The

LONG-TERM CARE FINANCING CRISIS:

Danger or Opportunity?

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A Case Study in Maryland

Presented to
Health Facilities Association of Maryland
September 15, 1995

by
LTC, Incorporated
"The Long-Term Care Specialists"

Stephen A. Moses, Director of Research
with the assistance of Kathryn J. Tjelle
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EXECUTIVE SUMMARY

The Chinese character for "crisis," which is replicated on the front cover of this report, is comprised of the characters for "danger" and "opportunity." This is a perfect symbol for the predicament Maryland finds itself in with respect to long-term care financing.

The long-term care financing crisis in Maryland has become so serious that everyone involved in public policy, Medicaid and the provider community feels a strong sense of hazard, jeopardy, and risk.

On the other hand, talk of major reform at the national level and a strong sense of impending urgency at home impart a new feeling of hope and enthusiasm. Things are going to change soon whether we like it or not. Anything is possible now!

This report searches for ways to minimize the danger and maximize the opportunity of long-term care financing reform in Maryland. It documents the current problems; posits a new way of analyzing the status quo; and proposes a completely different approach to long-term care financing.

In a nutshell, we found in this study that Maryland already has a publicly financed long-term care system that covers most of the state's citizens. Unfortunately, this system co-opts privately financed home and community-based services, discourages home equity conversion, impedes the marketing of private long-term care insurance, promotes Medicaid estate planning, traps middle-class seniors on welfare, overburdens nursing homes with underfinanced Medicaid recipients, and strains the state government's ability to finance medical care for the poor and other worthy programs such as education, corrections, and highways.

To remedy this situation, we recommend changing the incentives in public policy to encourage early planning for long-term care risk. If families know they will either pay now for long-term care (through insurance or direct service payments) or pay later (through liens and estate recoveries), they will be more likely to plan ahead and avoid dependency on public programs. This will help the public programs to fulfill their proper mission of helping those who cannot help themselves.

We estimate that full and aggressive implementation and enforcement of the program recommended in this report can (1) save the state of Maryland $80 to $100 million per year on

Medicaid nursing home expenditures; (2) encourage increased employment and tax revenues in the financial services (home equity conversion), long-term care insurance, nursing home, and home and community-based services industries; and (3) improve access to a full range of long-term care services for rich and poor Marylanders alike.

To achieve results of this magnitude, however, much more work must be done. Many more questions must be asked and answered. Many more people and interest groups must be introduced to these ideas. Now is the time to plow, plant and tend this new approach so Maryland can reap the harvest of a rational long-term care financing system next season.

FOREWORD

by

Adele Wilzack, R.N., M.S.
President of the Health Facilities Association of Maryland

As the President and the Congress continue to debate reductions and significant changes in the levels of federal assistance for the Medicare and Medicaid programs, the Health Facilities Association of Maryland (Association) has been examining options—in response to these possibilities—that have focused on the maintenance of quality for health care while preserving sound and fair reimbursement principles.

In the past six years, the long-term/post-acute care industry has absorbed 200 million dollars in budget cuts caused by Maryland's inability to fund the state's reimbursement methodology at required levels. Nursing facilities have struggled to operate under very difficult financial challenges and there has been a corrosive effect on the industry which needs to end.

Under a block grant proposal, Maryland would lose approximately 3 billion dollars over a seven year period. By the year 2002, Maryland may be losing as much as 800 million dollars in federal Medicaid funding per year based on estimates from the White House. In continuing this scenario, if nursing facility reimbursement were to be reduced on a pro-rata basis for the 800 million dollars of lost Medicaid funding in the year 2002, payment would have to be reduced by over 30 dollars per patient day - a reduction in rates of approximately 35 percent.

More reductions in provider reimbursement are neither a wise nor equitable solution—the scope of these federal actions require structural changes in the Medicaid program.

The Association contracted with Mr. Stephen A. Moses, Director of Research for LTC, Inc., a national expert on Medicaid reform, to work with our members and to produce a paper which will provide the state with a series of options for structural changes that could occur either under the current federal system or, should major changes be enacted, under a new system.

On behalf of our Association, I would like to thank the members of the executive and legislative branches of government, as well as representatives from several private entities, who met with Steve during the week of September 4, 1995.

Finally, our sincere appreciation to Steve for his expertise and willingness to engage in the challenge of maintaining a sound and viable long term/post acute care system in Maryland.

ACKNOWLEDGEMENTS AND DISCLOSURES

This project was funded under contract with the Health Facilities Association of Maryland. The Association assisted the project by facilitating access to private long-term care experts, interest groups, key state staff, public officials and documents. The Association also arranged conference space, photo-copy support, and local telephone service.

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 44 respondents and interviewees who provided the information on which this report is based, (2) to Joe Coble, Director of Legislative and Government Affairs of the Health Facilities Association of Maryland, for organizing, scheduling, and attending the interviews, and for contributing his tremendous energy, enthusiasm and knowledge about long-term care in Maryland, and to (3) Adele Wilzack, President and Roger Lipitz, Member, Board of Directors, of the Health Facilities Association of Maryland for supporting this work and assisting its successful completion.

INTRODUCTION

The purpose of this study is to provide information to officials of the State of Maryland and other organizations on the general topic of how the State can reduce its Medicaid expenditures significantly without additional cuts in provider reimbursement.

A principal objective of the study is to encourage officials of the State of Maryland to support a more comprehensive program of Medicaid expenditure reduction, resulting in the eventual implementation of initiatives to save 80 to 100 million dollars per year in Medicaid nursing home expenditures, while relieving pressure on reimbursement rates.

In pursuit of this purpose and objective, the contractor (LTC, Incorporated in the person of the company's Research Director, Stephen A. Moses) visited Maryland during the week of September 4, 1995 and conducted a series of interviews and discussions. Specifically, he met with long-term care policy makers and stakeholders including representatives of Medicaid, staff of the Governor of the State of Maryland, members and staff of the State Legislature, health care providers, and others. A complete list of respondents and interviewees for the project is provided at the back of this report.

Each group of respondents received a packet of background information on the project including a copy of the report on a similar, but much more detailed and lengthy, study conducted in Illinois. A brief presentation introduced all study participants to a new approach to analyzing the long-term care financing system. Finally, each interviewee was asked to respond to extensive questions in a prepared interview schedule.

The goal of this report is to analyze the long-term care financing crisis in Maryland and present a variety of measures to contain the state's Medicaid nursing home expenditures. The report identifies the chief problems with respect to costs and explains why they persist. It provides alternative solutions that can be utilized under the existing Medicaid structure or, alternatively, under a new regulatory environment incidental to anticipated federal changes, including block grants.

Given the severely limited scope of this project—one week of field work and one week to write the report—we probably raise more questions herein than we answer. Therefore, if additional work or research is needed to identify a problem or craft a solution, the report recommends how this might be done.

CONDITION CRITICAL

The long-term care financing system in Maryland is seriously ailing. The system relies heavily and increasingly on Medicaid-financed nursing home care. Since 1983, Medicaid census in Maryland nursing homes increased from 50 percent to 70 percent.[1] Private census dropped proportionately. Although Medicaid nursing home costs have skyrocketed, increasing from $256 million in fiscal year (FY) 1989 to $410 million in (FY) 1994,[2] provider reimbursement rates have not kept pace. Medicaid pays only approximately 78 percent of the private-pay rate and frequently less than the cost of providing the care.[3] Simultaneously, patient acuity of Medicaid residents has increased significantly. Thus, nursing homes in Maryland are serving more Medicaid patients; these patients are sicker than ever before; and the compensation for their care is declining in relative terms. Not surprisingly, evidence suggests that quality of care is suffering; profitability is down; and the industry is having trouble attracting the capital to sustain itself or grow.

The trials and tribulations of the nursing home industry and the Medicaid program do not exhaust Maryland's long-term care financing problems, however. The state has tried unsuccessfully to encourage utilization of the less expensive home and community-based long-term care services that seniors prefer. Efforts to promote home equity conversion, e.g. reverse annuity mortgages or sale/leasebacks, as a means to generate needed cash flow for seniors to pay for long-term care have fallen flat.

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[1] Health Facilities Association of Maryland, Reed Smith Shaw & McClay, Ernst & Young, *Preserving a Commitment to Caring: A White Paper Examining the Inadequacy of Medicaid Funding for Nursing facility Care in Maryland Discussing the Threats That it Poses to Residents and Facilities, and Proposing a Solution to the Problem*, Annapolis, Maryland, 1993, p. 2.

[2] Personal correspondence from Stephen Hiltner, Supervisor of Nursing Home Programs for the Medical Care Policy Administration of the Maryland Department of Health and Mental Hygiene, to Joe Coble and Steve Moses dated September 12, 1995.

