The MAGIC BULLET

How to Pay for Universal Long-Term Care

A Case Study in Illinois

Presented by
LTC, Incorporated
The Long-Term Care Specialists

Publication Date: November 1, 1994
Public Release Date: February 1, 1995

Stephen A. Moses, Director of Research
with the assistance of Kathryn J. Tjelle
LTC, Incorporated
Two Union Square, 22nd Floor
601 Union Street
Seattle, Washington 98101-2365
206-223-0938

THE MAGIC BULLET:

How to Pay for Universal Long-Term Care

A Case Study in Illinois

[This report was originally published in Word Perfect and later translated into Word with a resulting loss of some formatting. Readers should be able to discern content and meaning, but may contact the author for clarification if necessary. Current contact information below.]

Presented

by

LTC, INCORPORATED

"The Long-Term Care Specialists"

Publication Date: November 1, 1994

Public Release Date: February 1, 1995

[Current contact information: Stephen Moses, President, Center for Long-Term Care Financing, 2212 Queen Anne Avenue North, #110, Seattle, Washington 98109, 206-283-7036 or smoses@centerltc.org .]

Stephen A. Moses, Director of Research
with the assistance of Kathryn J. Tjelle
LTC, Incorporated
Two Union Square, 22nd Floor
601 Union Street
Seattle, Washington 98101-2365
206-223-0938

TABLE OF CONTENTS

Executive Summary.. 1

Acknowledgements and Disclosures.. 4

Introduction... 5

The Status Quo in Illinois.. 7

The Ideal Long-Term Care System..11

The Conflict of Paradigms..14

A Phalanx of Fallacies...18

Discussion..52

The Senior Financial Security Program..55

The Magic Bullet: A Step-by-Step Plan..57

Respondents/Interviewees...72

Bibliography..79

Appendix A: Project Proposal and Work Plan......................................87

Appendix B: Background Quotations and Citations...............................93

Appendix C: Quality, Access, Reimbursement Under Medicaid...................120

EXECUTIVE SUMMARY[1]

There is no magic bullet.
Anonymous

Where there's a will, there's a way.
Anonymous

We have all heard the cliche' "There is no magic bullet" applied to complex, seemingly intractable problems. This expression is a common refuge of pessimists and cynics in all walks of life. Especially in the fields of long-term care financing and state Medicaid budgeting, doom-sayers abound who proclaim that disaster lies imminently ahead and no simple solutions exist. The vast and scary literature on aging demographics and entitlement funding certainly seems to support their gloomy prognostications. Sometimes, however, it is possible to reconceptualize a difficult problem and discover an easy solution. That is what we attempted to accomplish in this study.

According to the formal contract between LTC, Incorporated and the Illinois Department of Public Aid, the objective of this project was to "produce a step-by-step plan to save the state of Illinois $320 million per year in Medicaid nursing home expenditures while simultaneously assuring universal access to top quality long-term care for rich and poor citizens alike across the whole spectrum from home and community-based to nursing home care." The final three chapters of this report provide the promised plan to realize this result.[2]

To have any hope of achieving such an ambitious goal, however, we had to show that the apparent insolubility of the long-term care financing problem is not a function of the problem itself, but of a fundamental misunderstanding and misinterpretation of the problem. Therefore, we began by distinguishing between two models of the long-term care financing system: the "welfare paradigm" that pervades virtually all analysis of long-term care financing today and the "entitlement paradigm," which represents a radical departure from the common view. In a nut shell: if the welfare paradigm is true--if people have to impoverish themselves to qualify for Medicaid--then the public's failure to avoid welfare-financed nursing homes, seek out inexpensive home and community-based care services, and purchase private long-term care insurance is inexplicable. On the other hand, if the entitlement paradigm is true, if people can obtain free or highly subsidized long-term care benefits from Medicaid even at the last minute, then the otherwise strange behavior of long-term care consumers is completely rational. We should not be surprised that people fail to purchase private long-term care insurance or pay privately for home and community-based services if they can ignore the risks of long-term care and still receive

---

[1] See Appendix A for the original proposal and work plan of this project.

[2] This Illinois plan applies equally well to other state Medicaid programs that use "medically needy" nursing home eligibility criteria. States that use "income cap" eligibility criteria should refer to *The Florida Fulcrum: A Cost-Saving Strategy to Pay for Long-Term Care* by the same author at the same address and phone number on the cover of this report.

subsidized nursing home care from Medicaid if and when catastrophic illness strikes.

As we examined which of these two paradigms more accurately describes long-term care financing in Illinois, we discovered the following highlights:

· "...nursing home residents in Illinois can easily have several thousands of dollars of income per month and still qualify for public assistance."

· "...someone with a home worth $200,000, plus home furnishings of reasonable value, plus a car worth $50,000, plus burial allotments worth $10,000, plus a term life policy with a $100,000 death benefit, plus $72,660 (or more under court order) to transfer to a community spouse would qualify routinely for Medicaid nursing home benefits in Illinois."

· the "average [Medicaid] caseworker would routinely tell [Medicaid applicants] how to get rid of assets. As long as the applicant gets rid of the assets, the case is easier to handle for the worker, because [we] do not have to set up a spenddown program."

· "I don't identify myself as a public aid worker, but only as a state worker. Once someone finds out where I work, they all have an aunt or a parent or someone who needs to qualify for Medicaid and they insist on asking questions about how to get on."

· "I cannot think of a time that we have found someone ineligible because of an improper transfer."

· "We feel we are left out swinging in the breeze. We try to follow the letter of the law, but when someone squeaks a little, they can make us look stupid by challenging our decision. Pretty soon we don't even question those cases. That is one of the reasons the long-term care system is in a shambles. There are so many special interests. We cannot kowtow to everyone and carry on."

· "If [like the general population]...three-fourths of the caseload once owned real property (mostly free and clear), but divested it in anticipation of potential long-term care costs, then the cost of private liabilities assumed by Medicaid is [close] to $2 billion [for real estate alone]."

· "If half of Illinois' 55,000 Medicaid nursing home recipients have set aside an average of $5,000 each for burial arrangements instead of spending the money for long-term care, the cost to the state in additional Medicaid expenditures is $137,500,000."

· "If two-thirds of Illinois' 55,000 Medicaid nursing home recipients once possessed an average of $4,000 worth of personal property that is exempted at eligibility and excluded from estate recovery, then Medicaid expenditures are $146,520,000 higher than they would otherwise have to be."

· Medicaid nursing home census [in Illinois] has increased "from 60.9 percent in 1987...to 64.9

percent in 1993."

Clearly the welfare paradigm is undermined and the entitlement paradigm is confirmed by these findings. We believe it is possible to build a solution to the long-term care financing problem from this conclusion. The evidence, the reasoning and the proposed solution form the body of this report. We estimate that Illinois' Medicaid program could save $339 million per year by implementing this report's recommendations. Nationwide implementation of the same recommendations could save the state/federal Medicaid program upwards of $5 billion annually.

ACKNOWLEDGEMENTS AND DISCLOSURES

This project was funded under contract with the State of Illinois, Department of Public Aid. The state assisted the project by facilitating access to private long-term care experts, interest groups, key state staff, and public documents. The Department also provided conference space, photo-copy support, and local telephone service. Appendix A contains the original proposal and work plan for this project. Substantive work began July 18, 1994 and concluded November 1, 1994 with the submission of this report.

LTC, Incorporated, the contractor, 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.

Stephen A. Moses, the author, is Director of Research for LTC, Incorporated. He writes, speaks and consults 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). He directed and authored three national studies for HCFA and the IG on Medicaid estate planning. Mr. Moses was assisted in this project by Kathryn J. Tjelle, Research Coordinator, for LTC, Incorporated.

We would like to express our appreciation (1) to the 104 respondents and interviewees who provided the information on which this report is based, (2) to Jan Boone, Assistant Bureau Chief of the Bureau of Long-Term Care in the Illinois Department of Public Aid, Springfield for managing the project, for organizing, scheduling, and attending the interviews, and for sharing her wealth of knowledge about long-term care in Illinois, (3) to Scott Reimers, Summer Intern in the Bureau of Long-Term Care, Illinois Department of Public Aid, Springfield for his able and enthusiastic research assistance, and (4) to James Berger, Deputy Director of Administrative Operations for the Illinois Department of Public Aid, Springfield for authorizing the project and for his willingness to break new ground in long-term care management and financing.

INTRODUCTION[3]

Conventional wisdom and scholarly consensus agree. America faces a potentially cataclysmic long-term care financing crisis in the foreseeable future. The evidence of impending danger lies everywhere we look:

- frightening trends in aging demographics,
- reduced availability of informal caregivers,
- doubts about the quality of formal long-term care,
- inadequate supply of low-cost home and community-based services,
- rapidly escalating nursing home expenses,
- dwindling public finances curbed by economic sluggishness and recalcitrant tax payers,
- declining ability and willingness of families to pay privately for long-term care or insurance,
- cracks in our public and private pension systems, and
- the approaching retirement of the baby boom generation- which will radically exacerbate the crisis.

The President, the Health Care Financing Administration, the Administration on Aging, and every Governor, state legislature, and Medicaid agency in the country are struggling with these seemingly intractable problems. The irony that the world's richest nation is unable to provide access to appropriate long-term care for all its citizens is lost on no one. Yet, America's biggest and most concerted effort in history to achieve universal health care through public policy recently collapsed in abject failure.

When nothing you do seems to work but your predicament is so desperate you cannot give up, the best strategy is to examine your premises. This report contemplates a completely new and untested premise, that is: we do not face a long-term care financing crisis in America, but rather a public policy crisis. Perverse incentives in current long-term care financing policy discourage private planning for and

---

[3] This report is designed to be read quickly and easily like an essay, instead of a scholarly treatise. Readers who seek greater detail or documentation may feel free to contact the author directly. Also, I have included quotations from the gerontological and public policy literature (including citations) in Appendices B and C that substantiate many of my statements and interpretations in this report.

payment of long-term care costs. There is more than enough wealth in the American economy to provide access to quality long-term care for every citizen. Government alone, however, cannot sustain the cost of a burgeoning older population that is succumbing slowly and expensively to frailty, cognitive impairment, and degenerative illness. A practical solution is to redesign public policy to maximize private financing for people who are able to take care of themselves while preserving adequate public financing for those who have nowhere else to turn.

The idea that public policy discourages private financing of long-term care while over-burdening publicly financed programs is a radical departure from the usual assessment that government only pays after private financing has failed. This new hypothesis must be examined, tested and proven. Illinois is a perfect case study of both the problem and the potential solution.

THE STATUS QUO IN ILLINOIS

Illinois' long-term care financing system is in critical condition. A long series of task force studies and special reports has enumerated and documented the problems.[4] The litany of ills is so familiar now that only the briefest summary is necessary here.

Illinoisans, like all Americans, are living longer and they are steadily requiring more health care. Already, one in 50 Illinois seniors aged 65 to 74 needs long-term care. The proportion jumps to one in 13 for 75 to 84 year-olds and one in three for people 85 and older.[5] Although most long-term care in Illinois is still provided by family members and friends for free, the supply of informal caregivers is dwindling as family size declines, women join the work force, spousal caregivers get older and frailer themselves, and family members disperse geographically.

Formal care at the level of home and community-based services is also very limited in Illinois. According to one state official[6], Illinois has only a single person in community care for every three in a nursing home; precisely the opposite proportion as in Oregon, a state known for its deinstitutionalization of long-term care. Institutional bias is clearly a problem here. Illinois ties with Kansas for the lowest average number of deficiencies in activities of daily living[7] (ADLs) among nursing home residents. If Maine's new law-which requires three or more ADLs to qualify for Medicaid nursing home benefits--applied in Illinois, almost one-third (33.1 percent) of the state's nursing home residents could not qualify. By comparison, less than one-quarter of nursing home residents (23.9 percent) in the United States would fail Maine's standard.[8]

Rapid Cost Increases

Under these circumstances, the recent, rapid increase in Illinois' nursing home costs should come as no surprise. Total Medicaid nursing home expenditures in this state leapt from $644 million in fiscal year (FY) 1989 to over $1.3 billion in FY 1993.[9] In FY 1992, almost 55,000 Medicaid

---

[4] These reports are cited in the bibliography.

[5] Illinois Department of Public Aid, *Long-Term Care in Illinois*, prepared for the Governor's Health Care Reform Task Force, Springfield, Illinois, March 1, 1993, p. 1.

[6] Wayne Smallwood, Manager, Internal Operations, Bureau of Long-Term Care Quality Control, Illinois Department of Public Aid, Springfield.

[7] "Activities of daily living" include bathing, dressing, toileting, transferring, and eating. ADL deficiencies are a standard gerontological measure of functional impairment.

[8] Health Data Associates, Inc., *Nursing Home Yearbook: 1994*, Tacoma, Washington, 1994, p. A-2 and Table A-2.

[9] Data provided by Michelle Maher, Budget Analyst, Bureau of Management and Budget, Illinois

recipients per month resided in Illinois' long-term care facilities at an average annual cost of $22,000 each.[10]

More startling than the gross totals, however, is the proportion of Illinois nursing home residents who rely on Medicaid to pay their bills. From 60.9 percent in 1987, the figure has risen steadily to 64.9 percent in 1993.[11] This 4 percent increase in six years partially reflects the public's inability to pay rapidly escalating private nursing home rates that reached an average of $90 per day in 1994. The fast growth in Medicaid participation also derives from the liberalization in federal and state eligibility rules since 1988, which has made Medicaid eligibility for nursing home benefits much easier to attain.

The Department of Public Aid estimates it will serve 1.6 million Medicaid clients at a cost of $6.8 billion in 1995. Of these totals, 67,000 long-term care clients will consume $1.4 billion in 1995. In other words, the Department will spend 21 percent of its substantial budget on only 4.2 percent of its client population.[12] Institutional long-term care is quickly becoming a fiscal black hole that swallows more and more of the state's scarce public resources while benefiting only a tiny number of Illinois citizens. Meantime, other areas of state responsibility are going begging. The public clamors for more attention to education, children and family services, corrections, and highways even as the long-term care financing problem continues to worsen.

We will examine these trends in more detail below. The bottom line, however, is that the state of Illinois is spending a lot of money on Medicaid and long-term care without solving the problem. In his 1995 budget address, Governor Edgar said: "The cost of Medicaid has tripled in the last decade and doubled in the last three years alone. It now tops $5 billion a year-nearly three-fourths of the entire budget for the Department of Public Aid." The Edgar administration acted decisively this year to control Medicaid's acute care costs. Long-term care expenses are the next logical target for reform.

In fact, the situation is so serious that the state of Illinois has already considered or implemented a number of increasingly desperate measures. These include (1) considering a 9 percent reduction in Medicaid nursing home reimbursement rates but implementing an 18-month freeze; (2) considering severe curtailment of spousal impoverishment protections but implementing a "Granny tax" to leverage up federal financial participation; (3) considering austere cuts in Medicaid eligibility and coverage but implementing increased spending at great political peril; and (4) considering rate equalization and "first

---

Department of Public Aid, Springfield.

[10] Representative Robert W. Churchill and Senator Patrick D. Welch, *Medicaid: An Overview of Caseloads and Other Factors Affecting Its Growth*, Illinois Economic and Fiscal Commission, Springfield, Illinois, July 1993, p. 8.

[11] Data provided by James Hunter, Manager, Long-Term Care Rates, Bureau of Program Reimbursement and Analysis, Illinois Department of Public Aid, Springfield.

[12] Data provided by M. Lee Christie, Ph.D., Long-Term Care Policy Researcher, Bureau of Program and Reimbursement Analysis, Illinois Department of Public Aid, Springfield.

come, first served" policies but implementing institutional reimbursement delays. Each time, the state has stepped back from the brink of more extreme initiatives that might shatter the political status quo. Although everyone senses that the time for dilatory strategies and half measures is almost over, no one has a comprehensive plan that everyone is willing to accept. A state waiver specialist told me: "We are just cutting the pie in more pieces." A state researcher said: "We do not keep costs down. All we do is allow for cost shifting to the private sector."

Bleak Future

The future for long-term care in Illinois looks even bleaker than the present. All available projections indicate that institutional long-term care costs will continue to spiral upward. One report estimates that Illinois' institutional long-term care population will grow from 97,700 in 1990 to 149,514 in 2020 and that Medicaid nursing home costs will skyrocket from $1.1 billion in FY 1992 to $20.3 billion in FY 2020.[13] The possibility of another major recession, with declining revenues and increasing demands on services, chills the blood of politicians and administrators. The collapse of national health reform has given focus to the underlying pessimism and discouragement of pundits, policy makers, and the public. Each of the major interest groups in long-term care seems more than usually angry, frustrated, suspicious, volatile, and outspoken. Senior advocates, care providers, tax-payer representatives, and insurers compete for political advantage and work at cross purposes instead of searching for mutually beneficial ways to mobilize in common purpose. Almost no one is optimistic that a practical and affordable solution can be found to Illinois' long-term care financing plight.

[13] Illinois Department of Public Aid, *Long-Term Care in Illinois*, prepared for the Governor's Health Care Reform Task Force, Springfield, Illinois, March 1, 1993, pps. 3, 10.

THE IDEAL LONG-TERM CARE SYSTEM

Clearly, long-term care financing in Illinois is a big problem already and is likely to get much worse before it gets any better. The irony of this lamentable situation is that almost everyone in Illinois agrees on the architecture of an ideal long-term care system. Commonly agreed upon optimizing features show up consistently in task force reports, think tank studies, departmental policy papers, and in all the interviews conducted for this study. These features are:

- Generous eligibility
- Integrated acute and long-term care
- Easy access
- Quality control
- Case management
- Uniform client needs assessment
- Asset protection
- Home and community-based care
- Nonmedical social services, such as housekeeping and personal care
- Adult day care
- Respite care
- Assisted living and adult foster homes
- Pre-admission screening
- Custodial, skilled, and sub-acute nursing home care
- Services to meet the special needs of geriatric, developmentally disabled, mentally ill, and other patients
- Adequate financing

Here is the dilemma: we know what we want in long-term care; we know how to design an optimal service delivery system; we live in the world's wealthiest society; but we cannot seem to come

together politically and professionally to get the job done. Why?

The answer is simple. The wish list above is typical not only for its content, but also for its manner of dealing with the single most critical factor enumerated. **Financing** is always handled last and with the least amount of thought. Everyone wants to choose the accessories for a new long-term care vehicle. Researchers are eager to take it out for an expensive test drive. But no one wants to fill it with gasoline. Every academic dreamer's design and every policy maker's plan crashes quickly into the roadblocks of expensive woodwork factors,[14] discouraging cost-effectiveness studies,[15] prohibitive waiver eligibility limits,[16] skeptical legislators, cautious administrators, and reluctant tax payers. In the words of one highly experienced Illinois student of the problem:

> The major impediment to change is money. It is almost impossible to change an expensive distributive program without increasing costs....Since no change will occur unless you 'hold harmless' all participants-i.e., nobody loses money--any change will cost more money. There are always other programs and agencies competing for the limited resources that are available, and never enough money to satisfy even the most deserving of requests for increased state funds.[17]

---

[14] Woodwork factors refer to the insurance principles of adverse selection, induced demand, and moral hazard. In other words, if we make more public resources available to pay for home and community-based care, people who have been managing on their own will come "out of the woodwork" to take advantage of the new financing source.

[15] For example: the channeling studies and other research that indicate home and community-based care increases rather than decreases aggregate long-term care costs. See Appendix B for supporting quotations.

[16] For example: Medicaid home and community-based waiver restrictions that require participants to qualify medically for nursing home care, but cost less to care for in the community.

[17] Robert L. Mandeville, *An Rx for Medicaid*, Illinois Tax Foundation, Springfield, Illinois, 1993, p.

If we hope to break out of this public policy straightjacket and find the means to pay for universal long-term care, we have to explain: (1) why financing is inadequate under the existing system, and (2) how the system can be changed to increase overall financing without inflating the costs to key interest groups. This is a logical impossibility unless the current system contains some fundamental, underlying flaw or fallacy that explains its financial dysfunction and can feasibly be corrected through public policy. We can search for such a critical fallacy in the current system by conducting a thought experiment that I call the conflict of paradigms.

55.

THE CONFLICT OF PARADIGMS

Whether you read a newspaper article, a scholarly journal or a full-length book about long-term care financing, you will invariably find an argument that goes something like this:

> Long-term care, especially nursing home care, is extremely expensive. Very few Americans can afford $3,000 or $4,000 per month in extra expenses. Therefore, when stricken by the tragedy of Alzheimer's, Parkinson's, or stroke, most people spend down their life's savings quickly and fall into poverty. Once impoverished, they qualify for Medicaid, which pays the bills. Consequently, Medicaid nursing home costs are skyrocketing, and the government's ability to meet growing long-term care needs is severely strained.

This scenario--call it the *welfare paradigm*--comports with some of the facts and seems to explain certain phenomena. For example: nursing homes are very expensive; Medicaid is a means-tested public assistance program, i.e. welfare; approximately two-thirds of all residents in nursing homes do receive Medicaid; and Medicaid does suffer from severe financial problems. But let us set these issues aside for a moment, step back from the actual long-term care financing system, and ask: "if the welfare paradigm is true, what would we logically expect the long-term care financing marketplace to look like?"

The Welfare Paradigm Challenged

If long-term care impoverishes large numbers of Americans and forces them onto welfare, we would certainly expect seniors and their families...

- to worry and plan years in advance about the potentially catastrophic costs of long-term care;
- to avoid nursing home care as long as possible because of its expense and because of their preference to stay at home;
- to demand high-quality, low-cost, home and community-based care alternatives that delay institutionalization and impoverishment;
- to utilize home equity conversion products (such as reverse annuity mortgages) that can finance home care and postpone liquidation of the family home; and,
- to purchase private long-term care insurance that can protect against catastrophic financial loss caused by home or institutional care.

In practice, the opposite of these expectations is true. First, most families do not plan in advance for the risk of long-term care. That is why so many of them end up in crisis with nowhere to turn but to public

assistance. Second, nursing home care is often the first choice for care, not the last resort. That is why so many people end up in nursing homes who could be cared for at home more comfortably and for less cost. Third, the home and community-based care sector of the long-term care marketplace has been very slow to develop. That is why many people have no viable choice besides nursing home institutionalization when a health crisis strikes. Fourth, home equity conversion has failed as a private sector financial product, despite strong encouragement from the government. That is why the single biggest financial asset of seniors (their home) goes virtually untapped as a source of financing for quality long-term care. Finally, only about 5 percent of seniors have purchased private long-term care insurance. That is why nursing home costs are devastating to most people when they do occur.

The Entitlement Paradigm

Clearly, much of what we would expect rational economic decision makers to do if the welfare paradigm were true simply does not happen. Instead of torturing the old paradigm to account for these anomalies, we might consider a different view--call it the *entitlement paradigm*:

> In America today, people can ignore the risk of long-term care, avoid the premiums for private insurance, wait to see if they ever require formal care and, if necessary, shelter all their income and assets to qualify (virtually overnight) for nursing home benefits paid for by Medicaid.

If the entitlement paradigm is true, all the puzzles we encountered above disappear. For example, people do not plan ahead for long-term care, because they can wait until the last minute and receive publicly financed care. They often go to nursing homes instead of home care first, despite their preferences, because Medicaid pays generously for nursing home care, but covers very little home care. Moreover, few people want to take advantage of home equity conversion to finance long-term care or insurance, because Medicaid exempts the home and all contiguous property regardless of value. Finally, long-term care insurance is unpopular because most people will not pay for something they can get from the government for free.

Thus, if the entitlement paradigm is true, it is easy to understand why most people are eligible for Medicaid even before they enter a nursing home[18]; why Medicaid nursing home census and costs are rapidly increasing; why induced demand makes Medicaid financing of home care prohibitively expensive[19]; and why private financing of nursing home care is declining instead of increasing as a proportion of total costs.[20] Furthermore, if the entitlement paradigm is true, many exciting, new public

---

[18] 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. (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.)

[19] See Appendix B, "Cost-Effectiveness of Home and Community-Based Services," for substantiating quotations.

[20] In 1987, private out-of-pocket expenditures accounted for 49.3 percent of total nursing home

policy options open up for us. For example, we could save the tax payers a lot of money simply by making Medicaid a little less desirable and by providing an incentive for people to plan ahead to avoid public assistance. In other words, the magic bullet we are looking for in this study may reside in merging the two paradigms to gain the benefits of the welfare system without incorporating its negatives while eliminating the problems of the entitlement paradigm without sacrificing its benefits.

There is no point, however, in exploring these possibilities unless the entitlement paradigm is true. Unfortunately, to most people familiar with the long-term care financing system, the entitlement paradigm is highly improbable. Critics of the entitlement paradigm would cite federal and state laws that seem to require impoverishment to qualify for Medicaid. Furthermore, most experts accept the welfare paradigm uncritically. Almost no one seriously challenges it. Certainly, no one has ever tried to make the case that the welfare paradigm is wrong and the entitlement paradigm is true. That is what I will attempt to do in this report.

The remainder of the report conforms to the following structure. The next chapter enumerates and corrects the fallacies surrounding the welfare paradigm while providing evidence that the entitlement paradigm is fundamentally true. Then, the "Discussion" draws appropriate inferences for public policy. Next, a chapter entitled "The Senior Financial Security Program" explains how the interests of key long-term care stakeholders could be satisfied cooperatively and cost-effectively. Finally, the last chapter provides a step-by-step plan to improve long-term care access and quality while reducing public expenditures substantially by thoughtfully merging the two paradigms described above.

---

costs nationally ($40.6 billion); Medicaid paid for 43.9 percent. In 1991, private out-of-pocket expenditures accounted for 43.1 percent; Medicaid paid for 47.4 percent. (Source for 1987 data: personal communication with Helen Lazenby, Health Expenditure Analyst, Office of the Actuary, Health Care Financing Administration on May 3, 1990; source for 1991 data: Suzanne W. Letsch, et al., "National Health Expenditures, 1991," *Health Care Financing Review*, Vol. 14, No. 2, Winter 1992, p. 25.)

A PHALANX OF FALLACIES

I believe that the welfare paradigm is wrong, that it is surrounded by a phalanx of fallacies that shelter it from critical scrutiny, that the entitlement paradigm is demonstratively true, and that these facts elucidate the path to a very promising solution to the long-term care financing problem.

Webster defines phalanx as "a body of heavily-armed infantry formed in ranks and files close and deep, with shields joined and long spears overlapping" and fallacy as "a deceptive, misleading or false notion, belief, etc....a misleading or unsound argument...." This chapter explains, refutes, and describes the significance of 11 important fallacies that usually guard the welfare paradigm from thoughtful analysis and criticism.

****

Fallacy #1: Medicaid requires all Illinoisans to spend down into poverty before they qualify for publicly financed nursing home benefits.

Fact #1: There is no objective limit on how much income and assets someone can have and still qualify for Medicaid nursing home benefits in Illinois.

As long as a Medicaid applicant's countable monthly income is less than the cost of a nursing home, he or she is eligible. To compute countable income, the state subtracts a $30 personal needs allowance; a dependent spouse and child allowance; medical bills that Medicaid does not cover; and health, Medicare supplemental, and long-term care insurance premiums. Given that monthly nursing home rates in Illinois average $2,700 and costs deductible from income can be very substantial, **nursing home residents in Illinois can easily have several thousands of dollars of income per month and still qualify for public assistance.** Once eligible, a Medicaid nursing home recipient must contribute excess, nonexempt income toward the cost of care. But this obligation is computed only after subtracting additional exemptions such as a family maintenance needs allowance, medical transportation expenses, amounts to maintain a home in the community, and up to $1,816.50 per month (the federally allowed maximum) for a spousal maintenance allowance.

