to $72.55/day in 1993. (Patient payments contribute to only about 20% of total payment toward the Medicaid rate at present.) We do not know how much of the increased Medicaid expenditure is attributable to longer patient stays, variation in patient payment over time, estate planning, eligibility bracket creep, or other unidentified variables.

DE: Medicaid resident census has only grown proportionally to private pay census. We really haven't seen a big increase because of Medicaid estate planning.

GA: The census has increased from approximately 72% to 80% over the last 10 years. In addition to bracket creep, it is also attributable to expansion of the medically needy program. In 1984, the total expenditure for long term care was approximately $196 million. The comparable figure for 1993 was $529 million. Average nursing home reimbursement rates have increased by 79,8% over the last ten years.

IL: Yes, from 61% in 1982 to 67% in 1992.

(1) In FY'84, the long term care component accounted for 29% of the States total medical assistance expenditures and in FY'92 the long term care

component had increased to 35%.

(2) Nursing home reimbursement levels have increased from $29.11/day in 1983 to $70.08/day in 1993.

IN: From <u>1991 Indiana Nursing Facility Utilization Report</u>: In 1991, Medicaid reimbursement paid for 61.5 percent of the patient days; Medicare, 4.8 percent; private pay, 30.1 percent; and 3.6 percent from other sources.

IA: A census of nursing facilities indicates the percentage of Medicaid recipients has increased over the last two to three years. Prior to that time the percentage of Medicaid nursing facility recipients remained relatively stable.

The increase in Medicaid nursing facility usage is attributed to: (1) OBRA 87 nursing home reform which became effective October 1992. Nursing facility costs increased upon implementation of OBRA 87 changes. The OBRA 87 changes resulted in private pay individuals using up financial resources more quickly. (2) Spousal Impoverishment changes. (3) The increasing costs of nursing facility care. (4) Estate planning.

The increased usage of Medicaid nursing facility care has caused an increased impact on both the Medicaid budget and the reimbursement rate. The increased usage has resulted in an average 10% increase in per diem rates each year for the period of 1990 through present.

KS: The resident census has increased substantially in the last 10 years. This has appeared to be based more on an institutional bias in the state rather than eligibility measures or estate planning. The State enacted a 300% income cap for nursing home eligibility in 1991 and this has helped slow the growth. Greater emphasis is being placed on getting more people into home based alternatives. Medicaid program expenditures for nursing homes rose from approximately $18 million in 1984 to over $173 million in 1992. The number of recipients over the same time period rose from 11,361 to 13,460.

KY: Yes, but this information is not available. This is primarily attributed to the increased life span of the aging population. The state medicaid budget and nursing home reimbursement rates have increased significantly over the past ten years.

MD: There has been no significant change in the percentage of

Medicaid to private pay patients in nursing homes since 1986. In 1986 Medicaid recipients made up 63.7% of the population of nursing home recipients; in 1988 they made up 63.5%, in 1990, 62.23% of the population and in 1991 (now annual rather than bi-annual surveys) 64.97% of all nursing home recipients. There has been no significant change to the Medicaid budget and nursing home reimbursement levels.

MI: Medicaid resident census has not changed significantly in the past 10 years. We have emphasized home and community based care and pre-admission screening to prevent nursing home care. Yes our nursing home rates have been increasing due to federal mandates and Boren lawsuits.

MN: The Medicaid census in nursing homes has been increasing over the past years. The latest figure for the percentage of the nursing home census on Medicaid is 65.2 percent. In 1987, which is the earliest figure available, it was 64.6 percent. It is difficult to speculate about why the increase has taken place but, of course, it has an impact on the State budget.

MO: Yes, Medicaid resident census has increased in Missouri in the past ten years. No specific data is available.

MT: See Stephen A. Moses, Long-Term Care in Montana: A Blueprint for Cost-Effective Reform, LTC, Incorporated, Kirkland, Washington, September 24, 1993, 86 pages.

NE: Yes, from approximately 7,382 residents in 1983 to 8,547 in 1993 with expenditures increasing from $54.95 million in 1983 to $171.76 in 1993. We believe it can be attributed to the increased number of aged, the OBRA-87 mandate on nursing homes, etc.

NM: The Medicaid nursing home census has grown at a rate of 7.1% per year for the last eight years while the private pay census has grown at the rate of 8.6% per year. However, Medicaid recipients represent 71.8% of the total nursing home patients. We do not know what to attribute this increase to. Nursing home reform has had a greater impact on the New Mexico Medicaid budget than increases in nursing home patients.