[3] Health Facilities Association of Maryland, Reed Smith Shaw & McClay, Ernst & Young, *Preserving a Commitment to Caring: A White Paper Examining the Inadequacy of Medicaid Funding for Nursing facility Care in Maryland Discussing the Threats That it Poses to Residents and Facilities, and Proposing a Solution to the Problem*, Annapolis, Maryland, 1993, pps. 18, 23-28.

Although nursing home care consumes 80 percent of all senior health care costs in excess of $2,000 per year,[4] only five percent of Maryland seniors have purchased long-term care insurance.[5] Maryland's long-term care insurance partnership program is now dead in its tracks on account of a combination of problems with the state statute and federal requirements. In other words, creative approaches that might divert seniors from reliance on Medicaid nursing home benefits toward private financing options have been notably unsuccessful in Maryland.

Finally, as the fiscal vise of long-term care costs has closed in on Maryland, the state has taken and/or considered ever more drastic measures to respond to the crisis. For example, Maryland's Medicaid program already has no adult dental care and the lowest child dental payments in the United States. The program has reduced pharmacy dispensing fees by nearly ten percent. It has cut Health Maintenance Organization payments by $8 million. Maryland does not provide full Medicaid benefits to children as permitted under federal law.[6] Finally, even as the state is forced to consider yet more draconian cuts in eligibility, coverage and reimbursement for acute and chronic care services, the federal government threatens to slash the Medicaid program from a growth rate of over ten percent a year to five percent or less. Obviously, the condition of long-term care financing in Maryland is desperate already and getting more serious all the time.

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

[5] Susan Coronel and Diane Fulton, *Managed Care & Insurance Operations Report: Long-Term Care Insurance in 1993*, Health Insurance Association of America, Washington, D.C., March 1995, p. 14.

[6] Martin P. Wasserman and Carolyn D. Davis, "Constituency Group Roundtable Discussions," *Healthy People, Healthy Communities*, Maryland Department of Health and Mental Hygiene, August 28, 1995.

DIAGNOSIS

Why is Maryland's long-term care financing system in such terrible trouble? How can we explain the costly over-reliance on Medicaid nursing home benefits? What accounts for the failure of private financing alternatives such as home and community-based services, home equity conversion and private long-term care insurance? Once we understand why the current system is the way it is, we will be better able to propose and implement viable, cost-effective solutions.

The cause of Maryland's long-term care financing dysfunction is simple. Medicaid nursing home eligibility in Maryland is so generous that other, private financing alternatives have been relatively unattractive to consumers. Marylanders can ignore the risk of long-term care, avoid the premiums for private insurance, wait to see it they ever need formal long-term care, and if necessary, qualify for Medicaid nursing home benefits financed by state and federal taxpayers, while preserving most of their estates for their heirs. By the time they confront the tragic reality of long-term care, elderly Marylanders are no longer eligible for private insurance. They fall onto public assistance by default. Consequently, Maryland seniors end up disproportionately in nursing homes, uninsured, and on Medicaid. Today, the logical consequence of thirty years of this well-intentioned, but counterproductive system is choking the state's ability to finance long-term care.

This analysis contradicts conventional wisdom about Medicaid and is highly controversial. Therefore, we must substantiate the key points, before we can prescribe any corrective actions. Despite the common belief that Medicaid eligibility requires impoverishment, income level is rarely an obstacle to qualifying for the program. Maryland bases eligibility on medical and financial need. In other words, the state subtracts all medical expenses (including nursing home costs, deductibles and co-insurance for Medicare and private health insurance policies, non-covered expenses such as dental care and eye glasses) plus a $40 per month personal needs allowance and a home-maintenance allowance before determining income eligibility. If an applicant's income is insufficient to pay for all of these costs, he or she is eligible for Medicaid benefits—including extensive optional services not covered by Medicare—as well as nursing home care. Someone on Medicaid can easily have several thousands of dollars per month of income without being disqualified for assistance. Thus, based on income eligibility criteria, Maryland Medicaid would easily cover upwards of 90 percent or more of seniors who need nursing home care.

Surely, however, the Maryland Medicaid program's severe asset limit of $2500 must deny eligibility to most seniors until they spend down their life's savings catastrophically to qualify. Again, this conventional wisdom is wrong. In addition to $2500 in liquid assets, Medicaid recipients can retain unlimited exempt assets, such as a home, a car and a business of any value. If they possess too much in non-exempt assets, such as stocks or certificates of deposit, they can convert these disqualifying assets to exempt resources instantaneously and with impunity. Married recipients are able to preserve substantially greater income and assets because of spousal impoverishment protections mandated by federal law. Of course, any amount of assets transferred three years or more before applying, has no bearing on eligibility. Finally, sophisticated Medicaid planning techniques permit even wealthy people with access to good legal advice to divest or transfer unlimited assets while qualifying for Medicaid nursing home benefits very quickly. Similar techniques permit the same financially savvy seniors to protect their estates from liens and estate recoveries as well.

The extremely scarce time and space available for this report preclude developing the evidence of easy access to Medicaid benefits in greater detail. If the reader retains any doubts or questions, however, an extensive list of published information by the author on this topic is provided in the bibliography of this report. Likewise, these references refer the reader to an extensive legal literature on the subject. Review of the "options" section below will also be helpful in clarifying the issue.

Because Medicaid nursing home benefits are relatively easy to obtain without spending down, Marylanders have little incentive to plan early against the risk of long-term care. They have no need to spend their own money for home and community-based services when Medicaid provides subsidized nursing home care. They go to nursing homes even if home care or assisted living might be more suitable and cheaper, because Medicaid does not pay for home and community-based care. They do not tap the equity in their homes to generate funds for long-term care or insurance, because Medicaid exempts the home and all contiguous property regardless of value. They have no incentive to purchase insurance policies that might be easily affordable at 40 or 50 years of age, but may be prohibitively expensive at 75 or 80. When one puts together the pieces of the puzzle in this way, the long-term care financing crisis in Maryland not only makes sense, it appears inevitable.

PROGNOSIS

If Maryland keeps doing what it has always done, it will keep getting what it has always got. Until the state eliminates the perverse incentives in public policy which discourage people from planning ahead, buying insurance, and paying privately for the most appropriate levels of care, the fiscal hemorrhage in Medicaid nursing home expenditures will only continue and worsen. But eliminating the incentives to rely on Medicaid is not enough by itself.

Maryland must also provide strong, positive incentives for citizens to take responsibility—when they are relatively young, healthy, and prosperous—for their own long-term care. Unfortunately, federal Medicaid law makes this goal very difficult to achieve. Statutory requirements imposed by Washington, D.C. mandate eligibility criteria, lock in gaping loopholes, hamstring countermeasures such as liens and estate recoveries, and discourage options like private insurance and home and community-based services.

Nevertheless, it is possible for Maryland to do much more, even under existing federal law, than it is already doing to remedy the long-term care financing debacle. If Medicaid block grants pass with few regulatory strings attached, the state will be able to take even more reasonable and effective actions toward this end. Before we can recommend specific options for corrective action with and without the block grant, however, we must examine the preferred remedial plan of treatment in broad concept first. Without this foundation, the necessary regimen of detailed, interlocking proposals will not stand.

PRESCRIPTION

With the foregoing groundwork laid, the solution to Maryland's long-term care financing crisis is almost obvious. The state needs to implement five inter-related initiatives.

First. Retain (or restore) a publicly financed long-term care financing system with generous eligibility and provider reimbursement criteria. It is not politically feasible to continue ratcheting down eligibility standards, coverage, benefits, and payment rates indefinitely. On that course lies destruction of whatever merit remains in the current system and political disaster for those who advocate such stringency. If Maryland is to retain a generous public long-term care financing system, however, the state must become far more fiscally responsible about controlling its cost. Therefore...

Second. The state must stop divesture of assets entirely as a technique to qualify for the program's benefits. The current transfer of assets look-back period of three years is grossly inadequate. The average period of time from onset to death in Alzheimer's Disease—the leading cause of nursing home institutionalization—is eight years. Most people can plan for government financing three years in advance quite easily. To discourage divestiture planning effectively, Maryland must impose longer and stronger transfer of assets restrictions if possible. A look-back period of seven or eight years should suffice.

Third. Having eliminated the incentive to divest assets before eligibility, the state must assure that assets are not jettisoned while families are receiving assistance. For this purpose, the state needs to require some form of security as a condition of eligibility. In this regard, Maryland is already quite advanced. The state has the best Medicaid lien program in the country. Federal law limits the lien program severely, however, and it needs to be improved and strengthened.