Regarding assets, Medicaid nursing home recipients are technically limited by law to a $2,000 *disregard*. This draconian restriction is very misleading. In addition, recipients may retain a home and all contiguous property (of unlimited value); personal effects and household goods (on which a $2,000 legal limit is rarely enforced)[21]; an automobile of any value (for all practical purposes); a prepaid burial plan or a life insurance policy worth $1,500; additional assets in unlimited amounts if they are set aside for burial spaces and merchandise; interest earned on burial funds and appreciation in the value of burial investments; term life insurance policies of any amount for any beneficiary as long as they have no cash surrender value; and several additional, more esoteric exemptions. In addition to these exempt assets, a

---

[21] Eligibility workers in one local office told me: **"We never look at the $2000 limit."**

Medicaid nursing home recipient can legally transfer assets up to the federally allowed maximum of $72,660 to a community spouse. Finally, if the community spouse can establish at a fair hearing or through a court order that even more assets are needed to generate enough interest income to raise his or her total monthly income to the monthly maintenance needs allowance (up to $1,816.50 per month), the additional assets must also be exempted. In other words, there is no practical limit on how much money a Medicaid nursing home recipient and spouse can retain in Illinois as long as the assets are held in exempt status. For example, **someone with a home worth $200,000, plus home furnishings of reasonable value, plus a car worth $50,000, plus burial allotments worth $10,000, plus a term life policy with a $100,000 death benefit, plus $72,660 (or more under court order) to transfer to a community spouse would qualify routinely for Medicaid nursing home benefits in Illinois.** Of course, we have not even alluded yet to sophisticated asset transfers and trust strategies that permit even wealthy people to qualify for Medicaid.

Finding #1: Medicaid nursing home eligibility is very generous in Illinois. Generous eligibility is not a problem if the state retains other methods--such as divestiture controls, liens, and estate recoveries--to assure that paying privately for long-term care is preferable for most citizens to relying on Medicaid. The alternative of requiring catastrophic spenddown as a condition of eligibility is neither humane, administratively feasible, nor politically attractive. This report will offer numerous recommendations on how to finance the cost of liberal Medicaid long-term care eligibility standards by providing strong incentives for the public to avoid Medicaid eligibility unless, and until, it is absolutely necessary.

****

Fallacy #2: Medicaid eligibility rules are so complicated that most people spend down their life's savings long before they learn about ways to protect assets.

Fact #2: Information on how to qualify for Medicaid long-term care benefits without spending down privately is universally available throughout Illinois and almost impossible to miss.

Headquarters and field office Medicaid eligibility experts listed numerous sources of information, counseling, and advice on how to qualify for benefits. For example: Area Agencies on Aging, the Department on Aging, social service agencies, community groups that work with the elderly, senior advocates, medical doctors, hospital discharge planners, nursing homes,[22] and word of mouth through friends, family, and the media. One unlikely example is the Senior Health Insurance Program (SHIP), which primarily educates seniors on private insurance alternatives, but warns in its newsletter: **"Rule of thumb: When transferring assets greater than $100,000, be sure to wait 36 months before applying for Medicaid."**[23]

---

[22] Nursing homes often provide advice on and assistance with Medicaid qualification, because they seek a relatively stable and reliable funding source. A Medicaid resident, for whom payment may be too late and too little, is better than a private resident who does not pay at all. Nursing homes complained bitterly that they are often left holding the bill when Medicaid eligibility is delayed or denied.

[23] Illinois Department of Insurance, Senior Health Insurance Program, "New Medicaid Laws,"

Publicly financed legal services agencies routinely provide information on Medicaid eligibility. For example: Land of Lincoln Legal Assistance Foundation, Inc. publishes a brochure entitled "When One Spouse Enters a Nursing Home: Illinois Medicaid Income and Asset Rules for Couples." This publication lists exempt assets, describes spousal impoverishment protections, and explains exempt asset transfers. It concludes: **"If you need specific advice about a Medicaid problem you are having, you may seek free legal assistance at Land of Lincoln Legal Assistance Foundation, Inc."**

Private legal advice on how to qualify for publicly financed long-term care benefits without spending down is also becoming more and more readily available in Illinois. Medicaid estate planning specialists devise elaborate plans to restructure their clients' income and assets to make them quickly eligible for public benefits. The legal fees they charge for this service are often less than the cost of one month in a private nursing home.[24] The National Academy of Elder Law Attorneys (NAELA), which is the professional association of Medicaid estate planning attorneys, recently chartered a chapter of the organization in Illinois. One of the new chapter's officers distributes an advertising flyer for his practice that promises advice on: **"Medicaid - qualifying yourself, your spouse, a parent or friend for long-term care benefits, including assistance with Medicaid application forms and representation at Medicaid appeal hearings."** Another NAELA attorney in Illinois advertised in a seniors' newspaper: "Elder law is protecting your assets from catastrophic medical & nursing home costs...Medicaid planning & implementation."[25] Ads such as these are commonplace. Many respondents reported that continuing legal education seminars on Medicaid estate planning are also readily available to help new practitioners learn the field. One prominent workbook for such seminars advises: **"The objective in Medicaid eligibility planning is to make asset transfers and dispositions to protect assets from dissipation on expenditures that may otherwise be met by Medicaid."**[26] The practice of intentionally planning to qualify for welfare is obviously growing very rapidly in Illinois. In fairness, elder law attorneys provide many valuable services for elderly clients besides Medicaid estate planning. Most Medicaid planners agree that inequities in public policy, which allow savvy seniors to save their estates while sometimes crushing the unwary, should be corrected.

State Welfare Agency Gives Medicaid Planning Advice

Portrait of SHIP, Winter 1993-#2, p. 2

[24] See Appendix B, "Elder Law Issues" for an example of Medicaid estate planning fees.

[25] *Senior Citizens News & Views*, April 1994, p. 17.

[26] Janna Dutton, "Illinois Medical Assistance for Nursing Home Care," chapter in *Illinois Institute of Continuing Legal Education Handbook, Advising the Elderly Client*, Chicago, Illinois, to be published in 1994. This book describes numerous sophisticated techniques to qualify for Medicaid without spending down. It is also an excellent introduction to Medicaid nursing home eligibility laws and regulations in Illinois.

Probably the cheapest and most reliable way to get advice on qualifying for Medicaid long-term care benefits is to contact a local office of the Illinois Department of Public Aid. Headquarters eligibility policy staff; field office administrators, intake workers, and eligibility specialists; and nursing home owners and operators told me repeatedly that Medicaid applicants, their families, and their attorneys seek advice constantly--from all levels of the state agency--on Medicaid rules and ways to get around them. Official departmental policy is to give only the facts and not to speculate on how individual cases might qualify by creative interpretation of the rules. In practice, however, field staff acknowledged to me that the **"average caseworker would routinely tell [Medicaid applicants] how to get rid of assets. As long as the applicant gets rid of the assets, the case is easier to handle for the worker, because [we] do not have to set up a spenddown program."** The process is straightforward. First, the worker explains the exemptions and exclusions cited above: the generous income allowances, the $2,000 asset disregard, the automobile exemption, and so on. These conditions alone render most applicants eligible, but not all: **"They often say: 'Mom has $10,000 left in the bank.' My first question is: how do you plan to bury her?"** So the worker proceeds to explain the burial-related exemptions in more detail. Frequently, a representative of an applicant (usually an adult child) will indicate that the infirmed parent cannot possibly return home. As soon as the eligibility worker explains that "intent to return" is a prerequisite for the homestead exemption, however, the applicant's representative does an about face: "of course Mom intends to return home." One worker said: **"That is where you will find us [prompting]: 'It is homestead, isn't it?' You wanted me to be truthful, right?"** In other words, it becomes a waste of time to explain the legal requirements; workers might just as well encourage people at the beginning of the eligibility interview to make the most advantageous claims, regardless of their literal truth. With group care caseloads averaging 550 complicated cases per worker, time pressure is enormous, so staff often "skip to the chase" and approve the case if they know that the ultimate outcome will be the same, anyway. Sometimes, the public's demand for advice on Medicaid planning is so intense they don't even wait to come into the welfare office: **"I don't identify myself as a public aid worker, but only as a state worker. Once someone finds out where I work, they all have an aunt or a parent or someone who needs to qualify for Medicaid, and they insist on asking questions about how to get on."**

The sources of information on Medicaid eligibility criteria and methods to circumvent them are so widely available in Illinois today that one local office administrator concluded: **"by the time they come in here, they have everything [necessary to qualify for Medicaid benefits] done."**

Finding #2: No one should fault elder law attorneys or state eligibility workers for explaining how the Medicaid program works. That is their job. Attorneys are responsible to get their individual clients everything they are entitled to under the law. Medicaid eligibility workers are required to explain Medicaid rules and to help families apply the rules to their individual circumstances. Neither the lawyers nor the workers are responsible for establishing public policy. If the public policy, i.e. almost universal de facto access to Medicaid-financed long-term care benefits, is not what Congress, the state legislature, and the Governor intended, then it is the responsibility of these elected officials to change it. The bar and state workers will follow their lead. This report will provide many recommendations on how to target Medicaid long-term care benefits to the genuinely needy while diverting prosperous people toward viable private financing alternatives long before they face a caregiving crisis.

****

Fallacy #3: No one can qualify for Medicaid nursing home benefits in Illinois without first satisfying strict and objective eligibility criteria established by Congress and the state legislature and enforced by the Department of Public Aid and the courts.

Fact #3: Although Medicaid law and administrative rules appear strict and inflexible in published form, they are in truth extraordinarily elastic as applied. When they will not bend, they often break without consequences for the violators.

For this study, I interviewed Medicaid eligibility caseworkers in an urban office (Nursing Home Services in Chicago), a suburban office (Sangamon County) and a rural office (Franklin County). Caseworkers told me "anybody can apply for anybody who is familiar with their financial circumstances." In the Chicago office, a **"majority of applications are by mail....No one has to come in, look you in the eye, and say who has what."** Good faith efforts are made to interview clients in the nursing home, but this is often infeasible, as two-thirds of nursing home residents are cognitively impaired.[27] Thus, financial information workers must rely on to determine eligibility is often highly undependable.

The eligibility criteria caseworkers must apply are often just as indeterminate. Workers told me the single biggest hole in Illinois' Medicaid eligibility screen is the policy on "exempt transfers." When a Medicaid recipient or applicant has transferred assets for less than fair market value for the purpose of qualifying for assistance, the state can deny eligibility during a penalty period--the duration of which is specified in federal law. We will have more to say on this rule later. For now, I only want to explain why it rarely stands in the way of Medicaid eligibility in Illinois. According to the Illinois Auditor General: "In Fiscal Years 1991 and 1992, 35 of an estimated 42,000 applications for long-term care were initially denied due to improper property transfers."[28] Yet, staff in the rural eligibility office told me 10 percent of their cases involved asset transfers or planning; the suburban office said 50 percent; and Chicago indicated 75 percent.

Why are there so many transfers and so few penalties? A transfer is exempt from penalty if it meets any one of these five criteria: (1) the transfer occurred more than 30 months before the Medicaid application; (2) the client received or "intended to receive" fair market value; (3) the transfer was made to a spouse or other exempt relative under federal law; (4) denial of eligibility would create an undue hardship; or (5) the transfer was done for some other reason than to qualify for Medicaid. These exemptions are contained in state eligibility rules; they reflect federal law; and they seem very

---

[27] "For every 1,000 nursing home residents, 674 [67.4 percent] had at least one cognitive disability." (J.F. Van Nostrand, S.E. Furner, and R. Suzman, editors, *Health Data on Older Americans: United States, 1992*, National Center for Health Statistics, Vital Health Stat 3(27), 1993, p. 4.)

[28] State of Illinois, Office of the Auditor General, *Program Audit: Enforcement of Property Transfer Laws*, Springfield, Illinois, May 1993, p. iv.

appropriate and clear-cut. Workers are trained on them and urged to "use judgment" in applying them. But, here is what the workers have to say about interpreting and enforcing transfer of assets restrictions:

> **"We never had to worry about it because every transfer was already exempt: no knowledge, undue hardship, or they did not do it to qualify for assistance....I don't even investigate if they just claim in writing that the recipient didn't know or that the transfer was not done to qualify for Medicaid....When we find out about a transfer that is going to be a hardship on the client, we just kind of turn a blind eye....They call and say they have $150,000--we tell them the policy, then they come back and the assets are gone."**

Workers told me about transfers that were approved as exempt because the "client wanted to pay $7,000 for her granddaughter's wedding," or "Grandma wanted to pay $20,000 for my education," or the client "wanted the children to have [$130,610 plus a house] as gifts." Other cases gained exemption of $25,000 to $50,000 transfers on the grounds that "they promised it to me years ago," "I just left [the money] there in her account so mother could draw interest," "I loaned her the money, now she is repaying me," "I took care of her." Even headquarters staff acknowledged they "would allow receipts for 20 years of taking Mom to the beauty parlor" as a legitimate reason for an exempt transfer to pay back a dutiful child. One local office administrator said: **"I cannot think of a time that we have found someone ineligible because of an improper transfer."** When I summarized that the system sounds like a sieve that allows virtually anyone who knows what to say to qualify, a room full of Medicaid eligibility specialists wholeheartedly concurred: "That is true. It really is true."

Are the Loopholes Intentional?

Why is transfer of assets policy so loose? Workers believe the flexibility is intentional. By keeping the rules elastic, people who complain loudly or have strong political connections or get good legal advice can be accommodated easily. If they get what they want, they do not cause trouble. Others, who accept the rules at face value, do not cause trouble either. They pay the price, however, for their good intentions by spending down to a much stricter standard. For example: one local office respondent told me: **"As long as you get to a politician, and if you are squeaky enough, you can get satisfaction."** Another said the system "is a lot stricter for people without attorneys than with. The attorneys know the loopholes. They know the way through the maze." When I asked about sophisticated Medicaid estate planning techniques such as trusts or limited partnerships popular in other states, Illinois workers responded: "We don't need those [complicated techniques] to hide this stuff, because [eligibility] is so freely given anyway....There are so many loopholes, we have our hands practically tied."

Nor do eligibility workers in Illinois feel they will be backed up by headquarters policy and legal staff if they take a tough stand. These quotes from three different offices indicate their feelings: "I can tell you as a caseworker that I feel intimidated if I call or write to policy....Policy will not make a decision on whether a transfer is appropriate. We have been advised by other people who have tried to take cases to litigation that policy will not back you. We don't have enough teeth in the policy to hang

on....There is nobody on the front lines to help us. We don't have access to legal assistance to back us up." In summary, one very frustrated field office manager told me: **"We feel we are left out swinging in the breeze. We try to follow the letter of the law, but when someone squeaks a little, they can make us look stupid by challenging our decision. Pretty soon we don't even question those cases. That is one of the reasons the long-term care system is in a shambles. There are so many special interests. We cannot kowtow to everyone and carry on."** (In fairness, headquarters staff believe they provide "pretty good legal support to answer questions for the field." But they are up against ambiguous laws and regulations that change constantly, strong client advocacy groups, political pressures, low staffing, and severe time constraints.)

Financial Abuse of the Elderly

One unfortunate side effect of the field's inability to enforce strict asset transfer rules is that the system often inadvertently encourages financial abuse of the elderly. One local office told me that some level of inappropriate and sometimes illegal misappropriation of a senior's assets occurs in 50 percent to 70 percent of all Medicaid nursing home cases. Often, the easy way out of such situations is to excuse the matter as a "hardship" case and drop it. Workers cited numerous cases to me where adult children had taken their parents' money or homes in the process of qualifying the elders for Medicaid. A typical example is a case in which a daughter applied for her mother. Field staff told the daughter she could not transfer the mother's home into her own name, and that the mother's nonexempt income would have to be applied toward the cost of her care. The daughter took the house and keeps the income with impunity. To deny eligibility would be an undue hardship for the mother who is ably represented by a client advocate. The state could sue the daughter, but deems this option not to be cost-effective. The nursing home is stuck with trying to collect from the daughter because Medicaid deducts the mother's income from its payment to the home, whether the nursing home receives the money or not. Clearly, loose eligibility rules and active client advocacy in the absence of effective enforcement is an open invitation to fraud and abuse.

Finding #3: During this study, I made the following statement dozens of times to many groups, including Medicaid eligibility specialists: "There is almost no one paying privately for nursing home care in Illinois who cannot be on Medicaid in thirty days." Only one person challenged this comment, and he demurred as soon as I explained the exemptions, exclusions, ambiguities, elasticities, and loopholes in the law and policy. Estate planning attorneys call estate taxes "voluntary," because they are so easy to avoid. For the same reason, private nursing home costs in Illinois are also voluntary. Unfortunately, old people are vulnerable to chronic illnesses, and long-term care is expensive. As long as people can ignore such risks and still get the care they need from a publicly financed program, they will be tempted to do so. And their heirs will be tempted to help them--legally and illegally. This report's recommendations will offer many effective methods to tighten Medicaid long-term care eligibility criteria and discourage financial abuse of the elderly--without denying assistance to the genuinely needy and qualified.

****

Fallacy #4: Although it is true that Illinois citizens are allowed to retain some assets and possessions

and still qualify for Medicaid nursing home benefits, this does not add up to very much in terms of the state's Medicaid nursing home budget.

Fact #4: The cost to the state of exempting just three kinds of basic assets (the home, prepaid burial plans, and personal belongings) is staggering. Although these exemptions are popular and justified in some measure, state spending to support them must be balanced against the contingency costs of being unable to save the tax payers' money or allocate it to other priorities.

More than 77 percent of American seniors own their homes; of these, 83 percent own them free and clear of mortgage debt. Median home value is $70,418 nationally. The mean value is $95,175. Total home equity held by the elderly in America today exceeds $1.5 trillion.[29] In the six-county metropolitan area surrounding Chicago, 72 percent of people over age 65 own their own homes. Only 23 percent of them are still making mortgage payments. The median value of their homes is $99,000.[30] By the time Illinois seniors end up in nursing homes on Medicaid, however, state staff estimate that only 10 or 15 percent of them retain homes.[31] This estimate comports with data published by the General Accounting Office on senior home ownership, which ranged from 9 percent in Pennsylvania to 21 percent in Wisconsin and averaged 14 percent for the eight states GAO studied.[32]

What happens to the homes of approximately 60 percent of all American seniors between the time that they are occupying them as healthy, productive citizens and the time when they end up in a nursing home on Medicaid? No one knows for sure, but many writers assume or speculate that the answer is widespread catastrophic spenddown of home equity for long-term care. There is no evidence to support this hypothesis, however. In fact, recent studies suggest just the opposite.[33] Another possibility is that families effectuate a transfer of home ownership from senior to heir in anticipation of or in response to impending disability and the need for long-term care. Very little hard data supports this theory either, but the literature is full of anecdotal evidence. Caseworkers interviewed for this study confirmed that the practice is commonplace.[34] We cannot resolve this debate here, but we can offer

---

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

[30] Dan Stolze, "Research Data on the Elderly," presentation to the Illinois Governor's Long Term Care Committee by the Metro Chicago Information Center on May 10, 1993.

[31] Eligibility staff at the Nursing Home Services office in Chicago made this estimate.

[32] General Accounting Office, *Recoveries from Nursing Home Residents' Estates Could Offset Program Costs*, GAO/HRD-89-56, March 1989, p. 20.

[33] Over the past few years, a large number of spenddown studies have shown that only 15 percent to 25 percent of Medicaid nursing home recipients converted from private pay instead of the 50 percent to 75 percent formally believed. Several of these spenddown studies are listed in the bibliography.

[34] My publications on this topic are cited in the bibliography. One of these (*The Florida Fulcrum:*

these estimates for consideration: if only 10 percent of Illinois' 55,000 Medicaid nursing home recipients own homes worth an average of $50,000 each, then the state has used public funds to exempt $275,000,000 worth of home equity from long-term care liability. **If, however, three-fourths of the caseload once owned real property (mostly free and clear), but divested it in anticipation of potential long-term care costs, then the cost of private liabilities assumed by Medicaid is closer to $2 billion.** The actual number is undoubtedly somewhere between these two estimates. Of course, assets transferred to qualify for assistance are not vulnerable to recoupment through the lien and estate recovery program.

Burial Exemptions

Burial plans are another exempt resource that is easily overlooked but costs the state lots of money. If an applicant for Medicaid long-term care services has too many nonexempt assets to qualify, but has not made arrangements for funeral costs, eligibility workers told me: "We advise them to go take care of that." Medicaid rules exempt a prepaid burial plan worth $1,500 or less; plus a single premium annuity life insurance policy for burial services or merchandise of any value (e.g., Forethought Plans); plus burial spaces of any value for the recipient, the recipient's spouse, and the recipient's immediate family; plus burial merchandise of any value including headstones, vaults, coffins, and the expense of opening and closing the grave site. How many Medicaid nursing home recipients take advantage of this exemption? Headquarters eligibility staff estimated 10 percent, at an average cost of $5,500, but acknowledged the actual incidence may be higher. The field approves burial exemptions that headquarters rarely sees. Franklin County staff told me 25 percent of recipients use this exemption at an average cost of $4,250; Sangamon County said 55 percent and $5,000; and Nursing Home Services estimated 75 percent and $5,500.

While no one begrudges Medicaid recipients a decent burial, it behooves public policy makers to consider the tradeoffs. **If half of Illinois' 55,000 Medicaid nursing home recipients have set aside an average of $5,000 each for burial arrangements instead of spending that money for long-term care, the cost to the state in additional Medicaid expenditures is $137,500,000.** In 1993, Illinois paid for only 1300 burials of Medicaid nursing home recipients in Cook County--out of a caseload of 27,000. If one-third of the caseload can be expected to die each year, this suggests the majority of burials are pre-funded by exempt resources. When the state pays directly, the maximum allowed is only $945, but when the burial is prepaid by recipient exemption, the cost is more than five times as much. For this study, we contacted five funeral homes throughout the state of Illinois and found that a decent disposal of remains including a service can be arranged almost anywhere for half of the cost of the average Medicaid exemption. We also learned that funeral homes sometimes advertise their

---

A Cost-Saving Strategy to Pay for Long-Term Care, LTC, Incorporated, Seattle, Washington, 1994) contains a comprehensive bibliography of the literature on Medicaid estate planning and transfer of assets.

services as a Medicaid eligibility planning technique and that the funeral association lobbies annually to increase burial exemption limits. Under the circumstances, no one could expect them to do otherwise; de facto public financing of moderately expensive funerals is lucrative to their industry. The fundamental public policy question at stake, however, is whether state resources are adequate to provide critical services to the truly destitute, to meet other vital state financing responsibilities, **and** to indemnify heirs against the cost of burying their parents as well. If not, the relatively generous burial exemption is one place to look for savings.

Personal Property Exemptions

Finally, eligibility staff at Nursing Home Services in Chicago told me: "About 75 percent of geriatric cases involve some form of asset planning. You must understand that with the elderly, most of them have something....Everything Mom and Dad had, the children feel they are entitled to take." Often, household furnishings and personal belongings have substantial value. Although the exemption for such assets is technically limited to $2,000, that limit is rarely applied because the value of such goods is almost never determined. Even Illinois' estate recovery program does not recover hard assets. Yet Medicaid estate planners routinely encourage people to purchase exempt assets to qualify for Medicaid: "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....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."[35] This issue presents a quandary--no one wants to force seniors to sell their belongings to pay for long-term care, but if one's worldly possessions are not at risk, why would one save or plan ahead to be able to pay for long-term care? We cannot remove all the incentives people have to behave responsibly and then lament the fiscal consequences when they do not. **If two-thirds of Illinois' 55,000 Medicaid nursing home recipients once possessed an average of $4,000 worth of personal property that is exempted at eligibility and excluded from estate recovery, then Medicaid expenditures are $146,520,000 higher than they would otherwise have to be.**

Finding #4: Generous asset exemptions for Medicaid eligibility are very popular politically until the program's funding runs out or something else that is even more desirable becomes unaffordable. As Medicaid consumes an ever increasing proportion of the state budget and the share available for education and other important state services declines, the critical mass for publicly financed nursing home expenditures looms closer and closer. If the goal is to persuade more and more people to plan ahead so that they can pay for their own long-term care and not rely on Medicaid, then allowing people to shelter unlimited home equity, substantial funeral costs, and indeterminate amounts of personal belongings is not the best message to send. This report recommends several ways to retain generous asset exemptions without discouraging long-term care planning and private financing.

---

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

****

Fallacy #5: Congress and President Clinton closed the loopholes in Medicaid nursing home eligibility last year with the Omnibus Budget Reconciliation Act of 1993 (OBRA '93).

Fact #5: OBRA '93 was not a cure-all, but it gave states some of the tools they needed to develop effective asset control methodologies. Unfortunately, like other tools, the authorities in OBRA '93 are useless unless they are applied.

The Omnibus Budget Reconciliation Act of 1993[36] 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 ineligibility penalties for uncompensated asset transfers, ended multiple or pyramid divestment (which Illinois formerly allowed), plugged the joint account divestiture loophole (which Illinois never permitted anyway), 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 also empowered states to define "estate" more broadly than before to encompass assets such as life estates, joint tenancies, and living trusts that previously evaded recovery. On the other hand, the law set no standards regarding estate recovery, and left states wide latitude in how aggressively they could pursue this new revenue source. Furthermore, OBRA '93 left numerous eligibility loopholes open and created several new ones that Medicaid estate planners around the country are actively promulgating.

I have written elsewhere about sophisticated Medicaid estate planning techniques that survived OBRA '93 or have been devised since the law's enactment. Some of these techniques are not relevant yet to Illinois, because much simpler methods still suffice here to divest or shelter any estate. Therefore, I will only summarize the new methods below in a footnote.[37] As Illinois moves to establish tighter asset

---

[36] 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 legislatures to implement necessary statutory changes.

[37] "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 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."

controls in the future, however, the state may find that the Medicaid estate planning bar becomes much more creative and sophisticated in the techniques it uses to circumvent the rules. At that time, these footnoted observations may be more relevant.

To the credit of the Illinois Department of Public Aid, the agency has made steady progress toward implementing the new OBRA '93 authorities. For example, the state took timely action to seek state statutory changes required by OBRA '93. The necessary legislation passed July 14, 1994. State staff have also begun the required four-month administrative rule process to implement the changes. Plans have been made to distribute new rules and to train field staff on new policies as soon as possible. The bottom line, however, is that fully one year after the passage of OBRA '93, field staff still use a 30-month instead of a 36-month lookback period; the maximum transfer of assets penalty remains 30 months, instead of "unlimited" as prescribed by the new law; and multiple divestment and trust policy has yet to change. Most debilitating and discouraging of all is that the department's attempt to broaden the definition of "estate" as permitted by OBRA '93 was stricken from the state authorizing legislation just before the legislation passed. Without this new definition, anyone with the savvy to obtain good legal advice can evade Illinois' estate recovery program.

Why Implementation of OBRA '93 Was Delayed

The main reason for Illinois' delay in implementing OBRA '93 authorities is that former state law stipulated each federal requirement in detail. Therefore, each detail had to be changed in state statute when the federal law changed. State staff informed me that they drafted the new state legislation to implement federal requirements in general. Now, when federal rules change, state legislation will automatically remain in compliance. This is an excellent approach unless and until federal law changes in such a way that the state would prefer to delay implementation.

In addition to evaluating Illinois' implementation of OBRA '93, this study also examined the state's progress in carrying out related recommendations made by the state Auditor General (AG)[38] and by the Task Force on Long-Term Care Eligibility Asset Policy.[39] Some of the recommendations made by those groups were superseded or became moot upon passage of OBRA '93. Furthermore, much of this report is relevant generally and specifically to issues addressed in the AG's and the Task Force's studies. Nevertheless, a few comments are appropriate here. Eligibility policy staff made a good faith effort to comply with both studies. Many recommendations have been fully implemented, such as deleting the exemption for non-consensual asset transfers, placing the burden of proof concerning asset

---

Citation for Footnote 37: Stephen A. Moses, *The Florida Fulcrum: A Cost-Saving Strategy to Pay for Long-Term Care*, LTC, Incorporated, Seattle, Washington, 1994, pps. 57-58.

