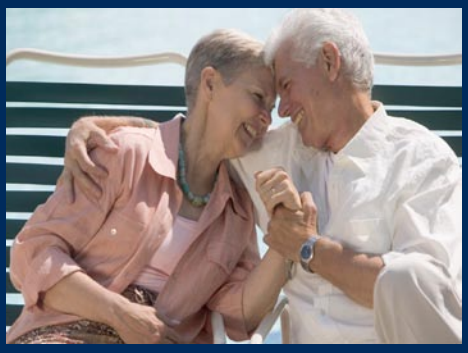
TEXAS PUBLIC POLICY FOUNDATION

Don't Mess With Texans' Long-Term Care—Fix It!

Questions and Answers From a Case Study of Medicaid and Long-Term Care Financing in Texas



By Stephen A. Moses | *March 2007*

CENTER FOR HEALTH CARE POLICY
WWW.TEXASPOLICY.COM

TABLE OF CONTENTS

ABOUT THE AUTHOR

Stephen A. Moses is President of the Center for Long-Term Care Reform in Seattle, Washington (www.centerltc.com) and a Senior Fellow with the Texas Public Policy Foundation. The Center promotes universal access to top-quality long-term care by encouraging private financing and discouraging welfare dependency for most Americans. Previously, Moses was Director of Research for LTC, Inc., a Medicaid state representative for the Health Care Financing Administration and a senior analyst for the Inspector General of the U.S. Department of Health and Human Services.

Moses is widely recognized as an expert and an innovator in the field of long-term care. McKnight's *Long-Term Care News* named him "one of the 100 most influential people in long-term care." *Nursing Homes* magazine reported "there is probably no more articulate spokesperson for privately financed long-term care than Stephen Moses." His articles have appeared often in distinguished publications like *The Gerontologist, The Journal of Accountancy, The Journal of Financial Planning, Contemporary Long-Term Care*, and *National Underwriter*. He has published chapters in several long-term care anthologies. Moses' recommendations are quoted frequently in the national media including the "CBS Evening News," PBS's "Frontline" and "The Financial Advisors," CNN, National Public Radio, *The New York Times*, *Newsweek*, *USA Today, Forbes, The New Republic, Smart Money, National Journal*, and Jane Bryant Quinn's syndicated column.

Moses has testified before Congress and two-thirds of America's state legislatures. He frequently addresses professional conferences in the fields of law, aging and insurance. He is currently working on a book for the Cato Institute provisionally titled "Long-Term Care: The Preventable Tragedy."

The Center for Long-Term Care Reform is a private research and advocacy organization with the mission to ensure access to quality long-term care for all Americans.

Don't Mess With Texans' Long-Term Care—Fix It!

Questions and Answers From A Case Study of Medicaid and Long-Term Care Financing in Texas

by Stephen A. Moses

EXECUTIVE SUMMARY

Across the country, lawmakers are increasingly sensitized to the growing demand on long-term care services and the significant cost of providing these services as the "Baby Boomers" age on to their expected benefits from Medicaid, Medicare, and Social Security. For the states, Medicaid already carries a significant financial cost, which will grow even more steep as Medicaid shifts from covering comparatively inexpensive acute care for poor women and children to covering the more expensive long-term care services for the elderly. As a result, states are desperate to identify reforms that will hold the aging onslaught at bay by directing people away from reliance on government programs and into private sector solutions to long-term care. But what can the state do and will there be time to put the needed reforms into place?

The Foundation asked Stephen Moses of the Center for Long-Term Care Reform to assess the Lone Star State's Medicaid long-term care program and identify potential solutions that can help relieve the increasing pressure on the state budget through reform. What follows is an examination of the state's current Medicaid long-term care program, its prognosis, and areas for possible reform. Using a question and answer format, the research addresses the following questions:

- What is long-term care and why is paying for it such a challenging problem for Texas? (p. 5)
- What roles does Medicaid play in financing long-term care? (p. 6)
- Are there other sources of funding for long-term care and how much do they contribute to the cost? (p. 7)
- Who provides long-term care for the elderly and what difficulties do they face? (p. 9)
- How have policymakers in Texas approached the challenge of financing long-term care? (p. 10)
- Does funding more home and community-based services and less nursing home care through Medicaid really save money? (p. 11)
- Who will pay for a full spectrum of long term care? Where will the money come from? (p. 12)
- How difficult is eligibility for Medicaid long-term care benefits to achieve for frail or infirm elderly citizens? (p. 13)
- Do people actually qualify for Medicaid long-term care benefits in Texas while preserving significant income and assets? (p. 14)
- Didn't the Deficit Reduction Act of 2005 put a stop to this kind of thing and has Texas implemented those provisions? (p. 16)

- Does all this really make any difference now that Texas will recover from the estates of deceased Medicaid long-term care recipients? (p. 18)
- Does the availability and attractiveness of Medicaid-financed long term care benefits affect the amount of private long-term care financing? (p. 19)
- Does the easy availability of Medicaid-financed long-term care further impede the market for long-term care insurance? (p. 20)
- Why don't legislators and public policy makers propose and implement restrictions on Medicaid long-term care eligibility? (p. 21)
- Is the situation hopeless? (p. 22)

Quick*Fact:*

In gross numbers, Texas' elderly population (over age 65) is expected to grow from 2.1 million in 2002 to 3.7 million in 2020. That's an extra 1.6 million people for Texas to worry about providing and funding long-term care starting in just another 14 years.