Fourth. Having protected seniors' assets from divestiture and having retained the assets for the seniors' benefit while they receive benefits, the program needs to assure that estate recovery restores the funds to the public program upon the death of the recipient. If the recipient predeceases a legitimate dependent such as a spouse, recovery should be made later from the dependent's estate. A reasonable goal for estate recovery is to restore five percent of the Medicaid nursing home budget, between $20 and $25 million per year in Maryland.

Fifth. None of the above measures will have much effect

unless the public is aware of them. Maryland should target approximately 10 percent of the proceeds of its lien and estate recovery program toward educating the public about (1) the risks and costs of long-term care, (2) the availability of insurance and seniors housing options, (3) the disadvantages of public financing such as strict eligibility constraints and mandatory estate recovery, and (4) the importance of planning many years before long-term care is needed. A program of this kind aggressively implemented should lower Medicaid nursing home census substantially resulting in savings of 15 to 20 percent in a short time.[7]

The effect of these five initiatives will be (1) to assure the financial viability of a publicly financed long-term care social safety net, (2) to eliminate the existing incentive for heirs to expropriate their parents' wealth and put them on welfare, (3) to secure the World War II generation's right to possess and maintain their home and much of their savings while they receive assistance with cash flow to pay for long-term care, (4) to restore seniors' dignity by empowering them to pay their own way through estate recovery—It isn't welfare if you pay it back!, and (5) to send a strong message to future generations that if they fail to plan ahead, buy insurance and pay privately for long-term care, they will have to pay eventually anyway out of their estates. The goal of these initiatives is to encourage middle-class and affluent Americans to take responsibility for their own long-term care planning, while giving the public program back to the poor people it was originally intended to serve.

[7] "Costs to Medicaid would increase or decrease proportionally to an increase or decrease in the percent of patients." Source: Personal correspondence from Stephen Hiltner, Supervisor of Nursing Home Programs for the Medical Care Policy Administration of the Maryland Department of Health and Mental Hygiene, to Joe Coble and Steve Moses dated September 12, 1995.

OPTIONS

This section is entitled "options" instead of "recommendations" because we are not prepared, based on such a limited project as this one, to propose a specific course of action. Therefore, consider this only a "Chinese menu" of possibilities. Such of these options as may be implemented under **c**urrent **f**ederal **l**aw are marked "**CFL.**" Such as would require a major **w**aiver or **b**lock **g**rant authority are marked "**WBG.**" See the section entitled "Model State Statute: Long-Term Care Financing Under a Medicaid Block Grant, Notes Toward a Model State Statute" for details on the block grant approach.

The fiscal objective of these options—assuming they are first refined into a well-researched, highly coordinated, and aggressively enforced plan of action—is to reduce Medicaid nursing home utilization in Maryland from 70 percent of all residents to 55 percent over a period of three to five years. This is a conservatively achievable goal and could save the state of Maryland $80 to $100 million per year or 20 percent of the Medicaid nursing home budget (in combination with enhanced lien and estate recoveries). If the state does nothing and Medicaid nursing home utilization continues to creep up to 85 percent,[8] Maryland will need to spend an extra $80 to $100 million per year for nursing home care not counting inflation adjustments.

The following options *do not* stand alone. They must be read in the context of the entire report (and preferably in the context of much more extensive Maryland-specific research that is yet to be done). Nor are these options comprehensive. They only suggest the magnitude, range, and general direction of the task at hand. Neither is any single option 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.

1 Retain Generous Public LTC Financing Program

1.1 **CFL:** Retain the "medically needy" eligibility system instead of adopting an "income cap" to save money. Consider adopting the federal maximum spousal impoverishment standards which allow all community

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

spouses to retain $74,820 instead of half of joint assets up to that amount as currently applies. Review and consider other measures to make Medicaid more "user friendly" for middle class families who lack the cash flow to pay for long-term care.

1.2 **WBG:** Adopt the "Senior Financial Security Program" (SFSP) outlined below in the section entitled "Long-Term Care Financing Under a Medicaid Block Grant: Notes Toward a Model State Statute." The SFSP assures access to high quality, publicly financed long-term care while retaining strong incentives for families to plan ahead for private financing of home, community-based, and nursing home services.

2 Control Divestiture and Medicaid Estate Planning[9]

2.1 **CFL:** Strengthen training, procedures and legal support to assist field eligibility staff in dealing with Medicaid estate planning attorneys, general practitioners, and other representatives of Medicaid applicants who seek "loopholes" in current law. Currently, according to headquarters eligibility policy staff, "if people ask how to save excess resources [while qualifying for Medicaid], we send them to an attorney."

2.2 **CFL:** Add a prominent warning to the pamphlet distributed to all Medicaid long-term care applicants by field eligibility staff[10] to the effect that Medicaid

[9] It should be noted that DHMH has acted quickly and relatively aggressively (compared to other state Medicaid programs) to implement the new authorities in the Omnibus Budget Reconciliation Act of 1993 which empower states to close some Medicaid eligibility loopholes. Of course, much, much more needs to be done. It is not within the scope of this project to detail all of the missed opportunities to close eligibility loopholes that Maryland might address. The bibliography of this report, however, cites numerous studies of a similar nature conducted in much more detail in other states. Many of the observations and recommendations in these studies will apply equally to the Maryland Medicaid program.

[10] "Some Questions and Answers About Financial Eligibility for Medicaid Nursing Home Services," published by the Maryland State Department of Health and Mental Hygiene.

is having severe financial problems, that Medicaid recipients may encounter difficulties in accessing quality care, that these problems may become much worse in the future, and that healthy friends, relatives and spouses of current Medicaid recipients should explore private insurance for their long-term care needs instead of expecting Medicaid to be there in the future as it has been in the past.[11]

2.3 **CFL:** Conduct a valid random sample of Medicaid nursing home eligibility cases in Maryland to determine the incidence and cost of asset divestiture and other techniques of Medicaid estate planning (such as trusts, annuities, purchase of exempt assets, life estates, dubious claims of exempt transfers, etc.). Compensate the contractor for this study on contingency from the savings incidental to its findings so that the state has little or no cost. To date, no such study has been done and the Department of Health and Mental Hygiene (DHMH) has no estimate of program losses caused by the legal stretching or illegal breaking of nursing home eligibility rules by applicants or their representatives.

2.4 **CFL:** Institute and enforce a legal limit on exempt household furnishings and personal property of $2,000. If recipients are permitted to retain personal belongings in excess of this amount, keep a record in the eligibility file to assure that such resources become part of the estate and are recovered at the appropriate time. Currently, the state limits such assets to "reasonable" levels but does not verify or attempt to recover them. Thus, expensive antiques, investment art, or precious gems easily pass to heirs of Medicaid recipients at the expense of taxpayers.

2.5 **CFL:** Clamp down on the use of annuities to shelter excess resources. According to state eligibility staff, this loophole is wide open in Maryland and is causing large financial losses to the program. The

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[11] As currently written, this pamphlet explains Medicaid nursing home eligibility criteria, describes how applicants may dispose of excess resources to qualify for Medicaid, and refers applicants to two sources of free legal advice on how to qualify for medical assistance. It does not, however, explain the downside risks of relying on Medicaid or the fiscal jeopardy the program currently faces.

subject is extremely complicated, affected by new guidelines recently published by the Health Care Financing Administration (HCFA), and requires extensive further study immediately. There may be much more Maryland can do than it already is doing, however, and a review of federal policy and restrictions utilized by other state Medicaid programs is urgently needed.

2.6 **CFL:** Establish safeguards to assure that seniors get the care they need despite stricter eligibility criteria. Recognize that Medicaid estate planning often shades into financial abuse of the elderly. When appropriate, Maryland 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.

2.7 **CFL:** Maryland should 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. This idea is fertile with potential, but will require considerable additional research.

2.8 **CFL:** The Maryland Medicaid program should subscribe to and carefully review elder law publications such as John Regan's *Tax, Estate and Financial Planning for the Elderly* and 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. Locally, The Maryland Institute for Continuing Professional Education of Lawyers, Inc. publishes a textbook entitled *Fundamentals of Elder Law 101* (Baltimore, Maryland, 1995) which contains advice for attorneys on how to use annuities, the "1/2 a loaf" formula, exempt transfers, trusts and other strategies

to qualify otherwise ineligible clients for Medicaid nursing home benefits. Publications like these supply vital clues on where to focus efforts to control and contain Medicaid estate planning abuses.

2.9 **CFL:** Similarly, state eligibility staff should attend all major elder law conferences including the annual Joint Conference on Law and Aging (coming up in Washington, D.C. October 19-22, 1995). 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. Alternatively, the Medicaid program can obtain advice from consultants or attorneys who attend these meetings and study the Medicaid planning literature.