[38] State of Illinois, Office of the Auditor General, *Program Audit: Enforcement of Property Transfer Laws*, Springfield, Illinois, May 1993.

[39] Illinois Department of Public Aid, *Final Report: Task Force on Long-Term Care Eligibility Asset Policy*, Springfield, Illinois, September 1993.

transfers on applicants instead of the department, adding questions on property and transfers to eligibility redetermination forms, and providing training on asset and transfer policy. Other important recommendations, however, were dropped. For example: the state has not pursued federal waivers on look-back periods, burial policies or spousal assets; nothing has been done to obtain additional financial statements, tax returns, and nursing home applications at eligibility determination; nor were the recommendations implemented to improve the unearned income match through the Internal Revenue Service. (In fact, field staff told me that they no longer receive this extremely valuable information at all).

Finding #5: I believe that departmental eligibility policy staff deserve a lot of credit for the progress they have made in implementing OBRA '93 and in responding to earlier studies and recommendations. But, as this study makes eminently clear, measures taken so far have not been sufficient to resolve the serious underlying problems. The Department of Public Aid needs to redouble its efforts to control eligibility bracket creep, to stanch the hemorrhage in exempt asset transfers, and to resolve other problems too numerous and complicated to explain here. The way to start is by listening to field staff on whom the problems weigh most heavily. As one local caseworker told me: **"This is the first time I have ever been asked these questions. How would anybody know the problems exist? We are never asked about these things. Too many people in central office have never worked in a local office."** This report's recommendations will offer several suggestions on how to relieve the burden of nursing home eligibility on field staff and engage them more beneficially in the process of policy development, interpretation, and implementation.

****

Fallacy #6: Medicaid nursing home financing entails such poor access to and quality of care that no one would intentionally plan to rely on Medicaid.

Fact #6: Although opinions on the subject differ widely, a strong case can be made that generous Medicaid nursing home reimbursement rates in Illinois have historically assured good access to high quality care for Medicaid recipients.

The gerontological literature is full of references to alleged deficiencies in the access to, quality of, and reimbursement for Medicaid nursing home benefits. Appendix C contains a number of examples. If these allegations are true, and if similar conditions exist in Illinois, then one would not expect rational Illinoisans who are able to pay privately for long-term care or insurance to plan deliberately to qualify for Medicaid. On the other hand, if Medicaid in Illinois pays for easy access to equal care, then the last remaining obstacle to potentially universal Medicaid estate planning disappears. Why would anyone pay privately for nursing home care if the same care (and possibly even better care according to some providers) is available without spending down by taking advantage of the exemptions, techniques, and readily available legal advice described above?

Based on the extensive interviews conducted for this study, the preponderance of opinion among the experts is that nursing home access and quality in Illinois is somewhat lower for Medicaid recipients than for private payors. Some providers acknowledged this problem openly, although it is an

extremely delicate subject for them, and all insisted that they make every effort to treat each resident the same regardless of payment source. Most senior advocates and state staff agreed, however, that Medicaid recipients, especially heavy care patients, have a somewhat more difficult time finding a bed in the most desirable nursing homes. They also cited examples of Medicaid discrimination, such as private pay preferences or inferior Medicaid wings. According to an elder law attorney: "If you are in a Medicaid facility and lose your dentures, look out; if you have durable medical equipment and it breaks, you're going to be without." A staff attorney for the Illinois Citizens for Better Care gave me a soon-to-be-published, book-length report that is a damning indictment of quality of care in Illinois' nursing homes.[40] Her data indicated a disproportionate incidence of violations in more heavily Medicaid-financed facilities. The state's Long-Term Care Ombudsman told me "things are getting worse instead of better with no IOC program [Inspection of Care], no QUIP [Quality Incentive Program], and delays in payments, the rate freeze, and the assessment [bed tax] program." Finally, recently published national data indicate that average survey rates of "important" deficiencies for long-term care facilities in Illinois have increased from 3.5 in 1992 to 4.0 in 1994, whereas the national average has declined from 3.7 to 3.0 during the same period.[41]

High-Quality Medicaid Nursing Home Care in Illinois

On the other side of the argument, the Illinois Council on Long Term Care made an impassioned and persuasive case that Medicaid nursing home care in Illinois is equal to or better than care provided to private payors. I cannot improve on the Council's argument, so here it is in their own words:

> ...the Public Health and Department on Aging survey data demonstrates that there is no less quality in high Medicaid homes than in the homes which maintain low Medicaid census through discriminatory admission practices. In fact, Public Aid's extensive survey data clearly indicates that Medicaid clients receive higher quality care, more services, and have better outcomes in homes with more than 80% Medicaid population than in homes with less than 20% Medicaid...The highest percentage of five and six star Quip [Quality Insurance Program] facilities (39.1%) are those facilities with a Public Aid population greater than 80%; the lowest percentage of five and six star Quip facilities (9.4%) are those facilities with a Public Aid population lower than 20%. On the other hand, only 5.8% of high Medicaid homes had no stars, as opposed to 64.6% of those homes with less than 20% Medicaid population...Based on the Department's Inspection of Care data: a greater percentage of Medicaid clients in high Medicaid homes (39.9%) receive restorative services than those in low Medicaid homes (18.8%); a greater percentage of Medicaid clients in high Medicaid homes (35.1%) receive rehabilitation service than those in low Medicaid homes (9.7%); a greater percentage of Medicaid clients in high Medicaid homes (55.5%) functionally improve than those in low

---

[40] Wendy Meltzer, *The Status of Nursing Home Regulation in Illinois*, Illinois Citizens for Better Care, Chicago, Illinois, 1994.

[41] Health Data Associates, Inc., *Nursing Home Yearbook: 1994*, Tacoma, Washington, 1994, pps. D-1 to D-3.

> Medicaid homes (30.3%); a greater percentage of pressure sore prevention programs are provided to residents in high Medicaid homes (27.9%) than those in low Medicaid homes (2.3%). Consequently, a significantly lower percentage of Medicaid clients have pressure sores in high Medicaid homes (4.3%) than in low Medicaid homes (7.2%); a greater percentage of clients in high Medicaid homes (30%) receive bowel and bladder retraining programs than those in low Medicaid homes (1%). Concurrently a lower percentage of catheterizations take place in high Medicaid homes (9.4%) than in low Medicaid homes (13.2%), and Medicaid residents in high Medicaid homes are less likely to be incontinent (34%) than Medicaid residents in low Medicaid homes (58%); a significantly higher percentage of psychosocial programs are provided to residents in high Medicaid homes (81.0%) than in low Medicaid homes (21.5%); a higher percentage of residents in high Medicaid homes (25.2%) receive preventative health and fitness programs than those residents in low Medicaid homes (8.5%).[42]

Department of Public Aid staff observed that the data on which the Council's argument is based are several years out of date and may be somewhat biased in favor of the Council's facilities. But, that is precisely the point that the Council was trying to make: the program that generated this data no longer exists, and in its absence the Council is at the mercy of purely anecdotal data that is definitely biased against it.

Finding #6: We cannot resolve the questions concerning Medicaid nursing home access, quality, and reimbursement here. It suffices to say that to the extent Medicaid-financed care is deficient, the attractiveness of Medicaid estate planning declines. To the extent that Medicaid offers equal or better access and quality than private pay, pressure can be expected to mount toward ever-increasing Medicaid nursing home census and ever-declining private pay census. Again: why pay privately for something the government is willing to subsidize for you? As increasing percentages of residents on Medicaid drive up total costs and pressures increase to moderate spending growth, everyone agrees that the time could come when Medicaid reimbursement would no longer suffice to assure access to quality care. That is the unfortunate eventuality that this report is intended to help avoid. This report will provide extensive recommendations on how to stem the tide in Medicaid nursing home census, control program costs, divert affluent people to private financing sources, and give Medicaid back to the poor people it was originally intended to serve.

****

Fallacy #7: Because people on Medicaid spent down their life's savings to qualify for welfare, they do not have much money; therefore, collecting from their estates is not cost effective.

Fact #7: As explained earlier, people in nursing homes on Medicaid can retain substantial assets and do not necessarily have to spend down significantly to qualify for assistance. Successful lien and estate

---

[42] This excerpt is from a September 22, 1994 letter from Peter P. Peters, Executive Director of the Illinois Council on Long Term Care to Robert Wright, Director of the Illinois Department of Public Aid.

recovery programs throughout the United States are not only highly cost-effective, they send a message to seniors and heirs that relying on Medicaid has a price and that paying privately or insuring privately have definite advantages.

In the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), Congress encouraged state Medicaid programs to recover correctly paid nursing home benefits from the estates of deceased recipients. The legislation protected recipients and their families by limiting recovery to benefits received after age 65 (or while institutionalized) and by delaying recovery until after the death of a spouse or other qualified dependent relative. According to legislative history, the purpose of estate recovery (in conjunction with transfer of assets restrictions and liens) was "to assure that all of the resources available to an institutionalized individual, including equity in a home, which are not needed for the support of a spouse or dependent children will be used to defray the cost of supporting the individual in the institution."[43] The Inspector General of the Department of Health and Human Services discovered in 1988 that Medicaid estate recovery programs in 22 states generated $14.42 in revenue on the average for every one dollar invested in them, but that state implementation of the voluntary programs was lagging.[44] Unhappy with the pace of state implementation, Congress made Medicaid estate recovery mandatory in OBRA '93 and expanded recoveries to benefits received after age 55. OBRA '93 also enhanced the legal protections against "undue hardships" for recipients and families affected by estate recovery.

Fortunately, Illinois did not wait to be pushed by Congress into liens and estate recoveries. In 1992, the Department of Public Aid started a "field consultant pilot project." The purpose of this project was "to discover situations where the Department can file liens against real property owned by clients to recover cash grant payments or claims against sources of assets owned by a deceased client to recover Medicaid and/or grant payments."[45] The pilot project was very productive and the new program has been an unmitigated success. Although only fully staffed since February 1994,[46] Illinois' lien and estate recovery program has increased recoveries from $2.4 million in Fiscal Year 1990, to $3.3 million in FY 1991, to $4.2 million in FY 1992, to $6.2 million in FY 1993, and to $9.0 million in FY 1994. They estimate recovering $15 million in lien and estate recoveries for FY 1995 and $22 million, for FY 1996. **Management staff of the recovery program agree that with full support**

---

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

[44] Stephen A. Moses, *Medicaid Estate Recoveries: National Program Inspection*, Office of Inspector General, Office of Analysis and Inspections, OAI-09-86-00078, San Francisco, California, June 1988, p. 30.

[45] Illinois Department of Public Aid, *Liens & Estates Field Consultant Handbook Pilot Project: 1992-1993*, Springfield, Illinois, 1992, p. 1.

[46] The program has 23 field consultants and two professionals downstate and five field consultants and two professionals in Chicago.

and some additional state statutory authority (which this report will recommend), Illinois' annual lien and estate recovery receipts could approach $60 million per year. If Illinois were to succeed in recovering from estates at the rate of the leading state in the country (Oregon), recoveries would approach $80 million per year. Already, despite start-up expenses, the state recovers $11.60 for every one dollar invested in the program. To quote the unit's supervisor: "Stockholders would be happy with this unit's results if it were a private company."

Obviously, Illinois staff have done a lot of things right in pursuing Medicaid liens and estate recoveries. A few examples of their best practices, from which other states newly implementing recovery programs could very beneficially learn, include: (1) starting small scale with an experimental pilot study; (2) using successful states such as Oregon as models for the program; (3) increasing staff only as increased recoveries justify budget increases; (4) targeting recoveries to an "expenses fund" to protect the program from "penny wise, pound foolish" budget cuts that impede recovery growth in most other states; (5) using estate recovery field consultants to help local office eligibility staff verify income and assets (including real property ownership and transfers); (6) recovering all benefits received by a deceased recipient (instead of restricting recoveries to benefits received after implementing the recovery program); (7) educating the public and the bar about liens and estate recoveries by speaking at community meetings and elder law conferences, and by publishing articles; (8) actively recovering from spousal estates and estates of former recipients; (9) experimenting with on-line verification of real property records available in Cook and the collar counties; (10) providing classroom and on-the-job training for estate recovery field consultants and local office eligibility staff; (11) relying heavily on eligibility staff for property information and time-of-death notification, instead of pursuing (often fruitless) statewide data matches; (12) attempting to settle liens when lien value approaches the recipient's equity in the property; (13) encouraging competition between field consultants over liens placed and assets recovered; and (14) pursuing recoveries of assets sheltered for funeral costs that are not expended and would otherwise pass unencumbered to heirs.

Lien and Estate Recovery Initiatives Illinois Should Try

Although Illinois' lien and estate recovery program has enjoyed a very successful start-up by proceeding in these measured and thoughtful ways, the state can try many additional initiatives and best practices pioneered in other states. These include: (1) recovering valuable hard assets such as antiques, vehicles, art work, etc. for disposal by auction; (2) establishing accounts receivable, including contracts for deeds and open-ended mortgages that permit recipients and their families to retain assets (such as the family home) while repaying Medicaid benefits over time;[47] (3) seeking state statutory authority for automatic recovery of small accounts held by Medicaid recipients in nursing homes and financial institutions (on the model of programs in Oregon and Wisconsin)--these generate high recoveries with low effort; (4) exploring contingency contracts with private firms to conduct special experimental projects as a means to expand some kinds of estate recoveries faster and more effectively; (5) seeking a waiver to merit compensation rules that prohibit bonusing field consultants on the basis of actual

[47] Such a program in Oregon generates more than $85,000 per month in on-going recoveries that would otherwise be discounted during estate liquidation.

recoveries generated; (6) setting a threshold below which estate recovery effort is deemed not to be cost-effective, instead of pursuing all cases equally--regardless of potential return. We will have more to say on these and other possible initiatives in the recommendations section of this report.

Program staff say the single most important thing that Illinois can do to enhance lien and estate recovery potential is to adopt the expanded definition of the term "estate" authorized by OBRA '93. Under current law, an estate does not include assets held in joint tenancy with right of survivorship. Inasmuch as most assets in America are held in this form of ownership and Medicaid estate recovery in Illinois is limited to formal probated estates, a lot of property that passes to spouses and other joint tenants outside an estate avoids the existing recovery process. Furthermore, Medicaid estate planning attorneys routinely advise their clients to place property in joint tenancy with right of survivorship or other exempt forms of ownership to avoid estate recovery. OBRA '93 authorized states to expand the definition of a recoverable estate to correct this problem. A recent transmittal from the Health Care Financing Administration clarifies the new law:

> In addition to property and assets under the probate definition, you may include any other real and personal property and other assets in which the individual had any legal title or interest at the time of death (to the extent of such interest). This includes assets conveyed to a survivor, heir, or assign of the deceased through joint tenancy, tenancy in common, survivorship, life estate, living trust, or other arrangement.[48]

To its credit, the Department of Public Aid included the new, broader definition of "estate" in proposed legislation to implement OBRA '93 last summer. Unfortunately, in last-minute negotiations, this provision was stricken before the final bill passed. This report should help inform and convince legislators and policy makers of the need for a wider definition of the term. At the earliest possible opportunity, the department ought to renew its efforts to pass state legislation to that effect.

Finding #7: Obviously, the non-tax revenue potential of liens and estate recovery is substantial. If Illinois' recovery program continues to build on its current record of creativity and achievement, the state will quickly achieve even its most ambitious revenue enhancement goals. But management says dollar recoveries are not the program's most important contribution to public financing of long-term care in Illinois. Rather, the "deterrent effect" of a strong lien and estate recovery program, which encourages seniors and their families to plan ahead and pay privately or purchase insurance for long-term care expenses, has an even greater potential impact on the system. Strongly--but equitably--enforced the Medicaid lien and estate recovery program can generate large sums of extra money to help the poor, without drawing upon the tax payers to do so, while simultaneously encouraging middle class and affluent people to pay their own way.

****

[48] Department of Health and Human Services, Health Care Financing Administration, "Part 3 -- Eligibility," *State Medicaid Manual*, Transmittal No. 63, September 1994, p. 3-9-5.

Fallacy #8: Liens and estate recoveries discourage vulnerable, infirmed seniors from seeking necessary care, because they fear losing their homes and savings.

Fact #8: Lien and estate recovery programs have the opposite effect. They encourage seniors and families to seek private home and community-based care, which the elderly prefer, instead of relying on Medicaid nursing home care, which most seniors say they want to avoid.

Generous Medicaid eligibility criteria and spousal impoverishment protections have gone a long way toward eliminating barriers to long-term care for seniors. Unfortunately, Medicaid's generosity often backfires. A family confronting the need for long-term care faces a difficult choice that frequently involves a fundamental conflict of interest. They must decide whether to spend the senior's savings for private care or to protect the savings by means of Medicaid planning, legal or otherwise. Often, the senior needing care is out of the decision-making process because of mental incapacity.[49] If the senior's family opts to pay privately, all doors are open. A full range of excellent options are available from chore services in the home, to adult day care, to assisted living, to nursing home care with the appropriate level of care guided by professional geriatric care management. Private payors, as we discussed above, are apt to have a much wider range of readily available, high quality care choices. If the family opts to protect the senior's assets, retain their inheritance, and rely on Medicaid, however, many doors are closed for the infirmed elder immediately. Home and community-based services are harder to obtain under Medicaid; nursing homes often require waiting lists; choices are likely to be very limited; and reimbursement is low. Ironically, generous Medicaid eligibility creates a perverse incentive for seniors and their families to rely on public assistance and to use a higher level of care than the senior would otherwise prefer.

Welfare stigma is also a problem. Both state eligibility staff and nursing home industry respondents told me that heirs (especially baby-boomers) will often ask how to qualify their parents for Medicaid in one breath and then beg them not to disclose to their parents that they are on public assistance in the next: **"You have hit the nail on the head with baby boomers. How many times have we had a son or daughter say we don't want Mom or Dad to know she or he is on Medicaid?"** Finally, as discussed above, families and other "concerned parties" sometimes cross the line between Medicaid estate planning and financially abusing the elderly. Vulnerable seniors are often helpless to defend themselves against individuals who would relieve them of their wealth while "taking care of them" by signing them up for Medicaid nursing home benefits.

Liens and Estate Recoveries Benefit Seniors

A strong Medicaid lien and estate recovery program has the capacity to resolve all these problems. By assuring that potential Medicaid recipients who possess resources will have to "pay now or pay later," liens and estate recoveries provide an incentive for families to purchase privately the kinds

[49] According to the November 10, 1989 issue of *The Journal of the American Medical Association*, 47 percent of people 85 years of age or older already have Alzheimer's Disease. (Reported in the *Older Americans Report* newsletter, dated 11/10/89.)

of care seniors prefer. Paying privately for inexpensive home and community-based care is preferable to starting the meter running prematurely on expensive nursing home care paid for by Medicaid and recoverable from the estate. Liens and estate recoveries also help to convince younger family members that long-term care is a significant financial risk for which they should consider insuring while they are young enough and healthy enough to obtain inexpensive private insurance coverage. By requiring Medicaid recipients who have exempt resources to pay back the cost of their care after they and their surviving dependents die, liens and estate recoveries relieve the stigma of accepting public assistance. **"It isn't welfare if you pay it back!"** a study respondent once told me. Finally, if it mobilizes effectively to do so, a lien and estate recovery program can strongly discourage financial abuse of the elderly. For example, when Oregon's estate recovery program suspects elder abuse, it petitions the court to appoint a conservator to represent the client and, indirectly, the state. Under this program, private attorneys have reversed illegal asset transfers, relitigated abusive divorce decrees, partitioned undivided property, and invaded expropriative trusts. The recipient gets the money back, reimburses Medicaid for care received, and may be able to pay privately for care in the future. The Medicaid program pays nothing because the private attorneys who act as conservators are paid on contingency. This is an efficient and cost-effective means to finance expanded adult protective services.

Parenthetically, before we proceed to the next topic, critics sometimes accuse Medicaid liens and estate recovery of having the opposite effect from the criticism summarized above. Instead of denying services to the needy, according to this argument: "Collecting from estates while providing free care to the indigent discourages responsible behavior; it punishes hard workers who save their money and rewards the sluggards who accumulate nothing." By this reasoning, it is grossly unfair that hard-working Americans who scrimped and saved to accumulate wealth have to pay for their own long-term care, whereas people who failed to prepare for a rainy day are generously subsidized by the government. This argument, of course, is a common criticism of the welfare state. The notion that public assistance encourages self-indulgence and irresponsible behavior, while penalizing hard work and self-denial is being raised more and more as fiscal pressure on public assistance programs mounts. What, however, is the alternative? Free care for everyone? Paid for by whom? The same hard-working, responsible people who are now affected by Medicaid liens and estate recoveries? In fact, lien and estate recovery programs encourage responsible people to plan ahead and take care of themselves, while simultaneously buttressing the fiscal viability of Medicaid to provide for those who cannot provide for themselves. By supplying what is, in essence, a line of credit on their estates, lien and estate recovery programs give responsible people a second line of defense: if their money or insurance runs out, they will still receive the care they need with the cost secured by their estates and without having to rely on the dole. To many of today's seniors, who struggled through the Depression, fought World War II, and saved diligently for their old age, the confidence that they will not have to die in a nursing home on welfare is very, very important.

Finding #8: Lien and estate recovery programs do not discourage needy people from obtaining the services they need. Rather, they encourage a more efficient use of both private and public long-term care resources and tend to divert seniors into the kinds of care they prefer and away from public assistance. Neither Maryland's lien program nor Oregon's estate recovery program, both national leaders, are unpopular with seniors or their advocates. So far, Illinois' program has received very few complaints or appeals. Properly implemented and run, liens and estate recoveries enhance the state's

ability to provide services for the poor without hampering the ability of the middle class and affluent to obtain needed services. This report will provide recommendations to enhance the ability of Illinois' program to achieve these benign objectives while protecting seniors from undue hardships incidental to recovery initiatives.

****

Fallacy #9: Private insurance will never play an important role in financing long-term care: most people do not think they need it and fewer still can afford it. The products are inferior and the industry does not market effectively.

Fact #9: Private long-term care insurance can defray a large portion of costs currently borne by the Medicaid program. Experts agree that widely affordable, high-quality products are readily available in Illinois. Low sales of private insurance up to now reflect Medicaid's domination of the market more than any other factor.

Private long-term care insurance has been very slow to develop in Illinois. The Department of Insurance reports that only 58 companies market nursing home and home health policies in the state compared to more than double that number nationally. Insurance agents that I interviewed for this project said that only six companies in Illinois sell more than half of the business. These agents estimated that fewer than 1000 agents sell private long-term care insurance in Illinois and only about 300 agents specialize full time in the complicated product line. Nursing home owners and operators told me that few of their residents are covered by private insurance--seldom more than one percent to three percent--and that their admissions staff and social workers are not very familiar with the products. According to elder law attorney Steve Perlis who strongly encourages his eligible clients to apply for private long-term care coverage: "Most people have good major medical and Medicare supplemental insurance. They have IRAs and investments. But when it comes to long-term care insurance, they feel it is too soon or too late." The Director of the Senior Health Insurance Program (SHIP), which trains seniors to advise their peers concerning all types of health insurance for older people, told me that until recently long-term care, was not much of an issue to the public. Now, all of a sudden, it is "really big."

What accounts for the slow market penetration of private long-term care insurance in Illinois despite the recent upsurge of interest among seniors in long-term care financing? Certainly, the state of Illinois cannot be criticized for not encouraging it. The state insurance department is knowledgeable about and supportive of private long-term care insurance. It responds to numerous inquiries from the public. It sponsors SHIP. It distributes "A Shopper's Guide to Long-Term Care Insurance,"[50] published by the National Association of Insurance Commissioners. The department also has a reputation among agents for fair and reasonable regulation of the product, thoughtfully balancing a dedication to consumer protection against the danger of making insurance unaffordable by mandating excessive eligibility and coverage requirements. Nor is agent abuse a big problem in Illinois. An

[50] National Association of Insurance Commissioners, "A Shopper's Guide to Long-term Care Insurance," NAIC, Kansas City, Missouri, 1993.

insurance analyst who specializes in long-term care for the department told me: "I don't think abuse is as common as the news media would like us to think...It is no worse in long-term care than in other lines or products." Leading agents themselves said bad insurance agents spoil the business for everyone, so they routinely refer "bad apples" to the department for discipline. But this only happens a few times per year. In addition to the direct support of the Department of Insurance, the state of Illinois has encouraged private long-term care insurance in other ways. For example, the state offers the coverage as a benefit option to its own employees. The state also sponsored a 48-member "Illinois Partnership Task Force" to explore and promote plans to encourage the public to purchase private long-term care insurance.[51] Many of the task force's recommendations were adopted, although they have not yet come to full fruition. All of this attention to the risks of long-term care in the context of widespread anguishing in the media over Medicaid financing problems has spawned an anxiety among seniors on the issue, but they have not yet turned in large numbers to private insurance as the solution.

Affordability of Long-Term Care Insurance

If quality long-term care insurance products, carefully regulated and actively encouraged by the state, are available in Illinois, and if the public is beginning to be concerned about paying for long-term care, why is private insurance not such a hot seller? Most of the people I interviewed thought the main reason was unaffordability. Older people with relatively low incomes simply cannot find the extra money to pay for another expensive insurance policy, or so their reasoning goes. Many ostensibly scientific studies have been done about the affordability of private long-term care insurance. Most of these studies are very biased. The ones conducted by senior advocacy groups, such as Families USA, usually estimate that 10 percent or 15 percent of seniors can afford private long-term care insurance coverage. Studies sponsored by the insurance industry often peg affordability at 40 percent to 60 percent. One relatively objective reviewer concluded:

> Most analysts agree that as many as 20% to 30% of elders, and a far greater percentage of younger people have the financial wherewithal to pay for high value products. This translates to a potential market of well over 10 to 15 million persons over age 55.[52]

Unfortunately, none of these studies is accurate, because they are all based on a false assumption that affordability is a function of seniors' ability to pay for long-term care insurance by expending an arbitrary percentage, usually 5 percent or 10 percent, of their disposable income. This assumption is fallacious, because the elderly are "cash poor, but house rich." Seniors are the wealthiest population cohort in American society, but as a group they do not have a lot of cash flow. Their wealth is illiquid and is usually tied up in their home and other real property. This is significant for two reasons. First, one study found that 57 percent of homeowners could purchase a prototype long-term care insurance policy with

---

[51] Illinois Department on Public Aid and Illinois Department of Insurance, *Illinois Partnership for Long Term Care Insurance*, Springfield, Illinois, September 1993.

[52] Marc A. Cohen, "The Market for LTC Insurance," *LTC News & Comment*, Vol. 5, No. 1, September 1994, p. 4.

nothing more than the proceeds of a reverse annuity mortgage.[53] Second, Medicaid exempts the home and all contiguous property regardless of value, rendering the need to rely on home equity conversion moot. Thus, a major reason people consider private long-term care insurance unaffordable is that Medicaid provides the same protection for free. As an insurance department analyst explained to me: "Why do I need long-term care insurance if the government is going to pay? I am a single parent, with two kids, in my 40s. I don't need it. I'm healthy. I'm going to live forever. The choice for me is new shoes or buy insurance, and if I get bad off, I'll just give my stuff to the kids and go on Medicaid."