NY: In State fiscal year '86-'87, Medicaid expenditures for nursing home care totaled $2.3 billion. The annual increase in expenditures has been approximately 9%. The projected Medicaid expenditures for nursing facility care for State fiscal years '94-'95 is $4.7 billion. Average

daily nursing home Medicaid reimbursement levels have increased from $88.17 for a skilled nursing facility and $54.75 for a health related facility in '85 to $131.65 in '93. Approximately 85% of all nursing home residents in New York State are Medicaid recipients.

The high percentage of persons who were Medicaid eligible at admission was discussed int he response to question 5. This percentage appears to be increasing according to indicators we have tracked since the survey was performed in 1988; however, we have no statistical proof. If, indeed, the high Medicaid at admission rates observed in the survey represent to some extent the results of estate planning activity, the impact on the State Medicaid budget and nursing home reimbursements would be enormous. As there is a differential between Medicaid and private pay rates, each loss of a private pay patient due to divestiture would result in 20% or more loss of potential income to the home. Concurrently, the cost to Medicaid would also increase. Assuming a length of stay of two years where:

Private Pay Rate = $150 Medicaid Rate = $120

*The home would lose $21,900 ($30 x 730 days) for each divestiture patient and;

*Medicaid would lose $87,600 ($120 x 730 days) assuming the patient would have had resources to cover the stay.

ND: Medicaid utilization--based on census reports as of 12/31 unless NA:

Year Ended 12/31	Licensed SNF & ICF Beds	MA Census	Occupancy %	Medicaid + or -
1983	6767	3709	54.81%	
1989	6962	3648	52.40%	-0.25%
1993	7080	3982	56.24%	+1.74%

We do not have any data as to whether this can be attributed to eligibility bracket creep and/or Medicaid estate planning.

PA: Unduplicated number of recipients goes back only to Federal Fiscal Year (FFY) 90/91. Days of care only go back to the same time frame--this is due to problems with data from FFY 89/90.

Recipients of Bed Days for MA NF Total Payments

FFY	MA NF Services	Recipients	for MA NF
'86			$ 676,910,399
'87			702,019,093
'88			775,672,803
'89			843,384,125
'90			942,965,792
'91	66,319	17,728,597	1,021,109,722
'92	70,399	19,259,557	1,249,640,324
'93	72,504	19,355,085	1,364,734,300

Between FFY '91 and FFY '93 there was a 9.3% increase in number of recipients, a 9.6% increase in the number of bed days, and a 33.7% increase in total payments. The increase in total payments from '86 to '93 is 201.6%.

The increase in number of recipients from '91 to '93 is greater than the increase in the state's population over 65 years of age.

The increase in total payments is far greater than the increase in the 65+ population plus inflation.

Explaining these increases is difficult. Perhaps the recession, declining assets, and reduced income because of lower interest rates forced many more below the threshold level for MA ineligibility than would have happened in less economically stagnant conditions.

At this point, I have no explanation for the decrease in bed days between '92 and '93 - I have theories.

SC: For a number of years, the South Carolina Medicaid Program has sponsored approximately 75% of the care provided in nursing homes.

UT: See attachment for changes in Medicaid resident census from 1989 through 1991. The increase has been relatively minor given the State's growth rate. Utah has had stringent medical criteria which we believe has helped mitigate the increase in Medicaid eligibles. Additionally, in 1989, Utah imposed a moratorium on building new Medicaid nursing home beds due to the very high vacancy rate across the industry in Utah. Reimbursement levels have increased but this results from factors other than bracket creep and estate planning, such as a legitimate need to pay more reasonable rates.

Excerpt:

Medicaid Census

1992	68.57%
1991	66.96%
1990	66.22%
1989	64.00%

VT: Nursing home census data from 1982 is not readily available. In FY '92, 70.18 percent of all Vermont nursing home beds were Medicaid.

In this period it is difficult to attribute specific increased cost or utilization to eligibility bracket creep and/or Medicaid estate planning. Significant factors in this period include inflation, four rate rebasings between 1991 and January 1992, the implementation of a case mix reimbursement system in January 1992, and the approval of additional beds at various periods of time.

WA: Medicaid resident census, as compared to private pay census, in the state of Washington's nursing facilities has not markedly increased in the past ten years. It has been fairly constant at a rate of approximately 65%, give or take 2%. We do not have sufficient information to attribute this to either eligibility bracket creep or Medicaid estate planning. Nursing facility reimbursement levels have increased at a fairly constant rate over the same period, i.e. approximately 10% every biennium. The effect of these factors historically on the state Medicaid budget may become clearer once the impact of last Fall's trusts/transfer of assets legislation in OBRA '93 has been determined.

WI: Wisconsin's reply to this survey refers the reader to Stephen A. Moses, The Senior Financial Security Program: A Plan for Long-Term Care Reform in Wisconsin, LTC, Incorporated, Kirkland, Washington, June 26, 1992, 76 pages.