2.10 **CFL:** Tighten medical eligibility criteria to require assistance with two or three activities of daily living as a condition for receiving Medicaid benefits.

2.11 **WBG:** Extend the look-back period for uncompensated asset transfers to eight years, hold transferees responsible for repayment to the transferors, and enforce these requirements aggressively. This will encourage seniors to keep their money instead of succumbing to the entreaties of heirs to give away their wealth and rely on Medicaid. Today's seniors earned their money; they struggled through the Depression; they fought WWII; they scrimped and saved to put a little nest egg aside. They should keep it and not be encouraged by public policy to give it away.

2.12 **WBG:** Limit the amount that Medicaid applicants can shelter in prepaid burial accounts to no more than the cost of a decent disposal of remains and a simple service, perhaps $2,500. HCFA recently reversed DHMH's attempt to cap funeral plans at $5,000.[12] Currently, there is no effective limit on how much money can be sheltered in this way and the vast majority of Medicaid

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[12] See the Medicaid nursing home eligibility policy letter from HCFA Medicaid Bureau Director Sally Richardson to all state Medicaid directors dated February 24, 1995.

nursing home recipients take advantage of this loophole. The public policy issue involved is whether scarce welfare resources are appropriately used to subsidize expensive funerals for people who could otherwise have afforded to pay longer for their own care and to indemnify heirs against the cost of burying their parents. The state should study (or retain a private contractor on contingency to examine) this issue immediately.

2.13 **WBG:** Put a stop to "wholesale" Medicaid estate planning, i.e. the practice of large (often charitable) organizations or retirement centers of requiring donation of all assets to qualify for their program by which means they insure that all participants are eligible for Medicaid nursing home benefits within 36 months. The state or a contractor should conduct a study to determine how widespread this practice is today and whether or not it is growing.

3 Enhance Asset Security

3.1 **CFL:** Maryland already has the single most effective Medicaid lien program in the United States. We cannot venture any suggestions on how to improve this program without additional study and review. It is true, however, that most Marylanders are unaware of the lien program and that state staff have made no effort to publicize it. Thus, for lack of this information, few people are motivated to buy insurance or purchase home and community-based services to avoid the lien liability on their homes incidental to receiving Medicaid nursing home benefits. To maximize such cost avoidance savings, the state should publicize its highly effective lien program as widely and promptly as possible.

3.2 **CFL:** Explore implementing a relative responsibility program to encourage adult children of Medicaid nursing home recipients to contribute toward their parent's cost of care. Such a program is difficult and has failed elsewhere, but is possible under existing law.

3.3 **WBG:** Formally require a lien on all property real and personal as a condition of receiving public long-term care benefits. Liens do not prevent property-owners from selling or transferring their property. All they do is assure that the creditor, in this case the

taxpayers, are privy to the transaction and have an opportunity to protect their security.

4 Strengthen Estate Recovery

4.1 **CFL:** Maryland should either staff up its lien and estate recovery program significantly or retain a private contractor on contingency to capture potential recoveries that are currently being lost. Last year, Maryland recovered less than one percent of Medicaid nursing home costs from lien ($1.9 million) and estate recoveries ($1.2 million) employing five staff. By comparison, Oregon routinely recovers five percent or more of its nursing expenditures employing ten staff. Since Oregon's Medicaid program is about 1/3 the size of Maryland's, Maryland would recover $20 to $25 million per year employing 13 staff if it geared up and achieved at the same level.[13]

4.2 **CFL:** Lien and estate recovery staff should train field eligibility staff in techniques to identify unreported property or asset transfers. Maryland cannot collect liens or estate recoveries from property that was divested by Medicaid recipients to qualify for assistance in the first place. Integrating the front-end eligibility process with the back-end lien and estate recovery program is absolutely essential but largely unachieved at present.

4.3 **CFL:** Pass pending state legislation to require nursing homes to remit the proceeds of personal needs accounts of Medicaid recipients who die. Maryland's average estate recovery is $5,000 compared to a national average of $2,000. This suggests that Maryland is missing many small estates and could vastly increase total recoveries by capturing more small estates.

[13] Maryland's lien and estate recovery chief states confidently that the program is already recovering 100 percent of all potential recoveries and that they do not need any additional staff. I would recommend, therefore, that the state consider retaining a private contractor on contingency to explore additional possibilities. Then, if there is nothing more to recover, the state will incur no additional expense. If the contractor is able to find additional sources or efficiencies of recovery, however, the state would still receive the lion's share of the new revenue.

Another possibility is to reduce the monthly personal needs allowance to the federal minimum of $30 for severely impaired residents who do not require or consume the current $40 limit. This would increase the monthly contribution of such residents toward their own cost of care, thereby relieving the burden on Medicaid.

4.4 **CFL:** Maryland should begin a cost-effective program to collect hard assets such as antiques, jewelry, vehicles, guns, investment grade collections, etc. Obviously, such assets should be collected only if cost-effective. Currently, hard assets drift out of estates or are cashed out for pennies on the dollar with the result that thieves, heirs, or investors prosper from Medicaid subsidies. Only objects of real sentimental value such as original wedding rings (not expensive substitutes purchased to shelter wealth in order to qualify for public assistance) should be exempted. If taxpayers are willing to protect a family's most prized possessions from long-term care costs, why should the family pay its own way?

4.5 **CFL:** Maryland should institute a more comprehensive system of accounts receivable. For example, instead of requiring that mortgages generating stable monthly income be sold for a fraction of their value to generate cash, set up a system to retain and enforce them. Oregon recovers over $85,000 per month from accounts receivable of this and many other kinds. If occasionally it becomes necessary to receive real property in a down market, consider placing the property in management with fees paid by rental income until the real estate market improves. Think creatively. Run the program like a business. There are endless ways to increase revenue and profitability.

4.6 **CFL:** Develop a system immediately to recover from the estates of spouses predeceased by Medicaid recipients. This is an enormous source of non-tax revenue currently lost by the state. By not pursuing spousal recoveries, Maryland allows substantial wealth to pass unencumbered to heirs regardless of how much money Medicaid contributed toward the recipient's care. (Some Medicaid estate planners argue that spousal estate recoveries are not permitted under federal law. Although the state would probably win any litigation on the issue, spousal recoveries would be much easier to achieve under waiver or block grant authority.)

4.7 **WBG:** Require all recipients to agree in writing as a condition of eligibility that all proceeds from the sale of everything they own[14] will go to pay for the cost of their care upon the death of their last, surviving exempt dependent relative and that all property of a predeceased Medicaid recipient will be encumbered by a lien until such time as it is recoverable from the estate of a dependent relative.

5 Educate the Public on and Actively Encourage LTC Financing Alternatives

5.1 **CFL:** 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 Maryland's imprimatur on the flyer and distribute it in mass mailings to all citizens of the state.

5.2 **CFL:** Draft an executive proclamation for Governor Glendening to deliver at a press conference declaring that Medicaid in Maryland 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.

5.3 **CFL:** Draft a similar statement as a "Sense of the Legislature Resolution" for introduction in the state House of Delegates and the Senate.

5.4 **CFL:** 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 delineated in this report.

5.5 **CFL:** Inform the Medicaid estate planning bar in no uncertain terms that efforts to stretch Medicaid eligibility rules far beyond the limits intended by

[14] With the exception of possessions that have high sentimental, but nominal, cash value, e.g. under $2,000.

federal and state lawmakers will not be permitted without a legal fight.[15] According to headquarters eligibility staff "most attorneys in private practice are ashamed that someone may think they are doing Medicaid planning." A recent public opinion poll summarized below confirms widespread disapproval of Medicaid estate planning. By standing up to the few attorneys who abuse the system, Maryland can reduce the fiscal impact of Medicaid estate planning considerably. This initiative will also help to encourage field eligibility workers who become angry and frustrated when "a family with thousands in hospital bills cannot get help but some attorney wants to put big clients on Medicaid for nursing home costs."

5.6 **CFL:** Mount a widespread, well-financed initiative to educate the public about the risk of long-term care, the cost of institutionalization, and the availability of private long-term care insurance to prepare in advance. If necessary, tap a percentage of lien and estate recovery revenues to finance this initiative. No stronger evidence of the need for such a program is needed than this quote from Maryland's chief Medicaid nursing home eligibility expert: "I bought [long-term care insurance] because I never want to apply for Medicaid." Maryland has a tremendous advantage over some other states in that the state Insurance Administration understands private long-term care insurance and looks favorably upon it.