If generous Medicaid nursing home eligibility did not remove the catastrophic consequences of long-term care costs, seniors and their heirs would look much more creatively for ways to afford private insurance. They would find lots of promising options. As I explained in an article for an elder law periodical once: "...many seniors are paying too much for life insurance and Medicare supplemental protection. Most people do not need life insurance after age 65. It just becomes a habit. Often, life insurance premiums can be diverted safely to long-term care coverage instead...Seventy-five percent of seniors have Medigap insurance, while only four percent have long-term care coverage. This is true despite the fact that 80 percent of out-of-pocket medical costs in excess of $2,000 for the elderly are for nursing home care. Some features of Medigap insurance, such as coverage for the $100 Part B deductible, are little more than dollar cost averaging, like paying a level gas bill each month through Winter and Summer. Many seniors could reduce their Medigap coverage to catastrophic-only protection and use the premium savings to pay for long-term care insurance...Finally, why should the elderly have to insure their children's inheritances anyway? Today's seniors struggled through the Depression; they scrimped and saved their whole lives through; and they are about to drop $6.8 trillion of net worth into the laps of the next generation. Why can't these heirs, who are now in their own peak earnings years, help with the cost of insurance to protect their parent's estates? The "kids" have the income; the folks have the assets. Sharing the cost of long-term care insurance premiums is an ideal intergenerational contract."[54] These ideas only scratch the surface. In an article published by the National Academy of Elder Law Attorneys, Chicago attorney Robert McCarty joined California insurance agent Marilyn Saunders in suggesting many other ways to finance private long-term care insurance premiums creatively. These included private reverse mortgages, annuities, installment sales, and charitable remainder trusts.[55]

Finding #9: Ironically, relatively easy access to Medicaid nursing home care for families in crisis, and little risk of estate recovery until very recently, undercut the urgency of purchasing private insurance for people who are young and healthy enough to qualify for inexpensive coverage. Once a loved one succumbs to Alzheimer's Disease, however, it is too late to buy insurance. The only alternative to

---

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

[54] Stephen A. Moses, "The Myth of Unaffordability," *Elder Law Advisory*, No. 16, July 1992, p. 2.

[55] Robert McCarty and Marilyn Saunders, "The Value of Long Term Care Insurance in Estate Planning," *National Academy of Elder Law Attorneys: 1994 Symposium Manual*, NAELA, Tucson, Arizona, 1994, pps. 11-18.

paying out-of-pocket is to rely on Medicaid. Ask yourself: How many people would buy fire insurance, if the government rebuilt every home that burned down? The low demand for private long-term care insurance is no mystery. It has very little to do with denial of the risk by prospective buyers, or the quality of the products, or the affordability of the premiums, or the competence of the industry. It has a lot to do with the unintended consequences of well-intentioned but perversely counterproductive public policy that allows the uninsured to protect their assets and obtain tax payer-financed care with few consequences, if any.

****

Fallacy #10: To make private long-term care insurance viable, government will have to subsidize the product heavily with tax deductions and forgiveness of Medicaid spenddown requirements.

Fact #10: No matter how much money the government spends to encourage people to buy private long-term care insurance, most people will fail to do so as long as Medicaid is available with few strings attached.

The primary initiative Illinois has taken to encourage private long-term care insurance through public policy is the partnership program. This is a project modeled on an earlier experiment sponsored by the Robert Wood Johnson Foundation and implemented in five states. The idea of the partnership is to encourage people to buy private long-term care insurance (and to discourage them from transferring or sheltering assets to qualify for Medicaid) by offering forgiveness of Medicaid spenddown requirements commensurate with the amount of insurance purchased. For example, if one buys a partnership policy worth $100,000 in benefits, and that amount of protection proves to be insufficient, then one is forgiven $100,000 worth of spenddown from personal assets, and therefore qualifies for Medicaid more quickly. According to the task force report that recommended implementing a partnership program:

> The Partnership policy...is budget neutral to the state Medicaid program. It allows an individual to arrange for a third party, the insurance company, to meet the individuals spend-down requirements for Medicaid, so the individual can retain his or her own assets....In addition, because an individual no longer has strong incentives to transfer assets for medicaid eligibility, and may 'over insure,' there is some possibility the state will realize a slight savings from the program.[56]

Before Illinois could get its partnership program underway, however, OBRA '93 removed the exemption for partnership-protected assets from estate recovery that earlier programs had enjoyed. To counteract this new policy, the state obtained a Medicaid state plan amendment, effective July 13, 1994, that exempts partnership-protected assets from the usual transfer of assets penalty. Thus, people who buy partnership policies in Illinois do not have to worry about estate recovery, because they can

---

[56] Illinois Department on Public Aid and Illinois Department of Insurance, *Illinois Partnership for Long Term Care Insurance*, Springfield, Illinois, September 1993, p. 2.

transfer assets with impunity up to the value of the disregarded resources.

Illinois Partnership Flawed

As currently designed, the Illinois partnership is doomed to disappoint. The fallacy inherent in the partnership idea is that people have no reason to buy insurance to avoid Medicaid's spenddown liability when they can wait to see if they ever need long-term care, and if they do, take advantage of Medicaid anyway--without having to spend down. In other words, the partnership idea will not work until the state solves the problems described earlier in this report of generous Medicaid eligibility compounded by last-minute Medicaid estate planning in the context of easy legal ways around liens and estate recoveries. But once the state solves these problems, it does not have to give away Medicaid benefits in the future to persuade people to buy insurance. They will buy it to avoid the strong lien and estate recovery liability. Unfortunately, with every good intention to encourage the sale of partnership policies, the state has emasculated its most important ally in encouraging the purchase of private insurance. By exempting partnership-protected assets from transfer penalties and hence from estate recovery, the state has underscored the dangerous message that Medicaid planning and financing is appropriate for the middle class if combined with minimal private insurance protection. The logical consequence of this policy is that insurance agents will market and their clients will buy shorter-term, lower-cost policies instead of moderately more expensive plans that offer full, lifetime private insurance protection. Why "overinsure" if the government is willing to let you jettison partnership-protected assets anytime and unlimited assets at least three years prior to application for Medicaid?

Another critical issue is what will happen to people with partnership policies when their private coverage runs out if the state of Illinois is no longer able to afford nursing home reimbursement levels that assure access to quality care. Already, the public is leery of the partnership's coordination of private insurance benefits with the dubious benefits of a financially strapped Medicaid program.[57] Department of Insurance staff told me that their "fact finding" research on the partnership indicated that the public demanded the right to remain in non-Medicaid facilities as long as their private insurance continues to pay: "The public did not want to go to a Medicaid facility until they were on Medicaid."

From a practical standpoint, the Illinois version of the partnership idea is burdened with certain technical features that make it hard to attract insurance companies to participate. For example, companies have to relinquish control over benefit eligibility by accepting the state's Medicaid

---

[57] According to an October 12, 1994 article in the *Chicago Tribune*: "As detailed last year in a *Tribune* series entitled 'Medicaid: System in Chaos,' the program has been eroding for years--a process fueled by political neglect and an unwillingness to pay very much or very fast...[B]y the score, health-care providers, disgruntled over the low Medicaid rates, bailed out rather than put up with the delayed payments. As doctors left, a shortage developed, and often the holes were filled with physicians without credentials who could not find work in the medical mainstream...Patients received substandard care or, often, no care at all, winding up in hospital emergency rooms, where the Medicaid bills were even higher." Reportage like this scares the public about the prospect of receiving acceptable nursing home care from Medicaid in the future.

determination-of-need standard and by using the state's case managers. Private insurance actuaries, who must keep loss ratios within reasonable limits, are frightened by the risk of adverse selection and moral hazard. The idea of turning over eligibility determination and service selection to a welfare agency that is politically motivated to maximize benefits for as many people as possible completely terrifies them. Finally, private long-term care insurance agents told me they are highly skeptical of the partnership's ability to encourage the purchase of private insurance. They pointed out, and state staff confirmed, that the partnership has very little budget, staff or resources to market the program to the public.

How to Save the Illinois Partnership

The partnership idea is not fatally flawed. The state of Illinois should drop the parts of the partnership that create unfunded liabilities for Medicaid in the future and prevent the plan from saving money. Retain the parts of the partnership that engage the state in evaluating private long-term care insurance products and encouraging the public to buy the best policies. To finance the new program adequately so that it will impact the market significantly, target a portion of the proceeds of the lien and estate recovery program to public education on the importance of planning ahead for the risk of long-term care. Take advantage of the statewide network of Senior Health Insurance Program (SHIP) staff and volunteers to advise the public about the need for long-term care insurance, the potential liability of liens and estate recoveries, and the appropriate criteria to apply in selecting a private insurance policy. Form a work group consisting of private insurance agents and staff of the Department on Aging, the Department of Public Aid, and the Department of Insurance to steer the new public/private partnership in directions that benefit the public. As the concluding section of this report will argue, an initiative of this kind, in tandem with other recommendations in this report, could quickly save the Medicaid program 10 percent of nursing home expenditures and much more over time.

Another idea often proposed to encourage the purchase of private long-term care insurance is to grant the product tax- favored status like other forms of health insurance. No one in the long-term care insurance industry would oppose such a plan. Many of the respondents to this study strongly encouraged its adoption. The purpose of this project, however, was to save the state money while improving access to quality long-term care. Tax expenditures, i.e. revenue not received by the state because of a tax deduction, have the same negative effect on the government's bottom line as any other expenditures. My advice is to take the cost-saving measures recommended in this report first, and if they do not eliminate the problem of excessive Medicaid nursing home expenditures, then consider using tax policy to encourage private insurance. As one interviewee told me: "Any fool can throw a million dollars at a problem and hit it with $10,000." The challenge is to save money and still solve the problem.

Skeptics might argue that diverting people from Medicaid to private insurance does not save any money. The public simply pays out of its "premium" pocket instead of its "tax" pocket. The fallacy in this argument is that when people buy insurance, their premiums are placed in reserves. The reserves are invested in the American economy for many years. The investment grows in value to cover the

insurance company's actuarially predictable losses, administrative costs--including taxes, salaries and commissions--and profits. Furthermore, when people buy long-term care insurance early, they pay less over the long run. Because the policies are age-rated, policy-holders who wait until age 75 to purchase coverage pay three times as much in total premiums for 10 years of protection as people who purchase the same level of coverage at age 55 have to pay for 30 years of protection. Thus, one reason Medicaid is so horrendously expensive is that it undertakes to protect people after the insured event has already occurred and loses the time value of money that private insurance is based upon. By diverting people to private insurance, Medicaid lowers its expenditures, private policy-holders save money, the insurance industry provides more private sector jobs, and the government receives more tax revenues.

Finding #10: The state of Illinois does not need to subsidize long-term care insurance lavishly to get people to buy it. Nor does the state need to create a big new unfunded liability for the Medicaid program. All the state has to do is stop giving away what the private sector is trying to sell. By closing divestiture loopholes, enforcing strong lien and estate recoveries, and encouraging the market for quality long-term care insurance products, the state can save a lot of money on Medicaid while helping to empower seniors to pay privately for excellent access to all levels of long-term care.

****

Fallacy #11: Medicaid can reduce overall long-term care costs by diverting current and future nursing home recipients to less expensive home and community-based services. Or conversely, Illinois cannot afford to provide long-term care for seniors in the home and community-based settings they prefer. Both statements are fallacious.

Fact #11: Most research indicates that home and community-based services delay, but do not replace, institutionalization and that they increase, rather than decrease, total long-term care expenditures. Nevertheless, Illinois can afford to assure access to home and community-based services by encouraging private payment sources, geriatric care management, long-term care insurance, and strong lien and estate recoveries.

From its establishment in the mid-1960s, the Medicaid program offered almost unlimited long-term nursing home care, but very little home care. Faced with the alternative of paying privately for home and community-based care or receiving subsidized Medicaid nursing home benefits, many people (or their representatives) opted for institutionalization under Medicaid, even if home care might have been personally preferable and more cost-effective. Thus, a strong home and community-based care system did not develop early in the United States for lack of demand and financing. Of course, the nursing home industry burgeoned with practically unrestricted public funding. In time, as Medicaid nursing home costs spiraled out of control, the government turned to home and community-based care as a way to save money by diverting light care patients from expensive nursing home care to cheaper home and community-based services. Through the 1970s and much of the 1980s, community care diversion was seen almost as a panacea to restrain long-term care costs. Medicaid home and community-based services waivers became nearly universal. By the late 1980s, however, this great hope had begun to fade. More and more studies showed that, although most seniors prefer it to nursing home institutionalization, home and community-based care does not save money overall. Nor does it

significantly reduce nursing home utilization. For example:

> Given a choice between nursing home care and nothing, many elderly will choose nothing. But when the choice is expanded to include home care, many will choose home care. Thus, the costs associated with large increases in home care more than offset small reductions in nursing home use.[58]
>
> For the majority of...clients receiving home and community-based services under the project, these services represented added costs for a new Medicaid benefit rather than a cost-effective substitute for nursing home care.[59]
>
> When compared to an elderly population for whom traditionally available care is offered, recipients of expanded community-based services do not use significantly fewer days of nursing home care.[60]

Appendix B contains several additional quotations from experts in the field to support the same conclusions. Note, however, that a recent General Accounting Office (GAO) study reported somewhat more positive findings on the results of home and community-based services initiatives in three key states:

> Despite deliberate limits on program size, one impact of the shift to home and community-based care is that the three states have been able to provide services to more people with the dollars available...While the total number of nursing facility beds operated in the United States increased by 20.5 percent between 1982 and 1992, the combined numbers of beds in Oregon, Washington, and Wisconsin declined 1.2 percent. These three states have accommodated all or most of the growth in their total long-term care programs in home and community-based care.[61]

It seems, therefore, that the jury is still out on the cost-effectiveness of home and community-based services. At least in these three states, a strong dedication and investment in building a home and community-based services infrastructure seems to be paying off to some extent.

---

[58] Joshua M. Wiener and Katherine M. Harris, "Myths & Realities: Why Most of What Everybody Knows about Long-Term Care Is Wrong," *The Brookings Review*, Fall 1990, p. 32.

[59] General Accounting Office, *Medicaid: Determining the Cost-Effectiveness of Home and Community-Based Services*, April 1987, p. 18.

[60] General Accounting Office, *The Elderly Should Benefit From Expanded Home Health Care But Increasing Those Services Will Not Insure Cost Reductions*, December 7, 1982, p. 43.

[61] General Accounting Office, "Medicaid Long-Term Care: Successful State Efforts to Expand Home Services While Limiting Costs," GAO/HEHS-94-167, August 1994, pps. 2-3.

The Illinois Medicaid program's experience with home and community-based services waivers is a good example of the cost-effectiveness quandary described above. Illinois' 1915(c) waiver[62] covered an unduplicated count of 14,170 Medicaid recipients in 1992. Waivered recipients were allowed to retain $283 monthly and received only homemaker, adult day care, and chore services. They were eligible only if their care in the community cost less than a nursing facility would have charged.[63]

HCBS Has Not Been a Cure-All in Illinois

During the course of this study, interviewees expressed many concerns to me about community-care diversion initiatives in Illinois. State legislators, worried about escalating long-term care costs, are concerned that Medicaid nursing home beds vacated by community-care diversions may fill up again unless they are eliminated. This creates pressure for stronger certificate-of-need restrictions. Senior advocates are bothered by the inadequacy of public resources dedicated to home and community-based services. This creates pressure for lifting the caps on service costs and for increasing appropriations. Recently, spousal impoverishment protections were extended to the home and community-based waiver population. This creates pressure on overall program participation rates and expenditures. The more costs and participation go up in the absence of hard evidence that home and community-based care is saving money, the more nervous legislators and the Administration become. Recently, a state proposal for $300,000 to fund "a study of reform strategies for an expanded, integrated, managed long term care system" was declined by the Robert Wood Johnson Foundation. Initiatives to moderate long-term care expenditures in Illinois by enhancing home and community-based services appear to be at an impasse: stuck between a rock (lack of financing) and a hard place (dubious cost-effectiveness).

Furthermore, Medicaid long-term care requirements have some interesting, unintended consequences for private financing of home and community-based care. According to Wendy Meltzer, Staff Attorney for the Illinois Citizens for Better Care in Chicago, people do not spend down privately in home care in Illinois as much as they otherwise might, because they need to use their private dollars to lock in a place in a good nursing home early. They must pay privately at least 60 days in advance to secure a permanent placement without having to pass the state's preadmission screening process. The "worry is to get into a good home [before] your money is gone...so you can change onto Medicaid [and

---

[62] "The Home and Community-Based Waiver Services Program under Section 1915(c) of the Social Security Act allows states, with approval of the Health Care Financing Administration (HCFA), to offer a variety of supportive services to chronically ill and disabled persons who, without these services, would require institutional care financed by Medicaid." (Donna Folkemer, *State Use of Home & Community-Based Services for the Aged Under Medicaid: Waiver Programs, Personal Care, Frail Elderly Services and Home Health Services*, Report #9405, AARP Public Policy Institute, Washington, D.C., May 1994, p. 3.)

[63] Donna Folkemer, *State Use of Home & Community-Based Services for the Aged Under Medicaid: Waiver Programs, Personal Care, Frail Elderly Services and Home Health Services*, Report # 9405, AARP Public Policy Institute, Washington, D.C., May 1994.

remain]," Meltzer said. Jean Blaser, Manager of the Division of Long-Term Care of the Illinois Department on Aging had the same concern. She said people pay privately for two months of nursing home care so they "do not have to worry about pre-screening." Incentives in Medicaid nursing home eligibility that discourage private spenddown in the community are counter-productive and very expensive. The result, according to Blaser, is that 18 percent or more of Medicaid nursing home residents in Illinois do not need to be institutionalized by Medicaid's standards. She recommends extending the pre-screening requirement to all nursing home admissions, whether Medicaid or not, and withholding Medicaid eligibility if a nursing home resident does not meet the determination of need standard. Such proposals would save money, but they are very sensitive politically.

Ms. Blaser also observed that Illinois seniors sometimes end up in home care financed with state funds exclusively. She said that the elderly are leery of Medicaid because of the welfare stigma. They do not want to apply. But without Medicaid eligibility, the state cannot shift some of the cost of their care to the federal government. Therefore: "We tell them to get the [Medicaid] card. They don't have to admit [they have it] or go to a Medicaid doctor, but we need it for the home care program. We have a number of them who apply, get the green card, and then never use it." The irony of the state encouraging people to qualify for Medicaid--who would otherwise not need the benefit--simply to tap another source of public financing is difficult to miss. Whether these additional public expenditures come out of the state pocket or the federal pocket, they have an identical effect on tax payers in general and the economy.

In Summary

The prospect of saving Medicaid money by paying for home care instead of nursing home care is dubious and implementing such a program presents numerous practical problems also. Does the availability of Medicaid financing create a "woodwork" effect? Will people who would otherwise pay privately for home care seek Medicaid financing if it is available? Are people more likely to turn to Medicaid prematurely if the program offers home care, as well as nursing home care? Will friends and loved ones be less likely to help financially and more likely to take seniors' assets for themselves if Medicaid benefits are easy to obtain? Is there a chilling effect on the purchase of private long-term care insurance, geriatric care management, and private home and community-based services if Medicaid provides similar services for free? These are questions that must be answered before we can predict the long-term public policy effect of expanding Medicaid financing of home and community-based services.

Although it is not conclusive, some interesting research was published last year that bears on these questions. According to authors Cutler and Sheiner:

> In states with more liberal Medicaid [eligibility] rules, the high income elderly are more likely to use a nursing home, while in states with larger underpayments [i.e., stricter eligibility rules], the poor suffer reduced access. The marginal source of community care for the institutionalized elderly appears to be support from children or other helpers, rather than living alone. Almost all of the elderly in nursing homes would have lived with children or others had they been in the community. In addition, as the ease of

> acquiring Medicaid increases or Medicaid payments become more generous, fewer elderly receive substantial day-to-day help from their children.[64]

If the tendencies identified in this research are commonplace, public policy makers have a very delicate task to balance the ameliorative effect of increased Medicaid spending with the potential inflation in nursing home and home care utilization and costs. As a Brandeis University researcher put it: "Increased financing for HCB services may be desirable but will not significantly influence nursing home expenditures. The underlying assumption is that the delivery system is correct, but funding is inadequate...We must seek to justify HCB on grounds other than cost effectiveness or clinical efficacy: the debate should focus on how much community care we are willing to purchase as a society, rather than how much money we can save by purchasing these services."[65]

Finding #11:

Even if increased Medicaid financing for home and community-based services adds to--instead of reducing--overall long-term care costs for the state, Illinois can still improve the access to and the quality of such services cost-effectively. The trick is to implement public policy incentives that encourage the public to pay privately for home care. A strong lien and estate recovery program, that applies equally to benefits received in Medicaid-financed home care and nursing home care, sends the message that Medicaid requires those who are able to "pay now or pay later." To avoid estate recovery liability, the public will seek out geriatric care management, cost-effective private home and community-based services, and long-term care insurance to pay the bills. The savings that accrue to the state Medicaid program in non-tax revenues from estate recovery and in cost-avoidance from increased private financing for home care may be put to use to fund additional or improved Medicaid services.

---

[64] David M. Cutler and Louise M. Sheiner, *Policy Options for Long-Term Care*, Working Paper No. 4302, National Bureau of Economic Research, Inc., Cambridge, Massachusetts, March 1993, p. i.

[65] Diane Dion Hallfors, "State Policy Issues in Long-Term Care for Frail Elders," Center for Vulnerable Populations, Institute for Health Policy, Brandeis University, March 30, 1993, p. 8.

DISCUSSION

We began this report with a puzzle. Why is a prosperous state in America's heartland shrugging under the burden of financing long-term care for all its citizens? We examined the question and discovered a mind-boggling web of complex, interconnected problems: dangerous demographics, dwindling supplies of home-based caregivers, institutional bias, access and quality problems, exploding costs, balking tax payers, and a languishing private insurance market. As we analyzed these problems, however, we discovered a large number of confusing anomalies. For example: if the risk of long-term care is so high, and if the cost is so catastrophically expensive, and if the only major third-party financing source is a welfare program that requires impoverishment to qualify, then why are consumers not insisting on private geriatric care management to identify inexpensive home and community-based services financed by home equity conversion and private long-term care insurance? If the welfare paradigm is true (if Medicaid requires impoverishment), we reasoned, this scenario does not make any sense. The welfare paradigm requires that we assume long-term care consumers behave irrationally and to their own financial detriment unlike consumers in any other market. But if the entitlement paradigm is correct, all the pieces in the puzzle seem to fit together. Consumers can ignore the risk of long-term care, avoid private insurance premiums, overlook cost-effective but privately financed home-based services, wait to see if they require expensive institutional care, and shift the enormous financial liability to Medicaid at the last moment.

Therefore, we embarked on a long examination of the phalanx of fallacies surrounding the welfare paradigm and carefully refuted each one based on hard evidence collected from original sources throughout the state of Illinois. Simultaneously, we provided similarly persuasive data to support the fundamental truth of the entitlement paradigm. It now remains to draw the logical inferences for public policy and to lay out a strategy to take advantage of this new perspective on the long-term care financing problem.

Last year, an article appeared in the only law journal in the United States dedicated exclusively to elder law. The journal is published by students of the College of Law, University of Illinois at Urbana-Champaign. This is an excerpt from that article:

> Originally, Congress enacted Medicaid as a welfare program to provide medical care for the poor, but today it has become a multi-billion-dollar insurance policy for the elderly middle class who need long-term health care...A better solution would be one that limits the government's involvement to providing a safety net for the truly impoverished--the original goal of Medicaid and the motivation behind state reforms. The new government assistance program, however, should encourage home and community-based care over nursing home care, because the former is both cheaper and preferred by the elderly. A shift away from nursing home care could be accomplished by reimbursing state and local programs which provide home and community-based care...Also, aggressive cost-containment strategies need to be built directly into the new system and stringently enforced. Otherwise, health care costs will continue to increase because any form of free service tends to attract more users and encourages higher fees

> by providers...For those who have some assets above the poverty level, long-term care financing should be essentially an individual's obligation. Rather than simply picking up the tab for the middle class's long-term care, the government should instead encourage the elderly and their families to take some responsibility for their own long-term care. The government should thus facilitate the sale and purchase of private long-term care insurance policies.[66]

For a young law student to see the problem and much of the solution so clearly is genuinely impressive. Even state agencies on aging and state Medicaid programs, however, are starting to come to similar conclusions. According to a recent report by the General Accounting Office of the United States Congress:

> State agencies believed that encouraging a greater private sector role could reduce government long-term care spending for the elderly. For example, many state agencies believed that government interventions could increase the use of private long-term care insurance and private residential care alternatives, which might reduce government long-term care spending for the elderly. State agencies agreed that informal or family care could reduce government long-term care spending.[67]

A Solution Emerges

What we need to do to solve the long-term care financing crisis in Illinois is now clear. We must reinstate some of the negative aspects of the welfare paradigm so that consumers will plan ahead to avoid Medicaid. But we must do this without sacrificing the benefits of the entitlement paradigm which protect seniors from catastrophic spenddown. We must maintain or improve Medicaid's generous eligibility criteria, while making the program more financially stable. We must guarantee that every key interest group will achieve a net gain for their constituents in terms of access, quality and cost of long-term care. We must change the center of gravity in long-term care from nursing home institutionalization to a broad continuum of home-based to sub-acute care. We must tip the balance toward private financing and away from public assistance.

The challenge is daunting, but achievable. The state of Illinois has already laid much of the ground work. An outstanding study by the State Auditor General cited earlier identified problems associated with Medicaid estate planning and offered valuable recommendations. A distinguished "Task Force on Long-Term Care Eligibility Asset Policy" followed up with many similar suggestions. The Department of Public Aid acted early and successfully to enhance Medicaid liens and estate recoveries.

---

[66] Jeffrey L. Soltermann, "Medicaid and the Middle Class: Should the Government Pay for Everyone's Long-Term Health Care?," *The Elder Law Journal* , Vol. 1, No. 2, Fall 1993, p. 251, 286-87.

[67] General Accounting Office, *Long-Term Care Reform: States' Views on Key Elements of Well-Designed Programs for the Elderly*, GAO/HEHS-94-227, Washington, D.C., September 1994, pps. 2-3.

Efforts are well underway to implement the key elements of the Omnibus Budget Reconciliation Act of 1993. The Illinois Department of Insurance has a reputation for sensible regulation of private long-term care insurance. The Department on Aging strongly supports the concept of a public/private partnership for long-term care. Client advocacy groups embrace the goal of improving access to and quality of long-term care while protecting seniors from catastrophic spenddown. All that remains is to build on this solid foundation.

THE SENIOR FINANCIAL SECURITY PROGRAM[68]

The politics of aging is changing in America (and in Illinois). 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 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 Illinois:

> **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;**

---

[68] This chapter is borrowed in principal part from earlier reports on Wisconsin, Montana and Florida 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 Illinois.

[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)

seniors and their heirs who wish to avoid such recovery from the estate should plan ahead and purchase private long-term care insurance.

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.

THE ILLINOIS BULLET:
A STEP-BY-STEP PLAN TO PAY FOR UNIVERSAL LONG-TERM CARE

The following recommendations **do not** stand alone. They must be read in the context of the entire report. Nor are these recommendations comprehensive. They only suggest the magnitude, range, and general direction of the task at hand. Neither is any single recommendation critical. There are many ways to reach the primary objective. All that really matters is to find humane and cost-effective methods to give Medicaid back to the poor and encourage the middle class to plan ahead so they can pay privately for long-term care.

The fiscal objective of these recommendations is to reduce Medicaid nursing home utilization in Illinois from 65 percent of all bed days to 50 percent over a period of three to five years. This is a conservatively achievable goal and could save the state of Illinois $279 million per year or 23.1 percent of the Medicaid nursing home budget.[70] In combination with estimated potential savings of $60 million

---

[70] This estimate is based on data provided by James Hunter, Manager, Long-Term Care Rates, Bureau of Program Reimbursement and Analysis, Illinois Department of Public Aid, Springfield. Mr. Hunter gave me the following table in reply to my request for information on the fiscal impact of a 10 percent increase or decrease in Medicaid nursing home utilization.

FY 94 FISCAL IMPACT FROM CHANGE IN MEDICAID PERCENT

	PATIENT DAYS	ANNUAL LIABILITY	PERDIEM
FY94 AT 65% MEDICAID**	22,103,145	$1,209,734,203.00	$54.73
FY94 AT 100%	34,004,838		
MEDICAID AT 55%	18,702,661	$1,023,621,248.69	[-$186m]
MEDICAID AT 75%	25,503,629	$1,395,847,157.31	[+$186m]

**BUDGET ESTIMATE FOR FY94

My estimates for 50 percent and 80 percent Medicaid utilization are straight-line projections from Mr. Hunter's data.

(Footnote continues on next page.)

(Footnote continued from previous page.)

My Estimates: SAVINGS/COST

per year from Illinois' lien and estate recovery program, the total potential savings to the Medicaid program is $339 million per year or 28 percent of the current nursing home budget. **Given immediate, aggressive implementation of these recommendations, savings within the first year of full operation could reach $100 million to $140 million from a combination of estate recoveries ($20 million to $40 million) and cost avoidance ($80 million to $100 million).** If the state does nothing and Medicaid nursing home utilization continues to creep up to 75 or 80 percent[71], Illinois will need to spend an extra $186 million or $279 million respectively per year for nursing home care not counting inflation adjustments.

Private Contractor's Role

Most of the following recommendations can be achieved without additional state appropriations or FTEs (full time equivalents) by improving management coordination and control and through the use of private contractors hired on contingency. Such contractors include private attorneys, real estate agencies and title companies as explained in the specific recommendations below. No connotation is intended that private contractors will necessarily do a better job than experienced state staff. The use of contractors on contingency allows the state to do projects immediately (and at little or no cost) that time, staffing and priorities might not otherwise justify. A principal and coordinating contractor should orchestrate the whole program and be compensated based on a percentage of the savings from reversing the trend toward ever-increasing Medicaid nursing home utilization. An independent, private, coordinating contractor compensated on contingency for producing actual savings is critical to insulate the program from bureaucratic turf battles and undue political influence. The coordinating contractor's principal responsibilities will be (1) to help the state revise laws, regulations and policies in order to discourage divestiture and maximize assets available for recovery, (2) to assist the state in drafting, promoting and passing stronger state statutes in support of liens and estate recoveries, (3) to educate the media, the public, the private bar, state judges, eligibility workers, hearings officers, and others on the importance of strongly enforced anti-divestiture rules and carefully monitored income and resource controls, (4) to develop, implement, and promulgate a public/private long-term care partnership program that saves the state money by diverting potential future Medicaid recipients to lifetime private insurance protection, and (5) to promote the use of private geriatric care managers and inexpensive home and community-based services as a private sector substitute for premature nursing home institutionalization under Medicaid.

The state should obtain "section 1115" streamlined waivers, as announced by USDHHS Secretary Donna Shalala on August 18, 1993, to implement any of these recommendations that are not otherwise achievable by changes in state law, regulation or policy. The Health Care Financing

---

MEDICAID AT 50%	17,002,419	$930,542,000.00	-$279m
MEDICAID AT 80%	27,203,870	$1,488,867,800.00	+$279m

[71] Medicaid nursing home utilization already exceeds 80 percent in the states of New York and Maine.

Administration published "the policies and procedures the Department will follow in reviewing demonstration proposals and granting waivers under Section 1115 of the Social Security Act" in the *Federal Register* on September 27, 1994. Statutes or regulations proposed here that need to be waived could be grouped appropriately into one or more formal waiver proposals under the combined title "Illinois Senior Financial Security Waiver Program."

Recommendations

1 Planning and Management

1.1 Estimate the potential savings from these recommendations and reflect them in the Governor's next budget. This strategy compels those who wish to preserve Medicaid divestiture and sheltering loopholes to explain what else in the state budget they would cut to continue or reinstate them.

1.2 Hire a contractor on contingency to reverse the upward trend in Medicaid nursing home census. The contractor's responsibility should be to design the necessary programs and orchestrate the implementation of these recommendations. Compensate the contractor with a percentage of the savings from reducing Medicaid nursing home census and increasing estate recoveries.

1.3 Establish an advisory committee to supervise the implementation of this program. The committee should include representatives of the Department of Public Aid, the Department on Aging, and the Department of Insurance as well as members representing all of the key long-term care interest groups (senior advocates, providers, insurers, etc.)

1.4 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 and recommend corrective actions.

1.5 Activate top management in the Department of Public Aid to fix the problems that can be solved under existing state and federal law, to initiate changes necessary in state statutes, and to investigate, design, request, and obtain waivers of federal Medicaid law as required.

1.6 Earmark portions of the savings incidental to implementing these recommendations as seed money to grow the Senior Financial Security Program. For example, target funds (1) to promote the expansion of home and community-based services; (2) to educate the public on long-term care risk, liens, and estate recoveries; (3) to administer and advertise the public/private partnership program; and (4) to encourage the public to avoid Medicaid by planning ahead for private financing of long term care. The entire program should be self-financing through Medicaid savings.

2 Medicaid Nursing Home Eligibility

2.1 Seek a waiver of federal eligibility rules to permit full implementation of the Senior Financial Security Program described in the previous section. For example: a five to seven year look-back period; liens as a condition of eligibility; limits on burial trusts, etc. For additional provisions, see Stephen A. Moses, *Medicaid Estate Planning: Analysis of GAO's Massachusetts Report and Senate/House Conference Language*, LTC, Incorporated, Seattle, Washington, 1993.

2.2 Explore privatization of the eligibility determination process on an experimental basis in one or two counties. The objective of this experiment would be the strictest possible enforcement of federal and state eligibility rules with a percentage of the savings used to compensate the contractor. Currently, there is no incentive for eligibility workers to enforce the rules. It is easier for them to put people on assistance whether technically eligible or not; it is easier for them to help applicants get rid of assets than to draw up a complicated spenddown plan.

2.3 Close the exempt transfers loophole. Develop clear and objective criteria for approval of exempt transfers and apply the standards consistently in all cases. Refer all requests for transfer exemptions to a specialized, legally trained, central group of experts or to a contingency contractor after field approval, but before payment. Alternatively, train eligibility workers to refer ambiguous or unusual cases through a hierarchical supervisory review process. Handle the most difficult cases centrally. Stop sending the message that people who complain the loudest have their cases approved, especially if they apply political pressure. Obtain and review the criteria on exempt transfers used by other states, especially Oregon.

2.4 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.

2.5 Continue efforts already well underway to operation-alize, 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.

2.6 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 Illinois law, regulations, and policy in this new context; and ensure that the new authorities are reflected as quickly as possible in state policy.

2.7 Verify and track real property and transfers on all Medicaid applicants and recipients through county assessor's and recorder's offices. Use field eligibility 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. Field consultants of the estate recovery program have the expertise to train eligibility workers in this new task. Alternatively, contract with title companies to conduct the verifications on contingency (i.e., in exchange for a percentage of the savings.)

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

2.9 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.

2.10 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. This requirement was in an early draft of OBRA '93 but dropped. It will require a waiver.

2.11 Conduct a study to determine by statistical sampling the total amount of loss to the Illinois Medicaid program from the homestead exemption, funeral arrangement shelters, personal property exclusions and other Medicaid planning techniques. Assign this task to a private contractor paid on contingency from savings incidental to limiting these exemptions or enforcing current exemptions more strictly and consistently.

2.12 Take advantage of the computerized property ownership and transfer data system to which the state of Illinois subscribes in Cook and the collar counties. (These five counties contain more than half of all of the Medicaid nursing home eligibility cases in Illinois.) Conduct a comprehensive match with Medicaid eligibility rolls. Identify ineligible cases and develop an error prone profile to help eligibility workers identify probable ineligible cases before they are approved. Consider on-line property checks at the point of eligibility determination for the future. Knowledge that public records are instantaneously searched and verified should have a chilling effect on fraud and misrepresentation. Retain a private contractor to conduct this study on contingency.

2.13 Study the problem of proxy applications and develop a control system for applications submitted by anyone other than the applicant. This is especially critical when the applicant's representative has a possible conflict of interest. Today, approximately one-third of Medicaid nursing home applications in Illinois are completed and submitted by the same nursing home that will receive payments from the Medicaid program on behalf of the applicant. Compensate the research contractor from direct savings identified in the project.

2.14 Either eliminate mail order applications for Medicaid benefits altogether or conduct a study to identify probable high-cost cases that are error prone. Submit the high-risk

cases to careful review. Develop a prioritization screen. This study should pay for itself like the others.

2.15 Reinstate matches with Internal Revenue Service (IRS) income and asset data. Field staff say this was a valuable verification source until discontinued. If too time consuming for state staff, give the task to a private contractor on contingency. Pay the contractor based on savings from identifying fraudulent or ineligible cases.

2.16 Obtain state legislation to provide an exception to the deadline for disposing of nursing home applications within 45 days (aged cases) to 60 days (disabled cases) under the Cohen case whenever complicated income and asset issues are at stake. Conforming to these relatively short deadlines in complex cases is causing incomplete case reviews and is resulting in payment for ineligible cases according to field staff.

2.17 Implement a quality control (QC) system for group home cases. Field staff report that QC reviews for nursing home cases are rare and that reviewers are usually unknowledgeable when reviews do occur. These are the most expensive cases Medicaid funds and they should be reviewed at least as assiduously as any others.

2.18 Direct hearings officers to use reason when approving excess "Community Spouse Resource Allowances" to supplement a well spouse's interest income. Obtain a waiver if necessary to control this potential abuse.

2.19 If necessary, seek state legislation and a federal waiver to prevent the "transfer of assets before income," which empowers wealthy Medicaid applicants to shelter hundreds of thousands of additional dollars while qualifying for assistance.

2.20 Continue to pursue recommendations from the Auditor General and Task Force reports that were dropped: The state has not pursued federal waivers on look-back periods, burial policies or spousal assets; nothing has been done to obtain additional financial statements, tax returns, and nursing home applications at eligibility determination; nor were the recommendations implemented to improve the unearned income match through the Internal Revenue Service (in fact, field staff told me that they no longer receive this extremely valuable information at all).

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

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

2.23 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 public benefits.

2.24 Establish safeguards to assure that seniors get the care they need despite stricter eligibility criteria. Also, recognize that Medicaid estate planning often shades into financial abuse of the elderly. When appropriate, Illinois should petition the court to appoint conservators in cases of suspected financial abuse. Oregon uses conservators in this way to: relitigate expropriative divorce decrees, reverse illegal transfers, invade trusts, partition undivided property, maintain and sell properties, etc. This same method could be used to stop the theft of recipients' income by "protective payees" which is a big problem for nursing homes because it deprives them of the patient's contribution to cost of care. By using private attorneys on contingency, these initiatives can be taken at no cost to the state while generating considerable revenue.

2.25 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 B, "Medicaid Planning Ethical Issues" on this subject).

2.26 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.

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

2.28 Stop wasting time in the eligibility interview dancing around the "intent to return" issue. Either grant the homestead exemption up front, or conversely, if the state wants to compel people who are permanently institutionalized to sell their homes, request a waiver to do so. Strong enforcement of the lien program is probably the best middle path.

2.29 Consider requiring that assets transferred to a community spouse by an institutionalized spouse in order to obtain Medicaid eligibility must revert to the Medicaid spouse if predeceased by the community spouse. This is the only way to retain such assets for estate recovery.

2.30 Tighten up state policy on personal representatives. Watch out for relatives, neighbors, friends, hospital discharge planners, social workers, or anyone else who might have a conflict of interest. Financial abuse is "commonplace" and "rife" according to the Inspector General of the Department of Health and Human Services.

2.31 Study and resolve the problem of hospital patients who drop their private insurance and out-of-state residents who move to Illinois in order to qualify for Illinois Medicaid's increased nursing home reimbursement under the exceptional care program.

2.32 Watch vigilantly for the appearance of new divestiture techniques. As the state of Illinois clamps down on exempt transfers, burial exemptions and other easy Medicaid planning options, the Medicaid program should anticipate that a growing elder law bar will become ever more creative in attempting ever more complex divestiture and sheltering techniques.

3 Medicaid Estate Planning

3.1 Monitor the growth of the Medicaid estate planning bar in Illinois carefully. Between December 23, 1992 and September 1, 1994, the number of Illinois attorneys listed in the *Experience Registry* of the National Academy of Elder Law Attorneys (the professional association of Medicaid estate planners) increased from 13 to 18. As Illinois implements OBRA '93 and eliminates many of the easier Medicaid planning strategies, the market for and the creativity of professional Medicaid estate planners is likely to increase significantly.

3.2 The Illinois Medicaid program should subscribe to and carefully review elder law publications such as The *ElderLaw Report* newsletter (published by Little, Brown and Company in Boston) and a good loose-leaf service like John Regan's *Tax, Estate and Financial Planning for the Elderly* or Clark Boardman Callaghan's Advising the Elderly Client. These publications are full of Medicaid estate planning techniques that lawyers are using to circumvent Medicaid eligibility rules. *The ElderLaw Report*, especially, is an excellent early warning system for Medicaid eligibility policy makers who seek to prevent excessive loopholes and shelters.

3.3 Similarly, state eligibility staff should attend all major elder law conferences including the annual Joint Conference on Law and Aging. Join the National Academy of Elder Law Attorneys and participate. Send representation to all NAELA conferences and "institutes." This is an excellent way to monitor old and new Medicaid estate planning techniques. It also provides an opportunity to convey the Medicaid program's point of view on Medicaid estate planning to professionals in the field and to enlist their help in correcting problems.

3.4 Make the elder law bar part of the solution instead of part of the problem. Medicaid estate planning attorneys are well-intentioned and want to help improve public policy. Invite them to get behind this program. Seek their assistance, pro bono or formally on contingency, to redesign Medicaid as a line of credit on recipients' estates instead of a welfare program for the middle class.

4 Coordination and Control

4.1 Establish an advisory board of field eligibility staff to meet regularly with headquarters eligibility staff to clarify and strengthen eligibility policy.

4.2 Give Medicaid nursing home cases new visibility and importance; place the best workers in group care eligibility and challenge them. Field offices say group care has not been a priority. In the past, poor performers were often placed in the program. Yet Medicaid nursing home cases are the program's most expensive and most complicated.

4.3 To reduce staff time, errors, and inconsistencies drastically and to restore confidence in the system's fairness: refer all complicated long-term care income and resource 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 "expert" unit. The new unit will pay for itself by preventing cases of "eligibility by default," reported by many study respondents, which occur because field workers lack the time or expertise to enforce complicated rules. Field staff may be better able to handle large caseloads if the more complicated cases are removed in this way. The more complicated cases are also the ones most likely to save the state money if handled correctly.

4.4 Establish a toll free "800" number to which all inquiries statewide concerning ways to shelter income and assets to qualify for Medicaid nursing home benefits can be referred. This toll free number will assure consistent answers regarding state law and policy on trusts, transfers, and other tricks of Medicaid estate planning. It will also relieve eligibility workers, local office managers, and departmental legal staff of an enormous burden they currently bear for providing financial planning advice to Medicaid applicants and their attorneys. The "800" number will save time, discourage eligibility bracket creep and assure that everyone receives exactly the same information.

4.5 Require attorneys, accountants and financial planners who contact eligibility workers for information on how to circumvent Medicaid eligibility rules to consult a central, objective, information source.

4.6 Back up field eligibility staff with strong legal representation. Support them when they are right. Shelter them from political interference.

4.7 Initiate a program of job trades so that field office and headquarters eligibility staff of the Department of Public Aid have the opportunity to walk in each other's shoes for awhile.

4.8 Establish a hot line for nursing homes to report suspected improper asset transfers or financial abuse of the elderly.

4.9 Help nursing homes to obtain payment for their fees. Instead of deducting presumed income from Medicaid reimbursement and then letting nursing homes do their own collections, take responsibility for the client and the reimbursement. Petition the court to appoint conservators to represent Medicaid clients on contingency to compel

representative payees to turn over Social Security checks and other income to the nursing home whenever Medicaid eligibility was contingent on such contribution of income. If the state takes a strong enforcement stance, the chilling effect will discourage others from financially abusing seniors.

5 Liens and Estate Recoveries

5.1 Resubmit legislation to adopt the strongest possible definition of "estate" including assets held in joint tenancy with right of survivorship, life estates, living trusts, etc. as permitted by OBRA '93.

5.2 Increase the use of field property consultants to support field office verifications.

5.3 Continue to use the experimental methodology of the field consultant project to expand into new areas of recovery.

5.4 Study estate recovery in other states for ideas and techniques or retain a contractor to do so.

5.5 Enhance recoveries from spouse's and former recipients' estates or retain a contractor to do so.

5.6 Expand recoveries of assets sheltered for funeral costs but not expended or retain a contractor to do so.

5.7 Collect personal property as well as real estate and have a fiduciary maintain and auction the proceeds on contingency, e.g. investment-grade jewelry, paintings, Persian rugs, cars, etc.

5.8 Establish an accounts receivable system including contracts for deeds and open-ended mortgages which permit recipients and their families to retain assets (such as the family home) while repaying Medicaid benefits over time.

5.9 Seek state statutory authority for automatic recovery of small accounts held by Medicaid recipients in nursing homes and financial institutions on the model of programs in Oregon and Wisconsin which generate high recoveries with low effort.

5.10 Explore contingency contracts with private firms to conduct special experimental projects as a means to expand certain kinds of estate recoveries faster and more effectively than is possible with limited numbers of state staff.

5.11 Use graphs and charts to measure and display recoveries. Encourage competition among collectors.

5.12 Seek a waiver of merit compensation rules that prohibit bonusing field consultants on the basis of actual recoveries generated. Take every opportunity to reward and compensate staff for actual results. Give incentive awards to outstanding recovery specialists whenever possible. After all, they are saving jobs, helping the poor, and diverting the well-to-do toward preferred private options.

5.13 Set a threshold below which estate recovery effort is deemed not to be cost-effective instead of pursuing all cases equally regardless of potential return.

5.14 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.

5.15 Prioritize all estate recovery cases. Work the biggest, most promising cases first. Do not waste the tax payers' money on universal, shotgun approaches that treat every case equally irrespective of the probability of recovery.

5.16 Allow people who receive lump sums to pay back past assistance or put money in escrow against future assistance.

5.17 Support the lien and estate recovery program with full-time legal help, field visits to top-ranked recovery programs in other states to learn new techniques, and performance-based incentives.

5.18 Set up a central unit of legal and eligibility experts in the estate recovery program to handle difficult divestiture and shelter cases strongly and uniformly while relieving field staff of the burden of such complicated cases.

6 Long-Term Care Insurance

6.1 Explore the feasibility of a program whereby the state government would subsidize long-term care insurance premiums for low-income seniors with the seniors' estates as security for the subsidies. Insured seniors who some day require long-term care would not become a liability to the Medicaid program. Their private insurance would pay. Those who die without needing long-term care would repay their insurance premium subsidies to the government out of their estates.

6.2 Explore the feasibility of government-underwritten home equity conversion.

6.3 Take a new look at the Illinois Partnership and modify it as recommended in the text: strongly encourage purchase of high quality, unlimited, lifetime, private long-term care insurance by publicizing the risk of catastrophic costs and the liability of Medicaid liens

and estate recoveries; do not discourage the purchase of lifetime insurance policies and create a new unfunded liability for the state Medicaid program by promising massive spenddown forgiveness years in the future. Simply: 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.

6.4 Rescind the Medicaid state plan amendment that exempts all assets disregarded for purposes of the partnership from transfer of assets penalties. This exemption undercuts severely the strongest incentive there is to purchase private insurance, i.e., the risk of estate recovery.

6.5 Target a portion of the proceeds of the lien and estate recovery program to public education on the importance of planning ahead for the risk of long-term care. This will help to finance the new partnership program adequately so that it will impact the long-term care insurance market significantly.

6.6 Form a work group consisting of private insurance agents and staff of the Department on Aging, the Department of Public Aid, and the Department of Insurance to steer the new public/private partnership in directions that benefit the public.

6.7 Consider tax incentives to encourage the purchase of private long-term care insurance, state revenue estimates permitting.

6.8 Work closely with the Insurance Department to encourage private insurance. Explain the enormous expense to the state of Illinois of Medicaid nursing home expendi-tures, the imminent need to curtail such costs, and the urgency of offering citizens a viable, affordable private insurance alternative.

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

6.10 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.

7 Home and Community-Based Services

7.1 The state should study private geriatric care management and find ways to encourage it. Geriatric care managers (GCMs) help seniors to use their income and savings to remain at home as the seniors prefer. GCMs assess seniors' care needs, identify necessary

services, retain caregivers, manage cases, and place worried (often out-of-state) relatives' minds at ease. The National Association of Professional Geriatric Care Managers is a valuable resource for information on this profession. Seniors whose assets are not divested or sheltered to qualify for Medicaid nursing home benefits can often remain at home for long periods by paying privately for home and community-based services guided by professional geriatric care management.

8 Publicity

8.1 Design a brochure that explains the risks of long-term care, the need for insurance, the liability of liens and estate recoveries, and the closing of eligibility loopholes. Put the state of Illinois' imprimatur on the flyer and distribute it in mass mailings to all citizens of the state.

8.2 Draft an executive proclamation for Governor Edgar to deliver at a press conference declaring that Medicaid in Illinois 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 in effect and expanding, and that seniors and heirs should carefully examine private long-term care insurance options.

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

8.4 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.

8.5 Make SHIP, the Land of Lincoln Legal Assistance Foundation, Inc., the Area Agencies on Aging and other organizations that serve seniors part of the solution instead of part of the problem. Engage them in spreading the word: Plan ahead to avoid Medicaid institutionalization, eligibility problems, liens, and estate recoveries; buy quality private long-term care insurance; use geriatric care management to arrange cost-effective home and community-based services as long as possible, etc.

8.6 If possible, use the measures announced in these proclamations and educational programs to produce the savings necessary to preserve Illinois' generous optional Medicaid services, medically needy eligibility system, and liberal spousal impoverishment guidelines.

9 Evaluation

9.1 Invite the Illinois Auditor General to do a follow-up study on "enforcement of property

transfer laws."

9.2 Establish a formal system to track, evaluate, and measure the fiscal impact of implementing these recommendations.

RESPONDENTS/INTERVIEWEES

Mayda Abbott, Public Aid Assistant Administrator II, Nursing Home Services, Illinois Department of Public Aid, Chicago

Fred Backfield, Chief, Bureau of Management and Budget, Illinois Department of Public Aid, Springfield

Barry J. Beckwith, Chief, Bureau of Program and Field Management, Division of Operations, Illinois Department of Public Aid, Springfield

Michael Belletire, Deputy Chief of Staff, Office of the Governor, Springfield

James Berger, Deputy Director, Administrative Operations, Illinois Department of Public Aid, Springfield

Jean Blaser, Manager, Division of Long-Term Care, Illinois Department on Aging, Springfield

Jan Boone, Assistant Bureau Chief, Bureau of Long-Term Care, Illinois Department of Public Aid, Springfield

Marlene Bowens, Acting Public Aid Assistant Administrator I, Nursing Home Services, Illinois Department of Public Aid, Chicago

Dennis Bozzi, Executive Director, Illinois Association of Homes for the Aging, Hinsdale

Richard Bracken, Administrator, Parkhill Medical Complex, Chillicothe

Myron Brigman, Staff Attorney, General Counsel's Office, Illinois Department of Public Aid, Springfield

Charles J. Budinger, CLU, Supervising Insurance Analyst, Illinois Department of Insurance, Springfield

John Budny, Manager, Program Development and Budget, Illinois Department of Mental Health and Developmental Disabilities, Springfield

Sherilyn Bundy, Intake Maintenance Specialist, Franklin County, Illinois Department of Public Aid, Benton

Kelly Carter, Supervisor, Medical Budgeting Unit, Bureau of Management and Budget, Illinois Department of Public Aid, Springfield

M. Lee Christie, Ph.D., Long-Term Care Policy Researcher, Bureau of Program and Reimbursement Analysis, Illinois Department of Public Aid, Springfield

Kathy Claunch, Program Director, Senior Health Insurance Program, Springfield

David B. Conklin, Board Secretary, Illinois Nursing Home Administration Association, Rockford

Don Cox, Methods Operations Analyst, Bureau of Program and Field Management, Division of Operations, Illinois Department of Public Aid, Springfield

William D'Arcy, Division Manager - Homes/Aging, Catholic Charities of Chicago, Chicago

George Anne Daly, Chief, Bureau of Long-Term Care, Illinois Department of Public Aid, Springfield

Vince DeMuzio, Senator, State of Illinois, Carlinville

Kurt DeWeese, Services Analyst, House Democrat Staff, Springfield

Donna Drew, Income Maintenance Specialist, Sangamon County, Illinois Department of Public Aid, Springfield

Florence Dunbar, Acting Public Aid Assistant Administrator I, Nursing Homes Services, Illinois Department of Public Aid, Chicago

Jill Egan, Director, Constituencies, Illinois Hospital Association, Naperville

Ann Fisher, Supervising Attorney, Legal Assistance Foundation of Chicago, Chicago

Curt Fleming, Bureau Chief, Bureau of Collections, Illinois Department of Public Aid, Springfield

Howard Gnatowsky, President, H&S Insurance Services, Inc., Palatine

Jason Gold, Legislative Liaison, Illinois Department of Public Aid, Springfield

Clarence Golden, Supervisor of Technical Recovery Unit, Bureau of Collections, Illinois Department of Public Aid, Chicago

Murray Gordon, President, MAGA, Limited, Deerfield

Patricia Grant, Public Aid Assistant Administrator I, Nursing Home Services, Illinois Department of Public Aid, Chicago

Andrew Gruber, Senate Democrat Staff, Springfield

Jim Haertel, Public Aid Program Consultant, Illinois Department of Public Aid, Springfield

Marie Havens, Bureau of Policy, Planning and Program Development, Illinois Department of Mental Health and Developmental Disabilities, Springfield

Melinda Hazelwood, Waiver Coordinator, Bureau of Long-Term Care, Illinois Department of Public Aid, Springfield

Ray W. Hemphill, Vice-President, Lutheran Social Services,
Des Plaines

John Hicks, Administrator, Division of Field Operations, Illinois Department of Public Aid, Springfield

Mary Hill, Bureau Chief, Field Operations of Long-Term Care, Illinois Department on Aging, Springfield

Mary Kaye Hirsbrunner, Chief Executive Officer/Administrator, Jackson Heights Nursing Home, Farmer City

George Hovanec, Administrator, Division of Medical Programs, Illinois Department of Public Aid, Springfield

Sharon Howard, Policy Analyst, Bureau of Long-Term Care, Illinois Department of Public Aid, Springfield

James Hunter, Manager, Long-Term Care Rates, Bureau of Program Reimbursement and Analysis, Illinois Department of Public Aid, Springfield

Johnetta Jordan, Manager, Technical Recovery, Illinois Department of Public Aid, Springfield

Richard L. Kaplan, Professor, University of Illinois at Urbana-Champaign College of Law, Champaign

Bev Kaydus, Supervisor, Project Staff, Bureau of Program and Field Management, Division of Operations, Illinois Department of Public Aid, Springfield

William Kempiners, Executive Director, Illinois Health Care Association, Springfield

David Krieger, Regional Manager, AMEX Life Assurance, Arlington Heights

Carolyn Kusnerik, Administrator, County Nursing Home Association, Ottawa

Land of Lincoln Legal Services declined to participate in this study because they "no longer do nursing home asset transfers... [and] would not be able to answer our questions."