5.7 **CFL:** Mount similar education campaigns to promote awareness of home equity conversion options, home and community-based services, and family subsidization plans. If families know they stand to lose estates and inheritances to Medicaid liens and estate recoveries, they will pull together, help each other out, defer expensive institutional care, and look creatively for ways to finance cheaper, more desirable levels of care. The Maryland Insurance Administration is considering a very creative idea for financing educational campaigns

[15] On January 15, 1994, the Maryland State Bar Association formally created an Elder Law Section. The National Academy of Elder Law Attorneys lists seven Maryland attorneys in its "Experience Registry." Anecdotal reports indicate that Medicaid estate planning is deeply entrenched in Maryland including newspaper advertising, brochures in law offices, radio call-in shows, and extensive word-of-mouth.

such as these, i.e. using the proceeds of a financial penalty levied against a national insurance company recently for abusive sales practices.[16]

5.8 **CFL:** Maryland 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.

5.9 **CFL:** Save the "Maryland Partnership for Long-Term Care Program" by redefining its mission. Currently, the program is tied up in statutory knots too complicated to explain in detail here. Fundamentally, however, the program will not work as long as people can ignore long-term care insurance and qualify for Medicaid quickly and easily. Furthermore, the program's feature which promises Medicaid spend down forgiveness in the future is not feasible. Maryland cannot afford another huge unfunded liability like that. The solution is to implement the portion of the Partnership which identifies quality long-term care insurance policies and encourages people to buy them, but drop the part that proposes to coordinate private insurance benefits with a welfare program on the verge of bankruptcy.

[16] The insurance company in question does not sell long-term care insurance. The Maryland Insurance Administration reports that it has not received a single complaint of agent abuse by long-term care insurance salespeople.

CONCLUSION

The state of Maryland truly faces a long-term care financing crisis. To a large extent, however, the problem is self-inflicted. Unforeseen consequences of unintended incentives in long-standing public policy plague the long-term care financing system. People can ignore the risk of long-term care, avoid the premiums for private insurance, shelter or divest their income and assets, and shift the enormous financial burden of long-term care onto the Medicaid program with ease. They can, so many do.

Consequently, Maryland cannot solve the long-term care financing crisis by denying the succor of medical care to more of her citizens. She cannot fix these problems by reducing provider reimbursement rates below the minimum required for adequate care. She cannot correct the system by plunging ever more of the taxpayer's money into the black hole of institutional long-term care. All of these conventional remedies have only made the situation worse.

The real solution is simple, economically sound and politically feasible. Merely change the incentives in the system so that Marylanders plan ahead for long-term care, purchase private long-term care insurance, tap the equity in their homes, and utilize private home and community-based services. Divert them from the sorry fate of ending up in nursing homes on welfare prematurely by default. By so doing, the state can save Medicaid for the truly needy who cannot manage without it, relieve the overburdened taxpayers, empower the providers of long-term care with more private payers, and supercharge the financial services and long-term care insurance industries.

This report suggests numerous ways to achieve these objectives. It is only the barest beginning, however. The state should start immediately to build on this foundation. Bold action now will assure that the historical legacy of today's long-term care financing crisis in Maryland will be opportunity and success rather than danger and defeat.

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MODEL STATE STATUTE

Long-Term Care Financing Under a Medicaid Block Grant Notes Toward a Model State Statute[17]

by
Stephen A. Moses

I. Introduction

Medicaid is known as the "pac-man" of state budgets and the "800-pound gorilla" of long-term care. We all know something has to be done to control this fiscally hemorrhaging giant.

On the positive side, if Medicaid block grants pass this year, states will have the authority for the first time to implement the proper corrective actions. That is a tremendous incentive to prepare now to meet the risks and opportunities that lie immediately ahead.

The big questions public policy makers face are what to do and how to do it. We cannot plot a course of corrective action until we understand completely the mess we are in and how we got into it. The purpose of this paper is to explain the problem, show how it developed and propose a solution.

Medicaid nursing home expenditures nearly doubled between Federal Fiscal Year (FFY) 1988 and FFY 1993. Today, Medicaid pays for 73.7 percent of all nursing home patient days in the United States. At least 85 to 90 percent of all nursing home payments come from Medicaid, Social Security benefits contributed by Medicaid patients toward their cost of care, Medicare, or private patient income (not assets). Dozens of recent empirical studies indicate that Medicaid "spenddown" is much lower than previously believed. In fact, there is no evidence whatsoever of the much-touted, widespread catastrophic spenddown.

Although Medicaid is ostensibly a means-tested public assistance program, i.e. welfare, evidence abounds that middle-

[17] This paper was originally presented at the 22nd Annual Meeting of the American Legislative Exchange Council in San Diego on August 10, 1995. I believe the analysis presented in the paper applies particularly well to the state of Maryland. I have modified the compilation of the model statute at the end of the paper to apply specifically to Maryland.

class Americans and even the well-to-do qualify easily for the program's nursing home benefits. Congressional actions (in OBRA '93) to close Medicaid eligibility loopholes and mandate estate recovery have had little effect because of unforeseen weaknesses in the law, sluggish implementation by the states, lukewarm enforcement by the Health Care Financing Administration, and creative end-running by public and private Medicaid estate planning attorneys.

Finally, Medicaid has developed a dismal reputation for problems of access, quality, reimbursement, discrimination, institutional bias, and welfare stigma. How did America come to provide for the long-term care needs of its proud, self-reliant World War II generation by consigning them to a welfare program that is going bankrupt?

II. **Background**

In 1965, America was just starting to have a problem with long-term care. People were living longer, but dying slower—of chronic illnesses that caused frailty and cognitive impairment. That was when a prosperous private market in low-cost home and community-based services and long-term care insurance might have developed in the United States. It did not.

Instead, with every good intention, the new Medicaid program offered publicly financed nursing home care. This subsidy confronted families with a very difficult choice. They could pay out-of-pocket for the home care and assisted living services seniors prefer or they could accept nursing home care paid for by the government. Most people chose the safety and financial benefits of the Medicaid option. Therefore, the market for home care withered, private long-term care insurance expired stillborn, and Medicaid-financed nursing home care flourished.

The nursing home industry took full advantage of this situation. As fast as the industry could build them, nursing home beds filled with Medicaid residents. Stunned by the cost, Medicaid attempted to control the construction of new beds with Certificate of Need (CON) programs on the principle that "we cannot pay for a bed that does not exist." By the mid-1970's, health planning for nursing homes was in full swing.

Capping supply, however, only spurred the nursing home industry to drive up rates. Government costs grew faster than ever. So Medicaid capped reimbursement rates too. This compelled the nursing home industry to increase private pay reimbursement rates to compensate. So began the highly

problematical differential between Medicaid rates and private pay rates. Today, Medicaid pays only 80 percent of private pay rates on average nationally.

Higher private rates made Medicaid more attractive to private payers and this led to pressure on legislators to liberalize Medicaid eligibility. A long process of eligibility bracket creep gradually made Medicaid nursing home benefits available even to upper middle class people who had or could obtain the expertise to manipulate eligibility rules. A whole sub-practice of law—Medicaid estate planning—developed to take advantage of this new opportunity.

With the supply and price of nursing home beds capped by government fiat and with Medicaid eligibility increasingly generous, nursing home occupancy skyrocketed to 95 percent nationally. Nursing home operators realized they could fill their beds easily with low-paying Medicaid patients no matter what kind of care they offered. To achieve adequate operating margins, however, nursing homes had to attract a sufficient supply of full-paying private patients or they had to cut costs drastically.

If they tried to attract more lucrative private payers with preferred treatment, however, the nursing homes were deemed guilty of discrimination against Medicaid patients. If they tried to cut costs instead, they came under fire for technical violations or quality problems. In response, Congress and state governments pressured the industry to provide higher quality care without discriminating against low-paying Medicaid recipients. Given its fiscal duress, however, Medicaid could not offer higher reimbursement rates to achieve these goals.

Caught between the proverbial rock and a hard place, the nursing home industry put up a strong fight. Armed with the Boren Amendment, a law that requires Medicaid to provide reimbursement adequate to operate an efficient nursing facility, many state nursing home associations took the battle to court. By now, however, state and federal Medicaid expenditures were rising so fast and taxpayers were so reluctant to pay for growing public spending that large increases in nursing home reimbursement were out of the question.

In the meantime, a wave of academic speculation in the late 1970's indicated that paying for home and community-based services (HCBS) instead of nursing home care could save a lot of money. For years, therefore, Medicaid experimented with HCBS waivers as a cost-saving measure. In time, however, hard empirical research showed that (desirable as they may be) home

and community-based services do not save money overall. Today, institutional bias remains Medicaid's strongest cost containment tool and one of its gravest deficiencies.