Mary Ann Langston, Administrator, Division of Policy, Illinois Department of Public Aid, Springfield

Jane Longo, Division Chief, Bureau of the Budget, Division of Public Assistance, Springfield

Olga Love, Local Office Administrator, Nursing Home Services, Illinois Department of Public Aid, Chicago

Michelle Maher, Budget Analyst, Bureau of Management and Budget, Illinois Department of Public Aid, Springfield

John Maitland, Senator, State of Illinois, Bloomington

Connie March, Vice President Geriatric Services, ServantCor, Kankahee

Greg Matarelli, Local Office Administrator, Sangamon County, Illinois Department of Public Aid, Springfield

Mary J. Mayes, Senior Policy Analyst, Long-Term Care, Illinois Department on Aging, Springfield

Carol Meeks, Vice President, Extended Care Division, EHS Health Care, Downers Grove

Wendy Meltzer, Staff Attorney, Illinois Citizens for Better Care, Chicago

Marti Merritt, House Republican Staff, Springfield

James L. Metzger, Executive Director, Apostolic Christian Restmor, Inc., Morton

Dwight L. Miller, President, Illinois Nursing Home Administrators Association, Robinson

Robert Molitor, Assistant Vice President of Operations, Alden Management Services, Inc., Chicago

Ken Molnar, Agent, AMEX Life Assurance, Arlington Heights

Dan Moore, Research Economist, Long-Term Care Rates, Bureau of Program Reimbursement and Analysis, Illinois Department of Public Aid, Springfield

Sam Morgante, Director of Product Development and Government Relations, AMEX Life Assurance, San Rafael, CA

Mike Murphy, Chief, Office of Legislation and External Affairs, Illinois Department of Public Aid, Springfield

Catherine C. Myers, Acting Public Aid Assistant Administrator I, Nursing Home Services, Illinois Department of Public Aid, Chicago

Myron P. Nidetz, Member, Metropolitan Area Satellite Group, American Association of Retired

Persons, Dolton

Ann O'Hagan, Manager, Regulatory Affairs and Constituencies, Illinois Hospital Association, Naperville

Bill Opper, Bureau Chief, Bureau of Policy and Training, Illinois Department of Public Aid, Springfield

Margel S. Peddicord, CPA, Manager, Office of Health Finance, Illinois Department of Public Aid, Springfield

Steven C. Perlis, Attorney at Law, Arlington Heights

David Peterson, Deputy General Council, Office of the General Counsel, Illinois Department of Public Aid, Springfield

David Phelps, Representative, State of Illinois, Harrisburg

Melody Platson, R.N., M.A., Vice President of Geriatrics, Chicago Golden L.I.G.H.T., Chicago

Scott Reimers, Summer Intern, Bureau of Long-Term Care, Illinois Department of Public Aid, Springfield

Kirk Riva, Director of Public Policy, Illinois Association of Homes for the Aging, Springfield

Marlene Robinson, Supervisor of Exceptional Care, Illinois Department of Public Aid, Springfield

Beverly Rowley, State Long-Term Care Ombudsman, Illinois Department on Aging, Springfield

Linda Ruggless, Public Aid Caseworker Lead Specialist, Sangamon County, Illinois Department of Public Aid, Springfield

John Rupcich, Supervisor, Medical and General Assistance, Bureau of Policy and Training, Illinois Department of Public Aid, Springfield

John J. Ryan, Executive Director, County Nursing Home Association, Springfield

Tom Ryder, Representative, State of Illinois, Jerseyville

Catherine Rylatt, Budget Analyst, Bureau of Management and Budget, Illinois Department of Public Aid, Springfield

James Samatas, Executive Director of Operations, Lexington Health Care Centers, Lombard

Jura S. Scharf, Associate Director, Catholic Conference of Illinois, Chicago

Maria R. Schmidt, Assistant Executive Director, Illinois Health Care Association, Springfield

Lester Sherer, Division Controller, Manor Healthcare Corporation, Naperville

Connie Sims, Medicaid Policy Manager, Illinois Department of Mental Health and Developmental Disabilities, Springfield

Wayne Smallwood, Manager, Internal Operations, Bureau of Long-Term Care Quality Control, Illinois Department of Public Aid, Springfield

Linda Smith, Insurance Analyst, Illinois Department of Insurance, Life, Accident and Health Compliance Unit, Springfield

Terry Sullivan, Associate Director, Illinois Council on Long Term Care, Chicago

Alan Summers, Local Office Administrator, Franklin County, Illinois Department of Public Aid, Benton

Teri Taggart-Sankey, Coordinator, Accounts Receivable Services, DEBES Corporation, Rockford

Kevin Taylor, Director of Program Analysis, Illinois Council on Long Term Care, Chicago

Steve Tenhouse, Director of Reimbursement, The Tutera Group, Elgin

Randy Tomlin, Medicaid Coordinator, Illinois Department of Rehabilitative Services, Springfield

David Weisbaum, Legislative Liason, Illinois Health Care Association, Springfield

Barbara Wexler, Administrator, Lieberman Geriatric Health Centre, Council for Jewish Elderly, Skokie

Mary Beth Woolard, Public Aid Lead Caseworker Supervisor, Franklin County, Illinois Department of Public Aid, Benton

Glen Zilmer, Administrator, Warren Barr Pavilion, Illinois Masonic Medical Center, Chicago

BIBLIOGRAPHY

Administration on Aging (USDHHS), *Infrastructure of Home and Community Based Services for the Functionally Impaired Elderly*, Washington, D.C., 1994.

American Association of Retired Persons and National Academy for State Health Policy, *Integrating Acute and Long-Term Care: Advancing the Health Care Reform Agenda, Conference Proceedings*, Report # 9408, American Association of Retired Persons, Washington, D.C., August 1994.

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

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

Churchill, Representative Robert W. and Senator Patrick D. Welch, *Medicaid: An Overview of Caseloads and Other Factors Affecting Its Growth*, Illinois Economic and Fiscal Commission, Springfield, Illinois, July 1993.

Cohen, Marc A., "The Market for LTC Insurance," *LTC News & Comment*, Vol. 5, No. 1, September 1994.

Crown, William H., Brian O. Burwell, and Lisa Alecxih, An *Analysis of Asset Testing for Nursing Home Benefits*, AARP Public Policy Institute #9409, Washington, D.C., August 1994.

Cutler, David M. and Louise M. Sheiner, *Policy Options for Long-Term Care*, Working Paper No. 4302, National Bureau of Economic Research, Inc., Cambridge, Massachusetts, March 1993.

Department of Health and Human Services, Health Care Financing Administration, "State Medicaid Manual: Part 3--Eligibility, Transmittal No. 63," September 1994.

Dutton, Janna, "Illinois Medical Assistance for Nursing Home Care," chapter in *Illinois Institute of Continuing Legal Education Handbook, Advising the Elderly Client*, Chicago, Illinois, to be published in 1994.

Edgar, Governor Jim, *Fiscal 1995 Budget Address*, March 2, 1994.

Fleming-Moran, Millicent, Teresa Kenworthy-Bennett, and Karen Harlow, *Growing Older in Illinois: Needs, Challenges, Opportunities*, The Illinois Department on Aging, Springfield, Illinois, 1991.

Folkemer, Donna, *State Use of Home & Community-Based Services for the Aged Under Medicaid: Waiver Programs, Personal Care, Frail Elderly Services and Home Health Services*,

Report # 9405, AARP Public Policy Institute, Washington, D.C., May 1994.

General Accounting Office, *The Elderly Should Benefit From Expanded Home Health Care But Increasing Those Services Will Not Insure Cost Reductions*, December 7, 1982.

General Accounting Office, *Long-Term Care Reform: States' Views on Key Elements of Well-Designed Programs for the Elderly*, GAO/HEHS-94-227, Washington, D.C., September 1994.

General Accounting Office, *Medicaid: Determining the Cost-Effectiveness of Home and Community-Based Services*, April 1987.

General Accounting Office, *Medicaid Long-Term Care: Successful State Efforts to Expand Home Services While Limiting Costs*, GAO/HEHS-94-167, Washington, D.C., August 1994.

General Accounting Office, *Recoveries from Nursing Home Residents' Estates Could Offset Program Costs*,
GAO/HRD-89-56, March 1989.

Hallfors, Diane Dion, "State Policy Issues in Long-Term Care for Frail Elders," Center for Vulnerable Populations, Institute for Health Policy, Brandeis University, March 30, 1993.

Health Data Associates, Inc., *Nursing Home Yearbook: 1994*, Tacoma, Washington, 1994.

Illinois Department of Insurance, *Senior Health Insurance Program: Counselor's Manual, 1994 Edition*, Springfield, Illinois, 1994.

Illinois Department of Public Aid, *Final Report: Task Force on Long-Term Care Eligibility Asset Policy*, Springfield, Illinois, September 1993.

Illinois Department of Public Aid, *Liens & Estates Field Consultant Handbook Pilot Project: 1992-1993*, Springfield, Illinois, 1992.

Illinois Department of Public Aid, *Long-Term Care in Illinois*, prepared for the Governor's Health Care Reform Task Force, Springfield, Illinois, March 1, 1993.

Illinois Department on Public Aid and Illinois Department of Insurance, *Illinois Partnership for Long Term Care Insurance*, Springfield, Illinois, September 1993.

Land of Lincoln Legal Assistance Foundation, Inc., "When One Spouse Enters a Nursing Home: Illinois Medicaid Income and Asset Rules for Couples," Springfield, Illinois, March 1993.

Letsch, Suzanne W., et al., "National Health Expenditures, 1991," *Health Care Financing Review*, Vol. 14, No. 2, Winter 1992.

Mandeville, Robert L., *An Rx for Medicaid*, Illinois Tax Foundation, Springfield, Illinois, 1993.

Marion Merrell Dow Inc., *Marion Merrell Dow Managed Care Digest, Long Term Care Edition, 1994*, Kansas City, Missouri, 1994.

McCarty, Robert and Marilyn Saunders, "The Value of Long Term Care Insurance in Estate Planning," *National Academy of Elder Law Attorneys: 1994 Symposium Manual*, NAELA, Tucson, Arizona, 1994.

Meltzer, Wendy, *The Status of Nursing Home Regulation in Illinois*, Illinois Citizens for Better Care, Chicago, Illinois, 1994.

National Association of Insurance Commissioners, "A Shopper's Guide to Long-term Care Insurance," NAIC, Kansas City, Missouri, 1993.

Senior Health Insurance Program, "New Medicaid Laws," *Portrait of SHIP*, No. 2, Winter 1993.

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

Soltermann, Jeffrey L., "Medicaid and the Middle Class: Should the Government Pay for Everyone's Long-Term Health Care?," *The Elder Law Journal*, Vol. 1, No. 2, Fall 1993, pps. 251-90.

State of Illinois, Office of the Auditor General, *Program Audit: Enforcement of Property Transfer Laws*, Springfield, Illinois, May 1993.

Stolze, Dan, "Research Data on the Elderly," presentation to the Illinois Governor's Long Term Care Committee, May 10, 1993, by the Metro Chicago Information Center.

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

Van Nostrand, J.F., S.E. Furner, and R. Suzman, editors, *Health Data on Older Americans: United States, 1992*, National Center for Health Statistics, Vital Health Stat 3(27), 1993.

Webster's Encyclopedic Unabridged Dictionary of the English Language, Portland House, New York, 1989.

Wiener, Joshua M. and Katherine M. Harris, "Myths & Realities: Why Most of What Everybody Knows about Long-Term Care Is Wrong," *The Brookings Review*, Fall 1990.

Related Publications

by Stephen A. Moses

"Advising the Elderly or Disabled Client," *LTC News & Comment*, Vol. 2, No. 6, February 1992.

"The Case For Long-Term Care Insurance (And How to Make It)," *Nursing Homes*, Vol. 42, No. 1, January/February 1993.

"Elder Lawyers Meet; Debate Ethics of Medicaid Muddle," *LTC News & Comment*, Vol. 2, No. 4, December 1991.

"Expect a Bitter Pill from Uncle Sam," *The ElderLaw Report*, Vol. 2, No. 6, January 1991.

"The Fallacy of Impoverishment," *The Gerontologist*, Vol. 30, No. 1, February 1990.

"A Flawed Assertion: Health Care is a 'Right'," *Orlando Sentinel*, August 8, 1993.

The Florida Fulcrum: A Cost-Saving Strategy to Pay for Long-Term Care, LTC, Incorporated, Seattle, Washington, 1994.

"Frontline Spotlights the Medicaid Muddle," *LTC News & Comment*, Vol. 1, No. 10, June 1991.

"Health and Long-Term Care Insurance," chapter in Louis A. Mezzullo and Mark Woolpert, editors, *Advising the Elderly Client*, Clark Boardman Callaghan, New York, 1992.

"How to Qualify for Medicaid Without Spending Down," *LTC News & Comment*, Vol. 1, No. 8, April 1991.

How to Resolve Elder Law's Ethical Dilemma, *The ElderLaw Report*, Vol. 2, No. 3, October 1990.

"In Defense of Private Long-Term-Care Insurance," *The ElderLaw Report*, Vol. 2, No. 9, April 1991.

"The Jig is Up for Medicaid Planning," *LTC News & Comment*, Vol. 3, No. 11, July 1993.

"Let's Compare Apples with Apples," *LTC News & Comment*, Vol. 2, No. 3, November, 1991.

Long-Term Care in Montana: A Blueprint for Cost-Effective Reform, LTC, Incorporated, Kirkland, Washington, September 24, 1993.

LTC Issue Briefs, LTC, Incorporated, Kirkland, Washington, 1990.
"The Massachusetts Muddle," *LTC News & Comment*, Vol. 1, No. 5, January 1991.

Medicaid Estate Planning: Analysis of GAO's Massachusetts Report and Senate/House Conference Language, LTC, Incorporated, Kirkland, Washington, 1993.

Medicaid Estate Planning in Kentucky: How to Identify, Measure and Eliminate Legal Excesses, LTC, Incorporated, Kirkland, Washington, 1993.

Medicaid Estate Recoveries: A Management Advisory Report, Office of Inspector General, Office of Analysis and Inspections, OAI-09-89-89190, Washington, DC, December 1988.

Medicaid Estate Recoveries in Maine: Planning to Increase Non-Tax Revenue and Program Fairness, LTC, Incorporated, Kirkland, Washington, 1993.

Medicaid Estate Recoveries in Massachusetts: How to Increase Non-Tax Revenue and Program Fairness, LTC, Incorporated, Kirkland, Washington, December 13, 1990.

Medicaid Estate Recoveries, Office of Inspector General, Office of Analysis and Inspections, OAI-09-86-00078, San Francisco, California, June 1988.

Medicaid Loopholes: A Statutory Analysis with Recommendations, LTC, Incorporated, Kirkland, Washington, 1991.

"Medicaid Loopholes Hurt Everyone," *Contemporary Long-Term Care*, Vol. 13, No. 12, December 1990.

"Medicaid Muddle Revisited," *LTC News & Comment*, Vol. 3, No. 7, March 1993.

"Medicaid Muddle: Part II," *LTC News & Comment*, Vol. 1, No. 6, February, 1991.

"Medicaid Planning: Another View," letter to the editor, *Journal of Accountancy*, Vol. 173, No. 2, February 1992.

"Medicaid Planning: Ethically Questionable?," letter to the editor, *Law, Medicine and Health Care*, Vol. 18, No.4, Winter 1990.

"Medicaid 'Spend Down' Provision Often Avoided by Wealthy," *Provider*, Vol. 17, No. 2, February 1991.

A Minnesota Prospectus for the Senior Financial Security Program LTC, Incorporated, Kirkland, Washington, 1992.

"The Muddle-Mania Express," *LTC News & Comment*, Vol. 2, No. 5, January 1992.

"Muddle Masters Meet, List Latest Medicaid Loopholes," *LTC News and Comment*, Vol. 1, No. 11, July 1991.

The Myth of Medicaid Spend-Down, LTC, Incorporated, Kirkland, Washington, 1991.

"The Myth of Unaffordability," *Elder Law Advisory*, No. 16, July 1992.

"No Excuse for Medicaid Muddling," *LTC News & Comment*, Vol. 2, No. 9, May 1992.

"Of Floods, Insurance and LTC," *LTC News & Comment*, Volume 4, No. 1, September 1993.

"Pauper Planners Potpourri," *LTC News & Comment*, Vol. 2, No. 10, June 1992.

The Perils of Medicaid: A New Perspective on Public and Private Long-Term Care Financing, LTC, Incorporated, Kirkland, Washington, 1994.

"Planning for Long-Term Care Without Public Assistance," *Journal of Accountancy*, Vol. 175, No. 2, February 1993.

"The Principled Approach to Medicaid Planning," *LTC News & Comment*, Vol. 3, No. 9, May 1993.

"Protect Your Older Clients from Their Children's Attorneys," *LAN: Life Association News*, Vol. 87, No. 2A, February 15, 1992.

The Senior Financial Security Program: A Plan for Long-Term Care Reform in Wisconsin, LTC, Incorporated, Kirkland, Washington, June 26, 1992.

"Shedding Tiers," *LTC News & Comment*, Vol. 2, No. 7, March 1992.

"Special Edition on Medicaid Estate Planning," *LTC News & Comment*, August 1992.

"Stop the Medicaid Gravy Train," *Best's Review*, Vol. 92, No. 6, October 1991.

Transfer of Assets in the Medicaid Program: A Case Study in Washington State, Office of Inspector General, Office of Analysis and Inspections, OAI-09-88-01340, San Francisco, California, May 1989.

"Undaunted Divesters Dig Deeper," *LTC News & Comment*, Vol. 4, No. 6, February, 1994.

"Ways to Monitor Asset Transfers by the Elderly: LTC Comment," *LTC News & Comment*, Vol. 2, No. 6, February 1992.

"Why Not Medicaid," *The ElderLaw Report*, Vol. III, No. 1, July/August 1991.

Spenddown Studies and Articles

Arling, Greg, et al., "Medicaid Spend Down Among Nursing Home Residents in Wisconsin,"

unpublished paper presented at the 1988 Annual Meeting of the American Public Health Association in Boston, Center for Health Systems and Research and Analysis, University of Wisconsin, Madison.

Branch, Laurence G., et al., "Impoverishing the Elderly: A Case Study of the Financial Risk of Spend-Down Among Massachusetts Elderly People," The Gerontologist, Vol. 28, No. 5, 1988, pps. 648-652.

Branch, Laurence G., "Impoverishment for the Elderly: A Case Study of Financial Risk," *America's Health Care Challenge: New Directions for Business, Government and Individuals*, Northwestern National Life Insurance Company, 1986, pps. 14-18.

Burwell, Brian O., E. Kathleen Adams, and Mark R. Meiners, "Eligibility Among Elderly Nursing Home Recipients in Michigan," *Medical Care*, Vol. 28, No. 4, April 1990, pps. 349-62.

Burwell, B., Adams, E., and Meiners, M., "Spend-Down of Assets Before Medicaid Eligibility Among Elderly Nursing-Home Recipients in Michigan," *Medical Care*, Vol. 28, No. 4, April 1990, pps. 349-362.

Deane, Robert T., "Medicaid Spend Down: Now We Can Separate Myth from Reality," *Provider*, Vol. 16, No. 1, January 1990, pps. 10-12.

Liu, Korbin, Pamela Doty, and Kenneth Manton, "Medicaid Spenddown in Nursing Homes," *The Gerontologist*, Vol. 30, No. 1, February 1990, pps. 7-15.

Liu, Korbin, Pamela Doty, and Kenneth Manton, "Medicaid Spenddown of Disabled Elderly Persons: In Nursing Homes or in the Community?," Health Care Financing Administration, unpublished paper prepared under Cooperative Agreement No. 18-C-98641/4-02 to the Center for Demographic Studies, Duke University, March 1989.

Short, Pamela Farley, et al., "Public and Private Responsibility for Financing Nursing-home Care: The Effect of Medicaid Asset Spend-down," *The Milbank Quarterly*, Vol. 70, No. 2, 1992, pps. 277-298.

Spence, Denise A. and Joshua M. Wiener, "Estimating the Extent of Medicaid Spend-Down in Nursing Homes," *Journal of Health Politics, Policy, and Law*, Vol. 15, No. 3, Fall 1990, pps. 607-626.

APPENDIX A:

Work Plan: Controlling Medicaid Long-Term Care Costs

Submitted to the Illinois Department of Public Aid
by
Stephen A. Moses, Director of Research
LTC, Incorporated

I. **Objective**: Produce a step-by-step plan to save the state of Illinois $320 million per year in Medicaid nursing home expenditures while simultaneously assuring universal access to top quality long-term care for rich and poor citizens alike across the whole spectrum from home and community-based to nursing home care.

II. **Problem**: Medicaid nursing home expenditures in Illinois have increased from $1.1 billion in 1992 to an expected $1.6 billion in 1995. This rapid cost increase severely impairs the state's ability to maintain generous Medicaid nursing home eligibility criteria, to expand the home and community-based services preferred by seniors, and to sustain adequate financing for other critical state services such as corrections, education, and highways. In his fiscal year 1995 budget address, Governor Edgar called for "a massive overhaul of our Medicaid program, one that targets fraud and abuse, and borrows heavily from success stories in the private sector...." This project would operationalize the Governor's vision as applied to Medicaid long-term care financing.

III. **Diagnosis**: Generous Medicaid nursing home eligibility rules in Illinois (and elsewhere), although well-intentioned and politically popular, have gradually converted a means-tested public assistance program (welfare) into an expensive, de facto long-term care entitlement program. Consequently, private out-of-pocket and insurance financing of home, community-based, and nursing home care have languished while Medicaid costs for these programs have sky-rocketed. The public policy dilemma is to contain Medicaid long-term care spending without incurring the wrath of voters by increasing taxes or cutting benefits.

IV. **Treatment**: The solution to this quandary, proposed in a long series of reports by the DHHS Inspector General, the General Accounting Office, and LTC, Incorporated, is to retain generous Medicaid eligibility criteria while restricting asset transfers and shelters, enhancing estate recoveries, and encouraging private long-term care financing alternatives. The difficulty with this solution, however, is that it is complicated to achieve and it is often opposed by various long-term care interest groups. Therefore, a two-fold public policy intervention is needed: the Medicaid program must assure that (1) every federal and state statutory, regulatory and administrative remedy is fully employed to target public assistance resources to the most needy while diverting more prosperous people to private financing options and (2) every stakeholder in the long-term care financing issue understands the benefit to its constituency of implementing the necessary measures. These are the specific goals that this project would seek to achieve.

V. **Work Plan**: To achieve the objective and goals of this project, we propose the following activities:

A. Examine Medicaid nursing home eligibility criteria in Illinois with attention to federal and state statutory, regulatory and policy guidelines. Thoroughly study and review all relevant state and federal statutes, regulations and policy manuals and compare them to eligibility policies in other states. Provide recommendations for state legislation, program policy changes and federal waivers to achieve a stronger and tighter asset control methodology.

B. Review the state's implementation of OBRA '93 (Omnibus Budget Reconciliation Act of 1993) authorities. Interview responsible state staff and study existing plans, proposed legislation, and policy options under consideration. Recommend ways that the state of Illinois can take full advantage of this powerful new federal legislation.

C. Appraise the status of Medicaid estate planning (the artificial impoverishment of frail seniors to qualify them for publicly financed nursing home benefits) in Chicago and down state. Review the legal literature on Medicaid planning in Illinois and interview five or more key, influential elder law attorneys. Recommend measures to control Medicaid estate planning and to encourage attorneys, financial planners, accountants and other senior advisers to suggest private long-term care financing alternatives while their clients are young and healthy enough to afford them.

D. Plan and conduct site visits to at least three local Medicaid nursing home eligibility local offices (urban, suburban, and rural). Interview supervisors and eligibility workers; review eligibility policies and procedures; examine a judgmental sample of Medicaid nursing home eligibility case records; compile examples of Medicaid estate planning techniques; explore the potential impact of possible alternative solutions on affected field staff; and obtain ideas and recommendations from front line workers.

E. Analyze Illinois' lien and estate recovery statutory authorities, regulations, administrative policies, program activity, and collections. Interview key program staff; analyze procedures; examine the integration of front-end eligibility controls with back-end collection efforts; estimate maximum recovery potential; research best practices from other states and explore the possibility of applying them in Illinois. Recommend initiatives to maximize non-tax revenue to the state of Illinois from lien and estate recovery programs.

F. Study long-term care insurance regulation in Illinois. Interview representatives of the State Insurance Commissioner's office; review laws, regulations and policies governing the content and sale of long-term care insurance products in the state; interview agents and brokers who market home health and nursing home insurance policies concerning the obstacles they face; compare policies and practices in Illinois with other states; and analyze the chilling effect of easy Medicaid eligibility on the marketability of private insurance alternatives. Recommend statutory, regulatory and policy changes to enhance early planning for private long-term care insurance as an affordable, high quality alternative to reliance on Medicaid nursing home benefits by default.

G. Interview and brief key long-term care stakeholders: e.g., senior and consumer advocates,

Governor's staff, key legislators and staff, proprietary and non-proprietary nursing home and home health providers, long-term care insurers, Medicaid planners, taxpayer representatives, the Chamber of Commerce and other business interests, Medicaid management, line and legal staff, and any other group which the Department believes would be appropriate. It is critical to meet with each group separately to target and concentrate on its particular interests. The purpose of these meetings is to discern the prevailing attitudes of the various interested parties, both public and private, in the long-term care area and to introduce them to the consensus strategy described in the Inspector General's reports and LTC, Incorporated's Florida, Montana and Wisconsin reports. We will conduct two-hour presentations (similar to my program for state executive staff in Springfield on March 30, 1994) for each interest group with a stake in the long-term care financing issue. Presentations will include a summary of the problem, an historical perspective on how we got into the fiscal and political predicament we are in, a summary of recommendations from the DHHS Inspector General and other government agencies on how to resolve the situation, and an explanation of why it is in the best interest of each group to work cooperatively with the others on the proposal under consideration to the mutual benefit of all. Each respondent will receive an information pack of articles and reports on the topic similar to the one distributed at my briefing in March.

H. Examine the overall social impact (upon the elderly population, families, etc.) from the transfer of resources and assets. We propose to explore every aspect of the potential ramifications for seniors of the transfer of assets and resources issue and to provide relevant recommendations on each. For example, what effect does Medicaid estate planning have on the state's ability to finance and the nursing homes' ability to provide access to quality long-term care? Will closing loopholes discourage vulnerable seniors from seeking needed care? Does the easy availability of Medicaid benefits discourage advance planning and purchase of private long-term care insurance products or continuing care retirement community contracts? To what extent are middle class people on Medicaid consuming state tax revenues needed to fund other public needs such as education, highways, and prisons? Are there ways to divert the middle class to other financing mechanisms while making Medicaid benefits more readily available to the poor than ever before? We will address all of these questions and many more similar ones in the final report of this project.

I. Prepare and submit an interim report mid-way through the project summarizing current status, problems encountered, solutions proposed, work remaining, preliminary findings, etc.

J. Analyze all data; write the final report including the action plan implementation strategy; and submit five original bound copies to the state. The final report will be entirely substantive, clear and readable as evidenced by our previous work products, samples of which have been provided. The goal is to prepare a document suitable for presentation to the state legislature as a game plan to improve long-term care access and quality, benefit seniors, reduce Medicaid expenditures and enhance the fiscal responsibility of state government.

K. Subsequent to publication of the final report, the author will be available in Chicago and Springfield for one week at the Department's convenience to present state legislative testimony, advise on implementation strategy, conduct media briefings, present findings to key interest group representatives, and provide any additional follow-up work desired by the state.