In a nutshell, just as heavy demand was building for a private seniors housing market in the 1960's, Medicaid co-opted the trend by providing easy access to subsidized nursing home care. Confronted with a choice between paying out-of-pocket for a lower level of care or receiving a higher level of care at much less expense, seniors and their families made the predictable economic choice. Not surprisingly, Medicaid nursing home caseloads and expenditures increased rapidly and drastically. In response, Medicaid capped bed supply and reimbursement rates, which led inevitably to excessively high occupancy, private-pay rate inflation, discrimination against low-paying Medicaid patients, and increasingly serious quality problems. In time, Medicaid nursing home care acquired its reputation for impeded access, doubtful quality, inadequate reimbursement, widespread discrimination, pervasive institutional bias, and excessive cost. Medicaid remains, however, the only way the middle class can pay for long-term care without spending their savings. That is why so many otherwise independent and responsible Americans end up dying in nursing homes on welfare.

III. **The Challenge**

If the foregoing analysis of the Medicaid malaise is accurate, a sensible solution comes easily into focus. To facilitate universal access to top quality long-term care for all Americans, a new, cost-effective, block-granted, publicly financed, long-term care program should have the following characteristics.

- It should save taxpayers money while improving access to quality long-term care for all citizens;
- It should encourage, instead of discouraging, private financing of home and community-based services and assisted living;
- It should encourage, instead of discouraging, the purchase of private long-term care insurance to pay for all levels of extended care;
- It should combine generous eligibility criteria to protect the unprotected with strong incentives for everyone to plan ahead for self-protection;

- It should pay market-based reimbursement rates to assure access to quality care for all participants and to eliminate discrimination;
- It should promote strong market competition between providers of all levels of care;
- It should maximize the number of consumers in the marketplace who have a pecuniary interest in getting the best possible care at the lowest possible price.

Is a single program that combines all these features possible? Yes, but only if it is based on a common understanding and agreement as to its goals and objectives. In the course of numerous research studies over the past 12 years, I have found almost universal consensus on the following ethical foundation.

IV. **The Moral High Ground**

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 public assistance for long-term care should reimburse the taxpayers before giving away their wealth to heirs. Seniors and their heirs who wish to avoid such recovery from the estate should plan ahead, purchase private long-term care insurance, and pay privately for the care of their choice when the time comes.

What would a publicly financed long-term care program based on this philosophical underpinning look like?

V. **Model State Statute for a Senior Financial Security Program (SFSP)**

(Rough draft state statutory language is presented below in ***highlighted italics***.) The following are the key components of the program.

A. Preserve generous eligibility

1. Status Quo

Despite the conventional wisdom that seniors must spend

down their life savings to receive Medicaid nursing home benefits, the truth is that most seniors qualify easily regardless of income or assets.

Most state Medicaid programs place no limit on how much income someone can have and still qualify for nursing home benefits. If your total medical costs, including nursing home care, approximate or exceed your income, you are eligible.

The well known $2,000 limit on assets is meaningless. Medicaid recipients can also keep exempt assets of unlimited value, such as a home, a business, and a car. Married folks have it even easier than single people. They can shelter an additional $74,820 in assets and $1,870.50 per month in income.

For the truly well-to-do, even these generous limits are easily overcome. Any competent Medicaid planner can deliver Medicaid eligibility almost overnight to practically anyone for less than the cost of one month in a private nursing home.

Given Medicaid's generous nursing home eligibility criteria, there is little wonder why most Americans (1) fail to plan ahead for long-term care risk, (2) neglect to purchase private long-term care insurance, (3) hesitate to spend their own money on home care or assisted living, and (4) end up in nursing homes subsidized by Medicaid.

2. Senior Financial Security Program

Drastically cutting Medicaid nursing home eligibility and coverage for the middle class is not politically feasible. Strong senior interest groups would fight such cuts aggressively and both private and legal services attorneys would tie such a system in knots of litigation. Fortunately, it is not necessary to burn the village in order to save it. The Senior Financial Security Program preserves Medicaid's generous eligibility and coverage. This is the programs's biggest political selling point.

3. ***Model State Statute***

"Seniors who need nursing home care may qualify for the Senior Financial Security Program if their income is inadequate to pay for such care and if their assets do not exceed $2,000 plus certain exempt resources enumerated below.

"To qualify for assistance, however, every participant must provide a net worth statement confirmed by a certified public accountant. This net worth statement constitutes security offered by program participants to assure repayment of benefits received. As the participant receives benefits, the cost to the SFSP will be deducted from the participant's net worth ledger. As long as the ledger has a positive balance, the program participant is in receipt of a government-sponsored loan. When the ledger's balance turns negative, the participant converts to 'public assistance.'

"Exempt assets that SFSP participants may retain are similar to those permitted by the traditional Medicaid program with a few additional limitations.

"Home: no limit on value for one single-family residence, however, expensive homes purchased (or additions constructed) within eight years of applying for benefits will be treated as a transfer of assets to qualify (see transfer of assets restrictions below).

"Automobile: one car of any value provided it is actually used for the benefit of the program participant. Transfer of an automobile, even though exempt, will be deemed a transfer of assets subject to penalty. Program participants may not give away exempt assets and replace them with new exempt assets as a means to qualify for assistance or avoid estate recovery.

"Funeral plan: one prepaid funeral plan, not to exceed the average cost in the state of a simple service and disposal of remains (perhaps $2,500). Program participants may not shelter tens of thousands of dollars in burial plans as a means to qualify for assistance.

"Other exempt resources and limitations to be delineated."

B. Prohibit divestiture

1. Status Quo

Under the existing Medicaid program, anyone who transfers assets three years before applying for assistance can give away any amount of money and qualify with no questions asked. Unfortunately, the average period of time from onset to death in Alzheimer's Disease is eight years. If the family transfers her assets the first time Grandma forgets to turn off the stove, they guarantee her unlimited

Medicaid nursing home benefits three years later with no expense or inconvenience.

Today, many Medicaid estate planning attorneys advise their clients and colleagues to initiate a "gifting strategy" years in advance in order to assure easy Medicaid eligibility. Such a strategy may include many tactics including outright gifts, establishment of trusts, retention of life estates, purchase of a partial interest in adult children's homes, and conversion of non-exempt into exempt assets. The options are limited only by the imagination of the Medicaid planner.

2. Senior Financial Security Program

The SFSP cannot protect generous eligibility and survive without eliminating divestiture planning altogether. Seniors and their heirs must get the message very clearly that long-term care is an enormous financial risk, that people should save and insure throughout their lives to protect against this risk, and that giving away assets for any reason at a time when the long-term care risk is at its peak is a very dangerous proposition.

Of course, by birthright, any American is free to dispose of his assets in any way he wishes and at any time. One must no longer be allowed, however, to give away one's wealth in order to compel other Americans to provide oneself with expensive long-term care benefits.

Adult children, other relatives, friends and charities to whom older people give away income or assets must realize that if such a gift leaves seniors unable to pay for their own care and dependent on the public dole, that the state will seek restitution.

3. ***Model State Statute***

"Any assets transferred for less than fair market value within eight years of applying for assistance constitute a debt owing the state (up to the total public benefits paid) and such debt is payable by the transferees who received the assets and/or by the estate of the program participant or by such persons who may have received the assets by means other than a formal probated estate. Any asset transferred in contemplation of qualifying for the SFSP or of avoiding estate recovery shall be considered a fraudulent conveyance.

"A transfer of assets is any divestiture of purchasing

power including but not limited to gifts, purchase of exempt assets, divorce, purchase of unsalable or undividable property, divestment into trusts, converting assets into joint tenancy, etc.

"The intent of this provision is to assure that no purchasing power possessed within eight years of application by anyone who later depends on the SFSP shall be used for any other purpose than the care and maintenance of the owner or reimbursement to the SFSP for providing such care and maintenance.

"If any purchasing power shall have been taken from an SFSP participant improperly or illegally, the program shall petition the appropriate court to appoint a private attorney as the participant's conservator (reimbursed on contingency) to recoup the misappropriated assets on behalf of the participant and the program. Such recoupment may include relitigating abusive divorce decrees, reversing improper asset transfers, invading inappropriate trusts, and partitioning undivided property."

C. Require legal security as a condition of eligibility

1. Status Quo

Exempt assets divested legally or illegally while on Medicaid are lost forever as a source of long-term care financing for seniors. Nor can such divested resources serve as a non-tax revenue source to the program. Under the existing Medicaid program, states are permitted—but not required—to place liens on the homes of recipients under certain highly restrictive circumstances. Very few states use the lien authority to secure assets for later recovery. Even states that utilize liens have limited success enforcing and collecting on them because of extensive exclusions in the federal law. Consequently, exempt and non-exempt assets held openly or concealed by Medicaid recipients routinely disappear during the period of eligibility either legally or illegally as relatives, friends and others take advantage of the senior's incapacity to relieve them of their resources.