L. We anticipate that the state will provide a desk, phone, and meeting space during our site visits and will assist us in obtaining necessary documentation, contacting appropriate respondents, scheduling interviews, and making other arrangements essential to the successful completion of the project. This kind of shared responsibility has worked very well in previous projects with other states. We estimate the total state staff time necessary to perform these functions during the entire project to be approximately 120 to 160 person hours.

VI. **Site Visits**: We anticipate the need to spend approximately 15 work days in Illinois during this project for the purpose of conducting interviews and briefings, visiting local eligibility offices, analyzing current policies and procedures, conducting legal research, etc. In addition, we have allowed and budgeted for a post-project trip of five days for follow-up, testimony, briefings, etc.

VII. **Schedule**: We recommend beginning this project by late July 1994 and completing it by early November 1994.

VIII. **Deliverables**: One interim status report of several pages and five copies of a formal, bound final report reflecting all of the commitments made within this proposal.

IX. **Experience and Credentials**: All tasks related to this project will be performed by Stephen A. Moses or Kathryn J. Tjelle of LTC, Incorporated as delineated below:

A. LTC, Incorporated is a private firm specializing in long-term care financing and insurance. The company also provides consulting services to state Medicaid agencies and publishes a well-known and highly respected national newsletter called *LTC News & Comment*.

B. As to the competence and bona fides of Stephen A. Moses, Director of Research for LTC, Incorporated to conduct this research, Mr. Moses served for nine years with the Health Care Financing Administration as a Medicaid State Representative. In this capacity, he conducted periodic reviews of Oregon's long-term care eligibility system, asset control methodologies, and estate recovery program; he directed a feasibility study of closing eligibility loopholes and implementing estate recoveries in Idaho; and he surveyed every Medicaid eligibility system, lien and estate recovery program in the country (*The Medicaid Estate Recovery Study*, Region 10, November 1985).

In 1987, Mr. Moses joined the Office of Inspector General of the U.S. Department of Health and Human Services where he was the national project director and author of another national study of Medicaid nursing home eligibility, Medicaid estate planning, and asset and resource divestiture problems entitled Medicaid Estate Recoveries, June 1988. He also directed and authored *Transfer of Assets in the Medicaid Program: A Case Study in Washington State*, May 1989 for the Office of Inspector General. Both of these projects delved deeply into all of the topics proposed for review in Illinois. Mr. Moses advised the General Accounting Office on all aspects of its study entitled *Medicaid: Recoveries from Nursing Home Residents' Estates Could Offset Program Costs*, March 1989. He briefed then-incumbent Secretary Otis Bowen of USDHHS and Administrator William Roper of HCFA on the growing national problem of Medicaid asset/resource divestiture and the need for Medicaid estate

recoveries and he wrote the Inspector General's contribution to the report to Congress on these subjects that was mandated by the Medicare Catastrophic Coverage Act of 1988 (*Medicaid Estate Recoveries: A Management Advisory Report*, December 1988.)

Since leaving federal service in 1989, Mr. Moses has published over three dozen articles on Medicaid estate planning, nursing home eligibility, transfer of assets, liens and estate recoveries; he has consulted on these subjects in over 25 states and spoken at innumerable national conferences; and he has testified before nearly two dozen state legislatures. As Director of Research for LTC, Inc., Mr. Moses has directed and authored studies on Medicaid nursing home eligibility, asset and resource transferring techniques, methods to control divestiture, estate recoveries, and how to implement OBRA '93 in numerous states, e.g.: *Medicaid Estate Recoveries in Massachusetts: How to Increase Non-Tax Revenue and Program Fairness*, December 1990; *The Senior Financial Security Program: A Plan for Long-Term Care Reform in Wisconsin*, June 1992; *Medicaid Estate Planning in Kentucky: How to Identify, Measure and Eliminate Legal Excesses*, March 29, 1993; *Long-Term Care in Montana: A Blueprint for Cost-Effective Reform*, September 23, 1993; and *The Florida Fulcrum: A Cost-Saving Strategy to Pay for Long-Term Care*, April 21, 1994. Of closely related significance is *Medicaid Loopholes: A Statutory Analysis with Recommendations*, which Mr. Moses presented to the minority staff of the United States Senate Committee on Finance in 1991 and *Medicaid Estate Planning: An Analysis of GAO's Massachusetts Report and Senate/House Conference Language*, presented to The United States Senate Committee on Finance and Special Committee on Aging, July 30, 1993. Any or all of these reports and publications are available for review upon request.

All clerical, organizational, logistical, and support duties for this contract will be performed by Kathryn J. Tjelle, Research Coordinator, LTC, Incorporated. Ms. Tjelle is a graduate of the University of New Mexico. She has 13 months experience with LTC, Incorporated performing such duties.

X. **References**: The following persons may be contacted concerning the projects referenced above:

A. Florida Contract Officer: Susan Ahrendt, Medical Health Care Program Analyst, Agency for Health Care Administration, Office of Medicaid Program Analysis, 1317 Winewood Blvd., Building 6, Room 235, Tallahassee, FL, 32301, 904-488-9350.

B. Montana Contract Officer: Terry Frisch, TPL Manager, Department of Social and Rehabilitation Services, 111 North Sanders Street, Box 4210, Helena, Montana, 59604, 406-444-4162.

C. Wisconsin State Contact: Gene Kussart, Executive Assistant, Department of Health and Social Services, P.O. 7850, 650 One West Wilson St., Madison, WI, 53707, 608-266-9622.

D. Inspector General contact: Michael Mangano, Principal Deputy Inspector General, Office of Inspector General, Room 5246 Cohen Building, 330 Independence Ave., S.W., Washington, DC, 20201, 202-619-3146.

E. U.S. Senate Contact: Roy Ramthun, Professional Staff Member, Senate Finance Committee, 203 Hart Building, Washington, DC, 20510, 202-224-5315.

F. Massachusetts State Contact: John Robertson, Acting Deputy Associate Commissioner, Medical Assistance, Essex Station, P.O. Box 68, Boston, MA, 02112, 617-348-5375.

APPENDIX B: BACKGROUND QUOTATIONS AND CITATIONS

The purpose of this Appendix is to provide a context and conceptual framework for readers who may not already be fully familiar with the gerontological and public policy literature on long-term care financing. I hope that these quotations provide some background that will be helpful to understand and evaluate the text. The topics covered are Aging Demographics, Health and Long-Term Care Statistics, Cost-Effectiveness of Home and Community-Based Services, Letter to Ann Landers, Long-Term Care Risk and Financing, Home Equity Conversion, Medicaid Background, Entitlement Program Problems, Elder Law Issues, Medicaid Planning Quotes Since OBRA '93, and Medicaid Planning Ethical Issues.

Aging Demographics

"The proportion of the population that is elderly is growing; it will explode as the baby-boom generation retires....No other demographic change will influence the Nation in the next 50 years as much....Every American and every facet of the society will be affected."

Council of Economic Advisers (CEA), *The Annual Report of the Council of Economic Advisers*, U.S. Government Printing Office, Washington, D.C., 1985, p. 160.

"Although the elderly represented only 12 percent of the population in 1987, they accounted for 44 percent of spending for personal health care."

Joseph S. Piacentini and Jill D. Foley, *EBRI Databook on Employee Benefits*, Employee Benefit Research Institute, Washington, D.C., 1992, p. 200.

"The elderly population doubled between 1950 and 1980 and will double again by 2030, accounting for almost one-fifth of the U.S. population."

Council of Economic Advisers (CEA), *The Annual Report of the Council of Economic Adviser*, U.S. Government Printing Office, Washington, D.C., 1985, p. 157.

"The fastest-growing segment of the population is the very old, who are at high risk of chronic illness, functional dependency, disability, and institutionalization."

Dorothy P. Rice and Mitchell P. LaPlante, "Chronic Illness, Disability, and Increasing Longevity," in Sullivan, Sean and Marion Ein Lewin, editors, *The Economics and Ethics of Long-Term Care and Disability*, American Enterprise Institute for Public Policy Research, Washington, D.C., 1988, p. 11.

"Presently there are approximately 2.5 million people over 85 years of age, or 1.1% of the total population. This is expected to increase to 16 million or 5.2% of the population by the year 2050. Of the over 85 age group, 20% reside in nursing homes."

National Association of Insurance Commissioners (NAIC), *Long Term Care Insurance: An Industry Perspective on Market Development and Consumer Protection*, 1987, p. 3.

"Poverty among the nations's elderly, counted from 1965, peaked at 5.4 million, or 29.5% in 1966. It was 4.8 million, 24.6% in 1970, 3.3 million, 15.3% in 1975, 3.9 million, 15.7% in 1980, 3.5 million, 12.6% in 1985 and 3.6 million, 12.2% in 1990." (Census Bureau reported in *Aging News Alert*, 9/9/92)

Income of elderly:

Households (1992 data)

Mean: $24,849 (U.S. Census [income], 1993, p. 5)

Median: $17,160 (U.S. Census [income], 1993, p. 1)

Per household member: $14,053 (U.S. Census [income], 1993, p. 15)

$8,149 for unrelated individuals (U.S. Congress, 1990, p. 26)

"The median income of the 20.9 million householders 65 and over in 1991 was $16,975, versus $16,855 in 1990...." (Census Bureau reported in *Aging News Alert*, 9/9/92) Increased to $17,160 in 1992. (U.S. Census [income], 1993, p.1)

Compare the elderly's poverty level (1994 data)

Couples: $9,840 (DHHS as cited in *Older Americans Report (OAR)*, 2/18/94, p. 57)

Individuals: $7,360 (DHHS as cited in *OAR*, 2/18/94, p. 57)

Median net worth (1991 data)

$88,192 (U.S. Census [assets], 1994, p. xi)

Excluding home equity: $26,442 (U.S. Census [assets], 1994, p. xi)

Home equity: $61,750 (U.S. Census [assets], 1994, p. xi)

70.0% of net worth of median elderly household is in the home (U.S. Census [assets], 1994, p. xi)

Home equity

Total home equity of the 65+ age group: over $1.5 trillion

15,734,000 elderly home owners (77.3% of all elderly households)

Of these, 12,969,000 are owned free and clear (82.5%)

Median home value: $70,418. Mean: $95,175.

American Housing Survey for the United States in 1991, Bureau of the Census, provided by Bruce Jacobs on 2/7/94, 1991 data)

"Boomers will inherit some $10.4 trillion from 1990 to 2040--for a mean inheritance of some $90,000, according to Robert B. Avery and Michael S. Rendall, professors of consumer economics and housing at Cornell University." (*Business Week*, 9/12/94, p. 64)

"Federal spending on the elderly accounted for 28.2 percent of total Federal expenditures in 1990, up from about 16 percent in 1965 and 23.4 percent in 1980. By 1995, these outlays are projected to constitute about one-third of total Federal spending. Benefits for the aged, as a share of gross domestic product (GDP), are projected to reach 7.6 percent of GDP by 1995, almost 2 3/4 times the 1965 level." (1993 Green Book, p. 1563)

"At the turn of the century, life expectancy was 47.3 years. By 1991, life expectancy (provisional estimate) had increased to 75.7 years...28.4 [extra] years of life gained over the century."
J.F. Van Nostrand, S.E. Furner, and R. Suzman, editors, *Health Data on Older Americans: United States, 1992*, National Center for Health Statistics, Vital Health Stat 3(27), 1993, p. 1.

As of 1985: 78 years for women, 72 for men.

United States Congress, Senate Special Committee on Aging, *Aging America: Trends and Projections*, February 1990 Edition, Serial No. 101-J, U.S. Government Printing Office, Washington, D.C., 1990, p. 14.

Health and Long-Term Care Statistics

"For every 1,000 nursing home residents, 674 [67.4 percent] had at least one cognitive disability."

J.F. Van Nostrand, S.E. Furner, and R. Suzman, editors, *Health Data on Older Americans: United States, 1992*, National Center for Health Statistics, Vital Health Stat 3(27), 1993, p. 4.

"Persons age 65 to 74 have a 1 in 25 chance of having [Alzheimer's disease]; for those 85 and older, this likelihood rises to a staggering nearly 1 in 2 chance. This 85-plus age group is the most rapidly growing sector of the American population, portending a dramatic increase in the overall number of AD cases in the coming century."

National Institutes of Health, National Institute on Aging, "Progress Report on Alzheimer's Disease, 1992," NIH Publication No. 92-3409, Washington, D.C., 1992, p.1.

"Elderly Americans are spending more than twice as much on health care, even after accounting for inflation, as they were before the government established Medicare, according to a new report [by FUSA]...from $1,589 in 1961 to $3,305 in 1991...out-of-pocket health expenses currently consume an average of 17.1% of an elderly family's after-tax income, compared with 10.6% in 1961." (WSJ, 2/26/92, p. B-3)

"The prevalence of disability rises steeply with advancing age. Only about 14 percent of people aged 65-74 were disabled in 1985, but that proportion rises to 58 percent for people aged 85 and over."

Alice M. Rivlin and Joshua M. Wiener, *Caring for the Disabled Elderly: Who Will Pay?*, The Brookings Institution, Washington, D.C., 1988, p. 5.

"...75% of LTC is given by family members, and...one-half of the patients so helped are bedbound or incontinent or both."

William E. Oriol, *The Complex Cube of Long-Term Care*, American Health Planning Association, Washington, D.C., 1985, p.210.

Cost-Effectiveness of Home and Community-Based Services

"An increasingly large number of studies, including the results of a national channeling demonstration program, have shown that noninstitutional services typically do not substitute for nursing home care, but, rather, represent additional services most often to new populations."

John F. Holahan and Joel W. Cohen, *Medicaid: The Trade-off Between Cost Containment and Access to Care*, The Urban Institute Press, Washington, D.C., 1986, p. 106.

"Expanded home care generally raises, rather than lowers, expenditures because large increases in such care more than offset small decreases in nursing home care."

Joshua M. Wiener and Raymond J. Hanley, "Long-Term Care Financing: Problems and Progress," *Annual Review of Public Health*, Vol. 12, 1991, p. 71.

"Evaluations of community care programs...tend to show not only that expansion of community care has little effect on nursing home use, but that it raises, rather than lowers, total expenditures."

Alice M. Rivlin and Joshua M. Wiener, *Caring for the Disabled Elderly: Who Will Pay*, The Brookings Institution, Washington, D.C., 1988, p. 190.

"Expanding home care services raises total long-term care costs because most home care is provided to people who would not otherwise enter nursing homes."

Alice M. Rivlin and Joshua M. Wiener, *Caring for the Disabled Elderly: Who Will Pay*, The Brookings Institution, Washington, D.C., 1988, p. 166.

"Although community-based LTC programs proved beneficial to both clients and informal caregivers in the LTC demonstrations, they did not prove budget neutral or cost effective."

Kenneth G. Manton, "The Dynamics of Population Aging: Demography and Policy Analysis," *The Milbank Quarterly*, Vol. 69, No. 2, 1991, p. 322.

"Informal care costs are almost three times the cost of formal care for persons with Alzheimer's disease in the community. Although these costs represent an imputed value rather than a dollar expenditure, if unpaid caregivers were not available, caregiving services would probably be purchased from paid providers, or else demented persons now cared for in the community would be placed in institutions. The changing nature of family composition and the increasing labor-force participa-tion of women will result in fewer available caregivers for elderly persons in the future. Therefore, more of these imputed costs may become actual expenditures."

Dorothy P. Rice, et al., "The Economic Burden of Alzheimer's Disease Care," *Health Affairs*, Vol. 12, No. 2, Summer 1993, pps. 172-3.

"HCFA now assumes that all those receiving home and community-based care otherwise would use nursing homes...HHS funded research and demonstration projects do not support this assumption. Many people who have participated in community care demonstration projects would not have entered a nursing home had the community-based care been unavailable."

General Accounting Office, *Medicaid: Determining the Cost-Effectiveness of Home and Community-Based Services*, April 1987, p. 3)

Letter to Ann Landers

"**From Long Island:** When my mother was 60 years old, (and in excellent health), she made me promise, with my hand on the family Bible, that I would never put her in a home. Now she is 83, bedridden and incontinent. Her mind is gone, and she screams constantly. I kept my word, but it cost me my marriage. Please tell your readers that they should never make this mistake. It has ruined my life. (*Seattle Post-Intelligencer*, 4/9/90)

Long-Term Care Risk and Financing

"The number of nursing homes remained virtually unchanged at 15,362 in 1992, with 1,665,319 licensed beds, up 2.4%...Average occupancy dropped to 94.5% of all licensed beds in 1992 from 94.8% in 1991....The ratio of nursing home beds to the U.S. population over age 65 rose slightly to 53.3 beds per 1,000 seniors in 1992, compared with 52.6 in 1991.

Marion Merrell Dow Inc., *Marion Merrell Dow Long Term Care Digest 1992*, Kansas City, Missouri, 1992, p. 4.

"Nine out of ten married children with four parents turning 65 can expect to have at least one parent use a nursing home."

Christopher Murtaugh, Peter Kemper and Brenda C. Spillman, "The Risk of Nursing Home Use in Later Life," *Medical Care*, Vol. 28, No. 10, October 1990, p. 960.

"For persons who turned 65 in 1990, we project that 43 percent will enter a nursing home at some time before they die. Of those who enter nursing homes, 55 percent will have total lifetime use of at least one year, and 21 percent will have total lifetime use of five years or more."

Peter Kemper and Christopher M. Murtaugh, "Lifetime Use of Nursing Home Care," *New England Journal of Medicine*, Vol. 324, No. 9, February 28, 1991, p.595.

"We project that almost one third of all persons who reached 65 years of age in 1990 will spend at least three months in a nursing home during their lifetimes; 24 percent, at least a year; and 9 percent, at least five years."

Peter Kemper and Christopher M. Murtaugh, "Lifetime Use of Nursing Home Care," *New England Journal of Medicine*, Vol. 324, No. 9, February 28, 1991, p.597.

By age group:

65-74: 2% in nursing homes (Census Bureau, 1990 data, as reported in OAR, 6/25//93)

75-84: 6% (Census Bureau, 1990 data, as reported in OAR, 6/25//93)

85-89: 19% (Census Bureau, 1990 data, as reported in OAR, 6/25//93)

90-94: 33% (Census Bureau, 1990 data, as reported in OAR, 6/25//93)

95+: 47% (Census Bureau, 1990 data, as reported in OAR, 6/25//93)

"In 1985...most nursing home residents were characterized by long stays in the facility; 64 percent had been in the facility 1 year or more and 18 percent had been in the facility 5 years or more...."

Esther Hing, "Nursing Home Utilization by Current Residents: United States, 1985," *Vital and Health Statistics*, Series 13: Data from the National Health Survey, No. 102, DHHS Publication No. (PHS) 89-1763, National Center for Health Statistics, Hyattsville, Maryland, October 1989, p. 5.

"For every person in a nursing home, there are two people outside with an equal level of disability."

Department of Health and Human Services, *Report of the Task Force on Long-Term Health Care Policies*, U. S. Government Printing Office, Washington, D.C., September 21, 1987, p. 59.

SSA Actuary says "induced demand could increase nursing home use 50 percent."

Department of Health and Human Services, *Report of the Task Force on Long-Term Health Care Policies*, U. S. Government Printing Office, Washington, D.C., September 21, 1987, p. 60.

"A dramatic change occurs in the category of people with out-of-pocket expenses over $2,000 a year; nursing home costs are responsible for over 80 percent of these costs, and hospital care for only 10 percent."

Thomas Rice and Jon Gabel, "Protecting the Elderly Against High Health Care Costs," *Health Affairs*, Vol. 5, No. 4, Winter 1986, p. 17.

"...a public opinion survey conducted in 1993 for the Employee Benefit Research Institute by the Gallup Organization found that 45 percent of respondents believe that Medicare pays for long term care." (*Provider*, 1/94, p. 23)

Home Equity Conversion

"The number of private sector reverse mortgages made in the U.S. between 1981 and the end of 1992 is estimated to reach 12,000--most of them made in this decade, the National Center for Home Equity Conversion said. The median income reported by reverse mortgage borrowers is $8,000--less than half the median household income for all elderly homeowners. On the other hand, the median value of a reverse mortgage borrower's home ($102,500) is more than 50 percent greater than the median home value for all elderly homeowners. (*OAR*, 7/24/92, p. 298)

"Government-backed 'reverse' mortgages are now available in 47 states, and homeowners 62 and over can get more money from the equity in their homes in more states due to lower interest rates and a growing federal insurance program....'The loan is fully insured by the federal government, and no repayment is required until she dies, sells her home or permanently moves...'." (NCHEC cited in *Aging News Alert*, 1/12/94.)

"Currently there are about five workers for every individual aged 65 and over; by the year 2020, there will be just over three workers for each elderly person."

Alan M. Garber, "Cost-Containment and Financing the Long-Term Care of the Elderly," *Journal of the American Geriatrics Society*, Vol. 36, No. 4, April 1988, p. 356.

Medicaid Background

"Originally intended to provide medical services to low-income women and children, Medicaid has evolved over time into the largest third-party financer of long-term care in the United States."

Health Care Financing Administration, Office of the Actuary, Division of National Cost Estimates, "National Health Expenditures, 1986-2000," *Health Care Financing Review*, Vol. 8, No. 4, Summer 1987, p 13.

"Although more than two-thirds of Medicaid recipients in fiscal year 1990 qualified because they were members of an AFDC family, they consumed only one-fourth of program benefits. Conversely, the aged, blind and disabled, who represent less than one-third of Medicaid recipients, consumed nearly three-fourths of Medicaid benefits."

Katherine R. Levit, et al., "National Health Expenditures, 1990," *Health Care Financing Review*, Vol. 13, No.1, Fall 1991, p. 36.

"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.

"Medicaid coverage for poor Americans seeking health care resembles the last lifeboat for passengers on the Titanic: it is not nearly large enough to accommodate even half of those in need."

Gordon Bonnyman, "Deciding Who Swims with the Sharks: Boren Amendment Litigation," *Clearinghouse Review*, Vol. 26, No.3, July 1992, p. 302.

"The medical 'safety net' that the giant Medicaid program provides to the nation's poor is full of holes, a study commission 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)

"The evolution of Medicaid, especially in the past five years, has made the program so complex that it is incomprehensible to recipients and providers and unmanageable for governors and states." (National Governors' Association, quoted in *NYT*, 8/4/92)

"Thus, in 30 states, all elderly who meet the resources test and who cannot afford to pay nursing home charges out of current monthly income are eligible for medicaid and, in the other states, all but relatively higher income elderly are eligible."

Edward Neuschler, *Medicaid Eligibility for the Elderly in Need of Long-Term Care*," National Governors' Association Center for Policy Research, Washington, D.C., September 1987, p. 20.

How the Middle Class Elderly End Up on Welfare

Key Points

- American seniors often lack the financial ability to pay for long-term care.
- After catastrophic illness strikes, welfare is usually the only way to save their estates.
- Adult children of the elderly can shelter their parent's assets to qualify them for Medicaid.

Medicaid is a means-tested public assistance program, i.e., welfare. How do people who possess significant income and assets qualify? We can explain this phenomenon best with a hypothetical, but stereotypical, example.

John and Mary Smith were born in 1900 when life expectancy was 46 years for men and 48 years for women. They married in 1920, began payments on a home, and started a family. Theirs was the American dream--happiness and prosperity--until the early 1980s. At age 80, with an actuarial life expectancy of 8 years remaining, John was stricken by Alzheimer's Disease. After a gradual onset, he began to require almost full-time care. Even with daily help from a home health aide and the children, in their late 50s themselves, the responsibility finally overwhelmed Mary. By 1985, the family concluded that nursing home institutionalization could no longer be postponed.

Robert, the couple's 58-year old son, did some research. He located several excellent long-term care facilities, but was alarmed to learn that they charge from $25,000 to $50,000 per year. His dad could easily live several more years. With his mom getting frailer every day, their combined care costs could consume the family's entire net worth (a $200,000 home owned free and clear and $175,000 in certificates of deposit) very rapidly. Even their monthly income of $2,500--John's Social Security and retirement pension plus the interest on their joint savings--would not go far. "But wait a minute," Bob thought, "the folks have had Medicare for 20 years. It does not cover everything, but surely it will ease the burden."

When Bob visited the local Social Security office, however, he learned that Medicare does not cover custodial long-term care. He checked his parents' Medicare supplemental insurance policies and found that they were no help either. Furthermore, the couple had not purchased a special long-term care insurance policy which would have covered custodial nursing home care.

As he began really to worry, Bob got some advice from a friend who had been through the same wringer. "Talk to the people at the Department of Public Assistance about Medicaid," she said. "It has its shortcomings, but Medicaid can be a big help." Somewhat abashed, Bob arranged an appointment with a Medicaid eligibility worker. He learned that his dad could have no more than $2,000 in assets and $446 per month of income and still qualify for Medicaid. Although the family home would be exempt, John's share of the couple's savings would make him ineligible indefinitely. "Spend down to the income and asset limits," said the eligibility worker, "and then come back to fill out an application."

At this point, Bob started to despair. Then he read an article in a national news weekly about legal planning for disability. He took the article's advice and called the local free legal services office. They referred him to a private attorney who specializes in "elder law." This attorney advised him that his father's excess income would present no problem. Up to $1,816.50 per month could be applied to his mother's needs. The rest would go toward the cost of his dad's care under "medically needy" income spenddown rules. As for the assets, up to $72,660 could be deducted as Mary's share. The remaining $100+ thousand would be disqualifying resources, but they could be handled in several ways. For instance, John and Mary might decide to remodel their home or invest in other exempt assets. More exotic options such as trusts, legal transfers, life estates, relocation, or even divorce could be explored if necessary. In any case, Medicaid nursing home eligibility would be no problem and attorney's fees would be less than $2,000.

Before Bob left, the attorney gave him two more pieces of advice which he immediately acted upon. First, his dad should enter the nursing home of choice as a private-pay patient for several months before converting to Medicaid. He might have trouble getting in as a public assistance recipient. Second, John and Mary's home, exempt now because of Mary's residence, could become nonexempt if Mary died or needed institutionalization herself. The state might also recover the home's value from John or Mary's estate. Bob's dad should transfer his equity to his mom and then have her hold the property in joint tenancy with the family. That puts the home out of the state's reach for estate recoveries. "Heck of a way to run a railroad," Bob thought. "Had we known, we could have transferred all the assets when dad first got sick and avoided these complications. Better yet, we could have helped the folks buy long-term care insurance to protect against the risk. All I know for sure--it's a damn good thing dad's too sick to understand that he's spending the rest of his life on welfare."

(A similar article by the same writer was published in Stephen A. Moses, *Medicaid Estate Recoveries*, Office of Inspector General, Department of Health and Human Services, OAI-09-86-00078, June 1988.)

"[In] a recent working paper from the National Bureau of Economic Research...[e]conomists David Cutler of Harvard and Louise Sheiner of the Joint Committee on Taxation note that public subsidies for long-term care tend to reduce assistance from relatives and other private sources. 'As the ease of acquiring Medicaid increases or Medicaid payments become more generous,' they write, 'fewer elderly receive substantial day-to-day help from their children....' Taking into account financial, demographic, and health information, they compare admissions in states with relatively generous Medicaid policies to admissions in states with lower subsidies and stricter standards. They find that looser rules and lower

co-payments lead to greater use of nursing homes among people who may not need them. 'Estimates suggest that all of the elderly admitted to nursing homes when policies change formerly lived with their children or with others,' Cutler and Sheiner write. 'The view that the marginal nursing home admission is an elderly person living alone and without other means of support does not appear true in our data." (*Reason*, 2/94, p. 12)

"'It's incumbent on us to realize that the states can't continue to pay for Medicaid, which is a complicated, second-class health-care system for less than half of the poor people in the country,' said Representative Henry A. Waxman, a California Democrat who is chairman of the House Subcommittee on Health and the Environment and the author of a number of Medicaid mandates." (*New York Times*, 3/24/92, p. A10.)