2. Senior Financial Security Program

No competent financial institution will extend a loan of hundreds of thousands of dollars to anyone without requiring security. The government can no longer afford to do so either. People who expect to depend on the SFSP while

preserving substantial income and assets for the support of their dependents must realize and agree that they lose some measure of control over these resources in the process.

Of course, all citizens have the option to use their income and assets as they see fit. For example, they can sell their homes and cars to pay privately for long-term care if they choose. But if they prefer to use a public program to pay for their care, they must recognize the obligation to encumber their resources for later recovery, after the resources are no longer needed by their legitimate surviving dependents.

3. ***Model State Statute***

"As a condition of eligibility for the SFSP, all participants must allow the state to place a lien on their exempt property. The lien shall apply to all real and personal property retained by the participant with the exception of the $2,000 liquid asset exclusion and certain highly private personal property such as original wedding rings.

"Such liens shall be officially recorded in the appropriate legal manner and shall be enforceable upon sale of the asset or upon the death of a program participant, or if the participant is survived by a legitimate dependent, upon the death of the last surviving exempt dependent relative (to be defined).

"Nothing in this statute shall be construed in any way to prohibit or prevent an SFSP participant from disposing of his property in any way he sees fit. The sole purpose is to assure that his creditor, i.e. the state in the form of the SFSP, knows of the transaction, can recover benefits paid as appropriate, and can terminate eligibility if appropriate."

D. Require estate recoveries

1. Status Quo

For most of the history of the existing Medicaid program, nursing home recipients could preserve unlimited exempt assets in the form of homes, cars and personal property and pass this wealth to their heirs completely unencumbered. It was not until the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA '82) that Congress gave state Medicaid programs the authority to recover from recipient's estates. It was not until the Omnibus Budget

Reconciliation Act of 1993 that Congress required estate recoveries. Consequently, few states have so far implemented strong, cost-effective estate recovery programs.

2. Senior Financial Security Program

As long as Americans can ignore the risk of long-term care, avoid the premiums for private insurance, wait to see if they ever need to go to a nursing home, and if so, get the government to pay while still passing all their wealth to heirs, most people will not pay for their own care and public costs will continue to explode. Extensive research indicates that states can save five percent or more of the cost of their nursing home programs by recovering benefits paid from the estates of deceased recipients. The potential liability of estate recovery provides a huge incentive for future generations to insure privately or pay for less expensive, lower levels of care in the private marketplace in order to avoid or postpone exorbitant nursing home costs. By requiring and strictly enforcing estate recovery, the SFSP assures that those participants, who are able, pay their own way thus preserving their dignity—it is not welfare if you pay it back.

3. ***Model State Statute***

"Every participant in the Senior Financial Security Program must agree in writing to pay back the entire cost of care from his or her estate or from the proceeds of sale of real or personal property during program eligibility up to the total value of the estate or sale. If the program participant should predecease a spouse or other legitimate, dependent heir or joint tenant, the participant's share of any jointly owned property or purchasing power shall be recovered from such third party as soon as it is no longer needed for the maintenance of the dependent, and in any case, no later than upon the death of the dependent third party.

"It is expressly understood that the term 'estate' is not limited to the formal probated estate, but includes all purchasing power held by the program participant within eight years of applying for the SFSP in whatever form it passes to another before or after program participation and later death.

"The intent of this rule is to assure that people pay for their own long-term care, either directly by retaining providers in the private marketplace or indirectly by reimbursing the Senior Financial Security Program. The financial viability of the SFSP and its ability to provide

care to less fortunate participants depends on strong estate recovery enforcement."

E. Encourage home and community-based services and long-term care insurance

1. Status Quo

As explained in the background section of this paper, Medicaid extinguished the private markets for home and community-based services (HCBS) and long-term care insurance when it began providing subsidized nursing home care in 1965. Later efforts to retrofit HCBS and encourage private insurance, i.e., Medicaid waivers and public/private partnerships respectively, have proven to be too little too late. With all its resources sucked into the black hole of institutional long-term care, state Medicaid programs have been unable to fund the HCBS waivers adequately. With regard to long-term care insurance: people do not buy apples on one side of the street when they can get them for free on the other.

2. Senior Financial Security Program

By prohibiting divestiture of assets to qualify, by requiring liens on all property as a condition of eligibility, and by mandating recovery from estates of every program participant who retains exempt assets, the SFSP creates an enormous incentive for future generations to plan ahead, buy insurance, pay privately for home care or assisted living, and avoid as long as possible starting the meter running for publicly financed nursing home care. Nevertheless, the SFSP should make this goal explicit in the program's statutory language.

3. ***Model State Statute***

"The purpose of the Senior Financial Security Program is to protect those who are unable to take care of themselves. The program does not replace any individuals' responsibility to provide for their own long-term care. Program requirements that prohibit divestiture of assets, require security for benefits paid, and mandate recovery from estates are expressly intended to encourage all citizens to plan ahead, purchase quality long-term care insurance, pay privately for appropriate, cost-effective levels of care, and rely on the Senior Financial Security Program only as a last resort."

F. Educate the public

1. Status Quo

The main reason that Medicaid nursing home costs have grown explosively for 30 years is that the program desensitized the public to the risk and cost of long-term care. Most people today do not know who pays for long-term care. Medicare, Medicaid or Santa Claus_why should it matter? All the public knows for sure is that someone must pay, because they hear few genuine anecdotes of catastrophic spenddown and they never see Alzheimer's patients wandering the streets with nowhere to go and no one to take care of them. Until Americans understand and internalize the risk of long-term care, they will not plan ahead to protect themselves against it and they will continue to end up in nursing homes on Medicaid.

Extensive research over the past 12 years suggests that Medicaid nursing home expenditures could be reduced by as much as 15 to 20 percent by persuading the public to pay privately for long-term care either out-of-pocket or by means of insurance coverage.

2. Senior Financial Security Program

The big challenge to public policy is to provide a long-term care safety net that protects the frail and vulnerable without discouraging the hale and able from planning ahead to take care of themselves. The SFSP achieves this objective by building a downside risk into reliance on public financing of long-term care, i.e. the lien and estate recovery liability, and by aggressively promulgating information about the probability, cost, and personal responsibility of long-term care. To assure that this critical feature of the program is not neglected, the SFSP model statute expressly incorporates a non-tax revenue source to support it.

3. ***Model State Statute***

"Ten percent (or such proportion as shall be necessary to achieve the objective) of the revenue generated by Senior Financial Security Program's lien and estate recovery efforts shall be used exclusively to support a public education initiative on long-term care. The purpose of this initiative is to educate the public, the medical profession, the bar, the judiciary, financial advisors, and all other individuals in the community who influence the lives of

older people, concerning the importance of long-term care planning. Such education and training will include but not be limited to (1) the probability of requiring long-term care, (2) the average incidence, duration and cost of nursing home care, (3) the principles of how to identify and select a reliable long-term care insurance policy, (4) the kinds of free and fee-for-service assistance available to postpone institutionalization (e.g., meals on wheels, chore services, adult day care, congregate care, assisted living, etc.), and (5) the eligibility, lien and estate recovery requirements associated with dependency on the Senior Financial Security Program.

"The purpose of this education program is to assure that no one in the state turns 50 years of age without having received complete information on long-term care risk and on all of the private options available to plan for it."

VI. Conclusion

Fully implemented and aggressively enforced, the Senior Financial Security Program will empower any state to assure universal access to top quality long-term care for rich and poor citizens alike across the entire continuum from home and community-based services to sub-acute nursing home care while simultaneously saving the taxpayers money and enhancing the private market for all long-term care providers and insurers.

The goal of the program should be to provide eligibility and coverage equal to or better than conventional Medicaid nursing home benefits at no more than 80 percent of the former cost. In 1993 dollars, this constitutes a savings to taxpayers of approximately $5 billion per year nationally.

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Appendix A

Model State Statute for a Senior Financial Security Program

This model statute must be adapted to fit the unique circumstances of each state. Differing aging demographics and long-term care infrastructure throughout the United States require such adaptation. The underlying principle, however—to provide a long-term care safety net, but not a hammock—should apply equally well throughout the country.

VII. Eligibility System

"Seniors who need nursing home care in Maryland may qualify for the Senior Financial Security Program if their income is inadequate to pay for such care and if their assets do not exceed $2,000 plus certain exempt resources enumerated below.