"Medicaid spending increased 13 percent in 1989; 19 percent in 1990, and 27 percent in 1991...Spending is projected to increase by 30 percent in 1992. At this rate, total federal and state Medicaid spending will exceed $140 billion and overtake spending by Medicare in the next year...."

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

"Medicaid increased to 17 percent of state spending in fiscal 1992 from 10 percent in fiscal 1987....These shifts confirm the Governors' concerns that the rising cost of health care is reducing the share of state spending going to education and other long-term investments....By fiscal 1995, Medicaid is expected to account for 25 percent of total state spending." (NGA *Governors' Bulletin*, 4/26/93, p. 2)

"And by some dire predictions, Medicaid alone could consume a third of state spending by the year 2000....For the first time, state financing for Medicaid exceeded spending for state colleges and universities in [fiscal year 1992]." (*NYT*, 7/27/93, p. A6)

"There is obviously enormous fiscal pressure on the Medicaid program already and it is just going to get worse....We don't have the resources either at the state level or the federal level to fund the Medicaid program through the '90s given the way it is now configured....I don't know when its going to fall apart. It'll be state by state. It is not going to happen tomorrow. But, it doesn't work." (Andy Schneider, Counsel to Waxman's House Health Sub-Committee speaking at JCLA Conference, D.C., 10/91)

"In the long run, restrictive Medicaid payment policies will limit the supply of beds below needed levels. Without adequate Medicaid payment levels, the supply of nursing home beds will grow sufficiently to meet only the demand from private patients. Because the Medicaid programs currently are the only

major third-party payers of nursing home care, and unless new financing options are created, the long-term care services available to many elderly Americans will be severely restricted in the future."

Robert J. Buchanan, R. Peter Madel, and Dan Persons, "Medicaid Payment Policies for Nursing Home Care: A National Survey," *Health Care Financing Review*, Vol. 13, No. 1, Fall 1991, p. 55.

Entitlement Program Problems

"A bipartisan group warned yesterday that entitlement benefits such as Social Security, Medicare, Medicaid and civil-service pensions are growing so fast that they will consume nearly all federal tax revenues by 2012, leaving the government with no money for anything else." (Bipartisan Commission on Entitlement and Tax Reform [Senator Bob Kerrey and Senator John Danforth, Co-Chairmen] in *Seattle Times*, 8/9/94, front page)

"Social Security officials warned yesterday that the trust funds for old age and disability benefits will go broke sooner than they predicted only last year...Although bankruptcy is 35 years away, the date has moved closer year by year. The 2029 'insolvency' date predicted yesterday was the largest single-year change since a financial crisis in 1983 forced a six-month delay in cost-of-living increases for beneficiaries..." (Spencer Rich, *Washington Post*, 4/12/94)

"Have Americans wised up to Social Security? Buried in a release from the respected Employee Benefits Research Institute recently was this stunner: 54% of those polled for EBRI by Gallup believe Social Security should be made voluntary. 'It is significant there were not major differences by age with regard to this question,' said EBRI President Dallas Salisbury. Of lower income respondents, who suffer hardest from the SS payroll tax, 52% of those sampled said they didn't expect to get anything back when they retired. Some 65% now realized that their taxes are being used to pay current retirees and aren't put into an actual trust fund." (*WSJ* [editorial], 4/4/94, p. A-12)

"If Congress takes no action, the Clinton Administration said today, the Medicare trust fund that pays hospital bills for the elderly will run out of money in seven years and a separate trust fund that pays benefits to disabled workers will be exhausted next year...Looking to the future, the report added, 'the Medicare program is not sustainable in its present form'...
the hospital-insurance fund 'is projected to become exhausted even before the major demographic shift begins to occur'...The reports, widely regarded as authoritative, were prepared by Government actuaries...In a statement attached to the report, the chief actuary of the Medicare program, Roland E. King, expressed some concern about the trustee's estimates of growth in workers' earnings. He suggested that the estimates might be too optimistic." (Robert Pear, *NYT*, 4/12/94)

"Medicaid and Medicare are often cited for their administrative costs of 5% and 2%, respectively. In comparison, private insurance reports an industry cost average of between 12% and 20%...[but] in an 'apples-to-apples' comparison, government spends more than half again as much (66% more) to provide a dollar of Medicare and Medicaid benefits as private insurance spends to provide a dollar of health insurance benefits...Central to this study is the recognition that there are more costs in running the Medicare and Medicaid programs than just paying benefits. For example, the legislative and executive branches devote time and resources to the management and direction of these programs...The judicial branch expends resources resolving the legal questions surrounding Medicare and Medicaid...[T]he costs of programs and activities benefiting Medicare and Medicaid exist in a number of other federal budget categories including Education and Training, Labor and The National Institutes of Health...Beyond Medicare and Medicaid program and activity costs, government operates at a deficit and issues debt to fund operations. Paying interest on that debt represents an enormous cost to government."

Mark Litow, *Rhetoric vs. Reality: Comparing Public and Private Health Care Administrative Costs*, The Council for Affordable Health Insurance, Alexandria, Virginia, March 1994, pps. 2-3.

Elder Law Issues

"Generally, the elder law practice centers on estate planning, planning for Medicaid eligibility, nursing home placement and patient rights, planning for possible incompetency, health care decisionmaking and right-to-die issues, pension rights, and employment discrimination."

Lawrence A. Frolik and Alison P. Barnes, "An Aging Population: A Challenge to the Law," *The Hastings Law Journal*, Vol. 42, No. 3, March 1991, p. 716.

"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)

"Policymakers and researchers alike have focussed substantial attention on the issue of asset transfer in the context of debates around long term care financing. A complete and accurate understanding of this dynamic is precluded by the nature of the data required to assess the frequency and magnitude of Medicaid-qualifying asset transfers. Many persons may be reluctant to discuss transfer of assets, because of fear of government action or concerns of social desirability...In an effort to begin to characterize persons likely to arrange for divestment or transfer of assets in planning to finance their long term care needs, respondents were asked directly, 'Were you able to give some of your assets or property to your children or relatives before you came here?' Rather surprisingly, 22% of the 286 individuals asked responded in the affirmative."

Terrie Wetle, et al., *The Transition from Community to Nursing Home: A Survey of Recently Admitted Nursing Home Residents*, Braceland Center for Mental Health and Aging, September 1993, reprinted by the Connecticut Partnership for Long-Term Care Research Institute, Hartford, Connecticut, p. 49.

"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, "Staying Ahead: Dealing with the Medicaid Shell Game," *San Francisco Chronicle*, December 19, 1988.

"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."

Kenneth M. Coughlin, "The Billing Practices of Elder Law Attorneys," *The ElderLaw Report*, Vol. 5, No. 5, December 1993, p. 2.

"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]."

Kenneth M. Coughlin, "The Billing Practices of Elder Law Attorneys," *The ElderLaw Report*, Vol. 5, No. 5, December 1993, p. 3.

"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; Purchase a long-term-care insurance policy."

Armond D. Budish, *Avoiding the Medicaid Trap: How to Beat the Catastrophic Costs of Nursing-Home Care*, Henry Holt, New York, 1989, p. 34.

Sample Medicaid eligibility plan by an elder law attorney reported by DHHS Inspector General:

I do everything from the beginning including all of the paperwork. For a fee of $950, I guarantee eligibility within 30 days. Income makes no difference. I

have never seen a case with too much income to qualify, because the couple's income is split in half to qualify. Washington is a spend down of income State. I change the ownership of all property including life insurance policies, car titles, mobile homes, residences and other real property, bank accounts, certificates of deposit, stocks, government or private bonds, and anything else. Property transfers go from the ill to the well spouse. If the client is competent, I do a Power of Attorney to establish authority for the transfers; otherwise, I do a guardianship and we get the court to order the transfers. If a contract or deed of trust is involved, I do an assignment so that the income becomes separate to the well spouse. I help them buy burial plots and other exempt property. I search the Code of Federal Regulations for all possible "set-asides." I help the family obtain the necessary documentation, verifications, and signatures from banks, the Social Security Administration, other private and government pension plans, etc. I even go to the nursing home for the patient's signature if necessary. Finally, I fill out the Medicaid application and go to the eligibility interview with the family. I have been doing this for 2 and 1/2 years and it is 90 percent of my practice. I fell into it by accident taking referrals from the local legal services agency which does the same thing I do, but for free, under a Federal grant.

Stephen A. Moses, *Transfer of Assets in the Medicaid Program: A Case Study in Washington State*, Office of Inspector General, Office of Analysis and Inspections,, OAI-09-88-01340, San Francisco, California, May 1989, p. 7.

"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."

Gordon Bonnyman, "Guiding the Elderly Through Medicaid's Serbonian Bog: Don't Just Do Something--Sit There!," *Tennessee Bar Journal*, November/December 1990, p. 18.

"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."

Amy Budish and Armond D. Budish, *Golden Opportunities: Hundreds of Money-Making, Money-Saving Gems for Anyone over Fifty*, Henry Holt and Company, New York, 1992, p. xiii.

"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)

Lawrence A. Frolik and Alison P. Barnes, "An Aging Population: A Challenge to the Law," *The Hastings Law Journal*, Vol. 42, No. 3, March 1991, p. 715.

"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."

John J. Regan, "Financial Planning for Health Care in Older Age: Implications for the Delivery of Health Services," *Law, Medicine and Health Care*, Vol. 18, No. 3, Fall 1990, pps. 275-6.

"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."

John J. Regan, *Tax, Estate & Financial Planning for the Elderly*, Matthew Bender, New York, 1991, 1993 update, p. 2-44.

"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...."

Ruth R. Longenecker, "Planning for Medicaid Eligibility," Tax *Management Estates, Gifts, and Trusts Journal*, Vol. 15, No. 4, July 12, 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."

Michael Gilfix, "Elders and Nursing Home Expenses: Preserving Client Assets," *Trial*, Vol. 29, No. 6, June 1993, p. 38.

"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."

Michael Gilfix, "Elder Law in the 90s: No Shortage of Issues," *Trusts & Estates*, Vol. 129, No. 4, April 1990, p. 45.

"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."

Michael Gilfix and Mark Woolpert, "Medi-Cal Asset Preservation and Your Clients or Estate Planning is Not Enough!: A California Elder Law Institute Continuing Legal Education Seminar," Gilfix Management Group, Palo Alto, California, 1990, p. 65.

"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 A. Mitchell, "Medicaid Planning for the Elderly: Using Supplemental Discretionary Trusts to Pay the Costs of Long-Term Care," *Washburn Law Journal*, Vol. 31, No. 1, Fall 1991, p. 94.

"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."

Armond D. Budish, *Avoiding the Medicaid Trap: How to Beat the Catastrophic Costs of Nursing-Home Care*, Henry Holt, New York, 1989, p. 38.

"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."

James D. Palmer, Jr., "Estate Planning for Public Welfare Recipients," *Probate and Property*, Vol. 2, No. 2, March/April 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."

Jonathan M. Forster, "Favorable Investment Vehicles for Public Benefits Planning (Part 1: Resource Planning and the Annuity," *Elder Law Advisory*, No. 7, October 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."

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

"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))."

Rebecca L. Shandrick, "The Family Business: An Exempt Resource for Medicaid Eligibility," *The ElderLaw Report*, Vol. 4, No. 3, October 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."

Bryan M. Dench, "Medicaid Planning with Retained Life Interests," *The ElderLaw Report*, Vol. 4, No. 6, January 1993, pps. 1-3.

"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."

James H. Young, "Medicaid Eligibility," *Maine Bar Journal*, Vol. 5, No. 4, July 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."

Ira S. Schneider and Ezra Huber, *Financial Planning for Long-Term Care*, Human Sciences Press, Inc., New York, 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."

Michael Gilfix and Mark Woolpert, "Medi-Cal Asset Preservation and Your Clients or Estate Planning is Not Enough!: A California Elder Law Institute Continuing Legal Education Seminar," Gilfix Management Group, Palo Alto, California, 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."

William G. Talis, "Medicaid as an Estate Planning Tool," *Massachusetts Law Review*, Spring 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."

Charles M. Delbaum, "Financial Planning for Nursing Home Care: Medicaid Eligibility Considerations," *Ohio State Bar Association Report*, Volume 57, Number 14, April 2, 1984, p. 373.

"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."

Peter J. Strauss, Robert Wolf, and Dana Shilling, *Aging and the Law*, Commerce Clearing House, Inc., Chicago, 1990, p. 16.

Medicaid Planning Quotes Since 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)

Baird Brown and Robert Fleming, "Planning Options that OBRA '93 Does Not Affect," *National Academy of Elder Law Attorneys 1993 Elder Law Institute Proceedings*, Section #12, NAELA, Tucson, 1993.

"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." (*Lawyers Weekly*, 9/27/93)

"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)

Baird Brown and Robert Fleming, "Planning Options that OBRA '93 Does Not Affect," *National Academy of Elder Law Attorneys 1993 Elder Law Institute Proceedings*, Section #12, NAELA, Tucson, 1993.

"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]

Baird Brown and Robert Fleming, "Planning Options that OBRA '93 Does Not Affect," *National Academy of Elder Law Attorneys 1993 Elder Law Institute Proceedings*, Section #12, NAELA, Tucson, 1993.

"**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)

"...the Medicaid planners have dug up some incredible new strategies to circumvent OBRA '93. These include charitable remainder trusts (previously used only for capital gains and estate tax avoidance by the very wealthy); 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." (Steve Moses, *LTCN&C*, 2/94)

"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)

"Medicaid is a middle-class entitlement, just like the deduction for mortgage interest and IRAs." (Mark Heffner, RI Coordinator of NAELA in *Providence, RI Journal*, 2/22/94)

Medicaid Planning Ethical Issues

"Simply put, the engine that drives the divestment of assets to qualify for Medicaid is the children. They feel entitled to an inheritance that, if denied, they regard as a breach of the social compact...."

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. 8.

"Great care should be taken by the practitioner to identify the client. The interests of elders and their children diverge radically. The children may only be interested in preserving their inheritance. The elders may be unaware that Michigan nursing homes practice discrimination in their admissions. Medicaid recipients, as the lowest paying residents, are the last to be admitted in almost all of the state's 450 homes. Serious ethical considerations must be weighed by the lawyer practicing in this area."

Hollis Turnham, "Medicaid Spousal Impoverishment: An Introduction," 69 *Michigan Bar Journal*, June 1990, p. 522.

"The elderly may often be victimized by those to whom they transfer resources. In many cases, the transferor of assets for less than fair market value is the victim rather than the perpetrator of fraud."

Michael Herron, "Medicaid Eligibility and Transfer of Assets: Randall v. Lukhard," *Detroit College of Law Review*, Vol. 1984, No. 4, Winter 1984, p. 1019.

"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."

Clifton B. Kruse, Jr., "Medicaid Planning Exposed to State Fraudulent Transfer Laws - The Responsive Rights of States as Creditors to Transfers Made by Public Benefit Recipients," paper presented at the Fifth Annual Symposium on Elder Law, Atlanta, Georgia, April 1993, p. CBK-47.

"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."

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

Frontline, *Who Pays for Mom and Dad?*, Program #917, originally broadcast on PBS on April 30, 1991, Boston, WGBH Transcripts.

"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)

"[HCFA Administrator] 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."

Mike Ebert, "Medicare Chief Takes Aim at Pockets of Middle Class," *Senior Spectrum*, 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)

"Healthcare advocates are especially irked by the transferring of assets by middle-and-upper-income elders to their children in order to achieve impoverishment on paper and thus qualify for Medicaid coverage to pay for nursing home care....To support asset shifting on the part of the comfortable is to demean not only the system but ourselves as well." (Paul A. Kerschner, Executive Director of the Gerontological Society of America, in *Aging Today*, July/August 1992, p. 3)

"Medicaid cannot afford to act as inheritance insurance for heirs, and a private LTC insurance market cannot fully develop if Medicaid plays this role."

Mark R. Meiners, , "Reforming Long-Term Care Financing through Insurance," *Health Care Financing Review: 1988 Annual Supplement on Post-Acute and Long-Term Care*, Health Care Financing Administration, Baltimore, Maryland, December, 1988, p. 111.

"Increasingly, transfer of assets is becoming the issue which has changed the moral tone of the long-term-care debate.... Seniors groups are losing the moral high ground." (Josh Wiener of the Brookings Institution quoted in *Modern Healthcare* cover story, April 20, 1992)

"Woe unto you also, you lawyers! for you lade men with burdens grievous to be borne and you

yourselves touch not the burdens with one of your fingers...Woe unto you, lawyers! for you have taken away the key of knowledge."

Luke 11:44, 52, King James Version as quoted in Michael Bagge, "The Eye of the Needle: Trust Planning, Medicaid and the Ersatz Poor," *New York State Bar Journal*, Vol. 40, No. 2, February 1992, p. 17.

APPENDIX C:

CITATIONS ON QUALITY, ACCESS AND REIMBURSEMENT OF NURSING HOMES UNDER MEDICAID

"Nursing homes whose patients are mostly private generally provide higher-quality care than facilities dependent on Medicaid patients."

Alice M. Rivlin and Joshua M. Wiener, *Caring for the Disabled Elderly: Who Will Pay?*, The Brookings Institution, Washington, D.C., 1988, p. 9.

"Although improvements to medicaid would make it a more humane program, relying exclusively on a welfare-based reform strategy has several disadvantages. First, because medicaid helps to fund care only for those people who have already depleted much of their income and assets, it cannot prevent the elderly from incurring catastrophic costs. Second, because many elderly cannot afford the costs of a nursing home stay, medicaid has become a welfare program on which the majority, rather than the minority, rely. Third, some stigma may attach to receipt of medicaid long-term care, as it does to the receipt of benefits under other welfare programs. Fourth, public support for means-tested programs is usually no more than lukewarm. **Fifth, partly because of the political unpopularity of welfare programs, politicians are always trying to hold down the costs of medicaid to the taxpayer. This in turn perpetuates a two-class system of long-term care, with medicaid recipients having inferior access to care of highly variable quality. Finally, because benefits are available only to the impoverished, a perverse incentive exists to hide or dispose of wealth in order to qualify** [emphasis added]."

Joshua M. Wiener, Laurel Hixon Illston, and Raymond J. Hanley, *Sharing the Burden: Strategies for Public and Private Long-Term Care Insurance*, The Brookings Institution, Washington, D.C., 1994.

"...there is a perception that Medicaid patients receive inferior quality care when compared to private paying patients."

Department of Health and Human Services, *Report of the Task Force on Long-Term Health Care Policies*, U. S. Government Printing Office, Washington, D.C., September 21, 1987, p. 25.

"One reason for poor quality is inadequate and poorly targeted reimbursements by Medicaid/Medicare, which forces some nursing home operators to 'cut corners' on care."

United States Congress, Senate Special Committee on Aging, *Nursing Home Care: The Unfinished Agenda*, Serial No. 99-J, U.S. Government Printing Office, Washington, D.C., 1986, p. vi.

"Facilities can attract as many Medicaid patients as needed without addressing quality, because Medicaid patients are most concerned with simply finding a bed. Accordingly, higher-quality homes attract private pay patients, and these facilities act on their preferences for such patients by admitting them first and filling the few remaining beds with Medicaid patients."

Mark A. Davis, "On Nursing Home Quality: A Review and Analysis," *Medical Care Review*, Vol. 48, No. 2, Summer 1991, p. 149.

"About 88% of U.S. nursing homes certified for Medicare and Medicaid are 'drastically short' of nurse aides and licensed nurses, according to a study...by the National Committee to Preserve Social Security and Medicare. Estimates of how much it could cost to correct the problem vary between $200 million and $2.6 billion...."

Older Americans Report, September 21, 1990, p. 366.

"Many doctors are caring for very few nursing home residents while a few doctors may be caring for too many patients. In addition, half the Medicaid recipients residing in Missouri's nursing homes in 1988 were attended by physicians without board certification, and almost one-third were attended by physicians who may be retiring between 2000 and 2010."

Larry W. Lawhorne, et al., "Who Cares for Missouri's Medicaid Nursing Home Residents? Characteristics of Attending Physicians," *Journal of the American Geriatrics Society*, Vol. 41, No. 4, April 1993, p. 454.

"States' efforts to limit the number of beds to control Medicaid costs provide a protective environment for most nursing homes. Operators can have little or no fear that their occupancy will fall or that a new home will try to enter their market even if the quality of care provided is somewhat deficient."

William J. Scanlon, "A Perspective on Long-Term Care for the Elderly," *Health Care Financing Review: 1988 Annual Supplement on Post-Acute and Long-Term Care*, Health Care Financing Administration, Baltimore, Maryland, December, 1988, p. 12.

"One way to interpret the current market outcomes in the nursing home sector is to say that, despite protest to the contrary, state Medicaid programs are acting effectively to buy the services they wish to purchase for Medicaid patients--a limited amount of relatively low-cost care of uncertain quality."

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

"...the quality problems that nursing homes have traditionally exhibited are linked to the absence of a need to compete for patients, created by the bed shortage conditions that continue to characterize a large portion of nursing home care markets in the United States."

John A. Nyman, "Excess Demand, Consumer Rationality, and the Quality of Care in Regulated Nursing Homes," *Health Services Research*, Vol. 24, No. 1, April 1989, p. 105.

"Because Medicaid pays nursing homes less than the cost 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.

"The findings in this paper lend empirical support to the hypothesis that nursing homes preferentially admit non-Medicaid patients, leading to barriers to care among certain subgroups of the Medicaid population."

Susan L. Ettner, "Do Elderly Medicaid Patients Experience Reduced Access to Nursing Home Care," *Journal of Health Economics*, Vol. 12, 1993, p. 278.

"Facilities frequently give preference to private paying residents and engage in a variety of practices to reduce the number of Medicaid residents served...."

Robert N. Brown, with Legal Counsel for the Elderly, *The Rights of Older Persons*, American Civil Liberties Union, Southern Illinois University Press, Carbondale and Edwardsville, Illinois, second edition, 1989, p. 291.

"...those most likely to have to wait for nursing home placement are those...financed by Medicaid."

General Accounting Office, "Long-Term Care for the Elderly: Issues of Need, Access and Cost," GAO/HRD-89-4, November 1988, p. 22.

"Medicaid recipients have more problems getting into nursing homes than higher paying private payers....An ample bed supply may go unfilled if Medicaid payment rates are too low to make it profitable to admit most Medicaid recipients."

General Accounting Office, "Nursing Homes: Admission Problems for Medicaid Recipients and Attempts to Solve Them," GAO/HRD-90-135, September 1990, pps. 2, 15.

"Medicaid facilities usually have waiting lists; facilities limited to private-pay patients usually have beds available at all times."

Peter J. Strauss, Robert Wolf, and Dana Shilling, *Aging and the Law*, Commerce Clearing House, Inc., Chicago, 1990, p. 485.

"Because private patients are preferred, these patients are admitted first, with the remaining beds allocated to Medicaid patients. Restraints on growth in beds therefore will sharply limit access for Medicaid recipients."

John F. Holahan and Joel W. Cohen, *Medicaid: The Trade-off Between Cost Containment and Access to Care*, The Urban Institute Press, Washington, D.C., 1986, p. 83.

"...there is a shortage of beds in many nursing home care markets and, under such circumstances, only private patients will have a free choice among nursing homes....Thus, if beds are occupied in the more desirable homes, Medicaid patients could be forced to choose a home that they would not otherwise have chosen. Private patients, since homes are competing for their business, will tend to have an unconstrained choice among homes."

John A. Nyman, "The Private Demand for Nursing Home Care," *Journal of Health Economics*, Vol. 8, No. 2, June 1989, p. 210.

"Medicaid recipients are excluded entirely from nursing homes that choose not to be Medicaid certified."

David Landes, "What Legislators Need to Know About Long-Term Care Insurance," pamphlet of the National Conference of State Legislatures, May 1987, p. 5.

"Nursing home bed supply has been closely restricted, so patients in need of care, especially Medicaid patients, often feel compelled to accept the first bed that becomes available."

Christine E. Bishop, "Competition in the Market for Nursing Home Care," *Journal of Health Politics, Policy and Law*, Vol. 13, No. 2, Summer 1988, p. 346.

"Nationwide, the median wait for a nursing home bed is 60 days....The longest waits were reported at public nursing homes (240 days)....Some facilities with 100% occupancy had waiting lists of six months or more."

Eldercare Business, March 5, 1990.

"Private-pay patients can usually find a nursing home bed quickly. Waiting lists for Medicaid patients (especially heavy-care patients), can stretch for several months, even a year or more. The only opening for a Medicaid patient may be in a facility that is not convenient to visitors, or that does not provide quality care."

Dana Shilling, *Financial Planning for the Older Client*, National Underwriter, Cincinnati, Ohio, 1992, p. 73.

"Pushed to the breaking point by an escalating barrage of costly regulation and a faultering [sic] reimbursement system, more and more facilities are questioning whether Medicaid participation is worth the aggravation....When push comes to shove, nursing homes in many states may very well find themselves in a no-win situation by participating in Medicaid. This could lead to mass defections, according to a Health Care Financing Administration official....If a substantial number of Medicaid defections does materialize, it's bound to turn the long-term care system on its ear. Traditional access, quality of care and financing patterns would quickly fall to the wayside. The new order of the day could very well be a two-tiered long-term care system that blatantly segregates the haves and have nots, with far fewer facilities available to care for the have nots....[P]roviders of choice would draw the more lucrative admissions and referrals, leaving a smaller pool of Medicaid facilities with significantly more high cost, low margin residents. This could ultimately force Medicaid providers into an even deeper financial quandry [sic], leading to quality of care compromises and the disintegration of Medicaid's long-term care infrastructure."

Jim Bowe, "Power Outage: Medicaid Overload Forces Providers to Pull Out," *Contemporary Long-Term Care*, Vol. 15, No. 7, July 1992, pps. 31-32, 7.

"Many doctors are refusing to take patients on Medicaid... because it pays them much less than Medicare or private health insurers, a federal advisory commission said yesterday."

Seattle Post-Intelligencer, April 2, 1991, p. 1.

"More than a third of doctors surveyed by *Medical Economics* exclude Medicaid patients from their practice...Reasons given: 'Too much trouble for too little pay,' 'It doesn't cover my overhead,' 'Low pay for high risk,' and frustration 'dealing with bureaucrats'."

Medicine and Health, October 11, 1993, p.1.

"Dissatisfaction with the current medicaid program is high. Not only does the demeaning means test often imply hardship for patients and their spouses, but low reimbursement rates mean that nursing homes frequently resist taking medicaid patients or provide poor care."

Alice M. Rivlin and Joshua M. Wiener, *Caring for the Disabled Elderly: Who Will Pay?*, The Brookings Institution, Washington, D.C., 1988, p. 203.

"Medicaid also causes the private [nursing home] price to be higher than it would be in the absence of Medicaid demand and overall supply restrictions."

Christine E. Bishop, "Competition in the Market for Nursing Home Care," *Journal of Health Politics, Policy and Law*, Vol. 13, No. 2, Summer 1988, p. 350.

"The adoption of long-term care insurance would substantially decrease the price of formally provided long-term care to consumers."

John A. Nyman, "The Private Demand for Nursing Home Care," *Journal of Health Economics*, Vol. 8, No. 2, June 1989, p. 210.

"Nursing homes in the United States showed 'anemic' profit margins of only 1.15% for fiscal year 1989, according to the 1991 version of the *Guide to the Nursing Home Industry*."

Provider, October 1991, p. 12.

"[T]he median total profit margin for the nursing home industry was 2.52 percent in 1990, up from 1.96 percent in 1989."

The Guide to the Nursing Home Industry, 1992, p. 17.