"To qualify for assistance, however, every participant must provide a net worth statement confirmed by a certified public accountant. This net worth statement constitutes security offered by program participants to assure repayment of benefits received. As the participant receives benefits, the cost to the SFSP will be deducted from the participant's net worth ledger. As long as the ledger has a positive balance, the program participant is in receipt of a government-sponsored loan. When the ledger's balance turns negative, the participant converts to 'public assistance.'

"Exempt assets that SFSP participants may retain are similar to those permitted by the traditional Medicaid program with a few additional limitations.

"Home: no limit on value for one single-family residence, however, expensive homes purchased (or additions constructed) within eight years of applying for benefits will be treated as a transfer of assets to qualify (see transfer of assets restrictions below).

"Automobile: one car of any value provided it is actually used for the benefit of the program participant. Transfer of an automobile, even though exempt, will be deemed a transfer of assets subject to penalty. Program participants may not give away exempt assets and replace them with new exempt assets as a means to qualify for assistance or avoid estate recovery.

"Funeral plan: one prepaid funeral plan, not to exceed the average cost in the state of a simple service and disposal of remains (perhaps $2,500). Program participants may not shelter tens of thousands of dollars in burial plans as a means to qualify for assistance.

"Other exempt resources and limitations to be delineated."

VIII. Divestiture Policy

"Any assets transferred for less than fair market value within eight years of applying for assistance constitute a debt owing the state (up to the total public benefits paid) and such debt is payable by the transferees who received the assets and/or by the estate of the program participant or by such persons who may have received the assets by means other than a formal probated estate. Any asset transferred in contemplation of qualifying for the SFSP or of avoiding estate recovery shall be considered a fraudulent conveyance.

"A transfer of assets is any divestiture of purchasing power including but not limited to gifts, purchase of exempt assets, divorce, purchase of unsalable or undividable property, divestment into trusts, converting assets into joint tenancy, etc.

"The intent of this provision is to assure that no purchasing power possessed within eight years of application by anyone who later depends on the SFSP shall be used for any other purpose than the care and maintenance of the owner or reimbursement to the SFSP for providing such care and maintenance.

"If any purchasing power shall have been taken from an SFSP participant improperly or illegally, the program shall petition the appropriate court to appoint a private attorney as the participant's conservator (reimbursed on contingency) to recoup the misappropriated assets on behalf of the participant and the program. Such recoupment may include relitigating abusive divorce decrees, reversing improper asset transfers, invading inappropriate trusts, and partitioning undivided property."

IX. Lien Security

"As a condition of eligibility for the SFSP, all participants must allow the state to place a lien on their exempt property. The lien shall apply to all real and personal property retained by the participant with the exception of the $2,000

liquid asset exclusion and certain highly private personal property such as original wedding rings.

"Such liens shall be officially recorded in the appropriate legal manner and shall be enforceable upon sale of the asset or upon the death of a program participant, or if the participant is survived by a legitimate dependent, upon the death of the last surviving exempt dependent relative (to be defined).

"Nothing in this statute shall be construed in any way to prohibit or prevent an SFSP participant from disposing of his property in any way he sees fit. The sole purpose is to assure that his creditor, i.e. the state in the form of the SFSP, knows of the transaction, can recover benefits paid as appropriate, and can terminate eligibility if appropriate."

X. Estate Recovery

"Every participant in the Senior Financial Security Program must agree in writing to pay back the entire cost of care from his or her estate or from the proceeds of sale of real or personal property during program eligibility up to the total value of the estate or sale. If the program participant should predecease a spouse or other legitimate, dependent heir or joint tenant, the participant's share of any jointly owned property or purchasing power shall be recovered from such third party as soon as it is no longer needed for the maintenance of the dependent, and in any case, no later than upon the death of the dependent third party.

"It is expressly understood that the term 'estate' is not limited to the formal probated estate, but includes all purchasing power held by the program participant within eight years of applying for the SFSP in whatever form it passes to another before or after program participation and later death.

"The intent of this rule is to assure that people pay for their own long-term care, either directly by retaining providers in the private marketplace or indirectly by reimbursing the Senior Financial Security Program. The financial viability of the SFSP and its ability to provide care to less fortunate participants depends on strong estate recovery enforcement."

XI. Home and Community Based Services and Long-Term Care Insurance

"The purpose of the Senior Financial Security Program is to protect Marylanders who are unable to take care of themselves.

The program does not replace any individuals' responsibility to provide for their own long-term care. Program requirements that prohibit divestiture of assets, require security for benefits paid, and mandate recovery from estates are expressly intended to encourage all citizens to plan ahead, purchase quality long-term care insurance, pay privately for appropriate, cost-effective levels of care, and rely on the Senior Financial Security Program only as a last resort."

XII. Public Education

"Ten percent (or such proportion as shall be necessary to achieve the objective) of the revenue generated by Senior Financial Security Program's lien and estate recovery efforts shall be used exclusively to support a public education initiative on long-term care. The purpose of this initiative is to educate the public, the medical profession, the bar, the judiciary, financial advisors, and all other individuals in the community who influence the lives of older people, concerning the importance of long-term care planning. Such education and training will include but not be limited to (1) the probability of requiring long-term care, (2) the average incidence, duration and cost of nursing home care, (3) the principles of how to identify and select a reliable long-term care insurance policy, (4) the kinds of free and fee-for-service assistance available to postpone institutionalization (e.g., meals on wheels, chore services, adult day care, congregate care, assisted living, etc.), and (5) the eligibility, lien and estate recovery requirements associated with dependency on the Senior Financial Security Program.

"The purpose of this education program is to assure that no one in the state turns 50 years of age without having received complete information on long-term care risk and all of the private options available to plan for it."

PUBLIC OPINION SURVEY

The following are excerpts from a public opinion survey released by the American Health Care Association, September 7, 1995.

A Special Report from Luntz Research:

AMERICAN OPINIONS ON REFORMING MEDICAID

From August 1 through 6, 1995, the Luntz Research Company conducted a nationwide survey of public opinion on Medicaid. This sample of 1200 adults, 18+ years of age, was selected by means of a random digit dialing technique so as to be representative of the national population of adults. A survey of this size has a margin of sampling error of +/- 2.8% (at a 95% confidence level). Here are some of the most important results...

Which makes more sense to you: to continue a program in which people can qualify for government payments of their nursing home care by getting rid of their savings, or to encourage people to buy insurance which would cover the costs of nursing home care if they need it?

6%	CONTINUING PROGRAM
86%	ENCOURAGE PEOPLE TO BUY INSURANCE
8%	DON'T KNOW/NO RESPONSE (DO NOT READ)

...Nursing home care costs an average of $38,000 a year. If you had a close relative who needed nursing home care but couldn't pay for it themselves, do you think you and your family could afford to pay for that care yourselves?

24%	YES
72%	NO
4%	DON'T KNOW/NO RESPONSE

...If a family member, close relative or friend was seriously

ill, and you could not care for that person yourself, would you consider placing him or her in a nursing home?

76% YES

20% NO

4% DON'T KNOW/NO RESPONSE

...What is your opinion on the circumstances when the government should pay for the long term care of an elderly or disabled person? Do you think:

3% THE GOVERNMENT SHOULD NEVER PAY FOR THIS TYPE OF CARE

54% THE GOVERNMENT SHOULD PAY FOR THOSE WHO ARE GENUINELY DESTITUTE

23% THE GOVERNMENT SHOULD PAY FOR ANYONE WHO DEPLETES THEIR SAVINGS IN ORDER TO BECOME DESTITUTE

13% THE GOVERNMENT SHOULD PAY FOR ANYONE WHO WANTS IT

7% DON'T KNOW/NO RESPONSE (DO NOT READ)

...As things stand now, to get long term nursing home care paid for by the government, you have to be destitute. Would you favor or oppose a move toward paying for long term care through insurance, which did not require you to become destitute? Is that strongly or somewhat?

39% STRONGLY FAVOR

37% SOMEWHAT FAVOR

76% **subtotal**

8% SOMEWHAT OPPOSE

6% STRONGLY OPPOSE

11% DON'T KNOW/NO RESPONSE

...The government program which pays for the long term care of the elderly is only available to the poor. Often elderly people in need of long term care get rid of their savings in order to qualify. In your opinion, is this practice appropriate or not appropriate?

20% APPROPRIATE

73% NOT APPROPRIATE

7% DON'T KNOW/NO RESPONSE

...One final question about Medicaid. How important do you feel it is that we find a way to control the increasing costs of the Medicaid program to the federal government: does this seem to you to be very important, somewhat important, somewhat unimportant, or very unimportant?

66% VERY IMPORTANT

24% SOMEWHAT IMPORTANT

3% SOMEWHAT UNIMPORTANT

2% VERY UNIMPORTANT

6% DON'T KNOW/NO RESPONSE

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