The good news is that the situation is not hopeless, but it will require bold action on the part of the states and the states' courage to push Congress to act on additional reforms that can help stave off the coming crisis. To a large degree, states are limited in their flexibility to pursue the necessary reforms, but it is incumbent on states to use all tools currently available to them.

INTRODUCTION

Long-term care (LTC) for the frail or infirm elderly is very expensive and is predominantly financed by Medicaid, a means-tested public assistance program, both in Texas and nationwide. Medicaid-financed LTC for the elderly is a worrisome public policy challenge because of the on-coming demographic "age wave." The problem is aggravated in Texas by rapid population increases and relatively high percentages of poor, minorities, older women and the disabled elderly, the very populations most likely to need long-term care.

People who receive Medicaid long-term care benefits must contribute most of their income toward their cost of care, which means Medicaid is vulnerable to any future cutbacks in seniors' income from Social Security or private pensions. Supplemental sources of long-term care financing such as long-term care insurance or reverse mortgages are minimal in Texas, and Medicare's future contribution toward nursing home and home health care costs is vulnerable due to that program's large unfunded liabilities.

The major nursing home and home health care providers in Texas claim that Medicaid reimbursements for their services are too low, impede recruitment and retention of high-quality caregivers, and are accompanied by excessive, often counterproductive regulations. Texas policy makers have responded to the challenge of funding long-term care by means of covering as many people as possible in Medicaid-financed home and community-based care which they affirm is less expensive per capita than nursing facility care. The difficulty with this strategy is that overall long-term care costs across individuals' lifetimes and across the whole population of the state may not be cost-effective and may discourage personal responsibility and early planning for the risk of long-term care by individuals and families.

One way to relieve the LTC financing burden on Medicaid is to increase private funding sources, but this will not happen as long as Medicaid LTC benefits are easy to obtain after the insurable event occurs. Despite the conventional wisdom that Medicaid eligibility requires total impoverishment, the truth is that most elderly Texans with a nursing home level of

medical need qualify easily for Medicaid-financed LTC. Middle-class and affluent Texans routinely qualify for benefits.

The Deficit Reduction Act, enacted February 8, 2006 and already implemented in large part by Texas, took some critical steps toward reducing the over-utilization of Medicaid LTC, but these measures are insufficient to solve the problem. Texas' important, though belated implementation of a Medicaid estate recovery program will help recoup some of the wealth sheltered by Medicaid from LTC costs in the past, but structured as it currently is, it will likely bring in only a fraction of the non-tax revenue that it should.

Easy access in Texas to Medicaid-financed long-term care benefits crowds out the market for private LTC insurance and reverse mortgages which might otherwise contribute significantly toward total long-term care costs.

Admittedly, Medicaid reform in general, and for long-term care in particular, is highly controversial and politically sensitive. Politicians rarely win elections nor do public officials protect their jobs by reducing publicly financed benefits and encouraging more personal responsibility. Thus, "Don't Mess with Texans' Long-Term Care" may be popular short-term advice, but staying the course will become a costly burden over time. The better advice is to "Fix Long-Term Care" before it's too late.

Federal Medicaid requirements hinder many important reforms, but to the extent possible, states must target Medicaid LTC benefits to people truly in need; prevent Medicaid from being free "inheritance insurance" by actively recovering from estates; and use some of the savings to educate and incentivize everyone else to plan early, save, invest and insure for long-term care.

What is long-term care and why is paying for it such a challenging problem for Texas?

Long-term care is the medical and custodial help frail or infirm people need when they are no longer able to take care of themselves. It may include highly skilled nursing care (usually in a nursing home), attendant services to help with daily activities like eating, dressing, bathing, and using the toilet (often in a home or community setting), or a combination of both. The need for long-term care affects people of all ages but our focus in this study is on providing and financing long-term care services for the elderly.

Long-term care for the elderly is a special challenge because it is costly already and we know for certain that the number and proportion of older people will increase rapidly in the future. According to the Texas Legislative Budget Board: "Nearly one-half of the increase in Texas' population since 1994 has occurred in the over-45 age group, which grew by 46.2 percent during the decade. Because this age group is reaching or has reached retirement age, its large growth rate may affect state services."[1] This is a description of the well known and highly worrisome "baby boom bulge."

Long-term care risk and cost is highly age-sensitive. The probability of needing expensive long-term care doubles every five years after age 65 and peaks after age 85. Citizens of Texas 85 years of age and older were only 1.2 percent of the population in 2002 (compared to 1.6 percent for the U.S. as a whole) but they're going up by a third to 1.6 percent in 2020 (compared to 2.0 percent for the U.S.). What's more, the rate of increase among this most

Talking*Point:*

According to the Texas Legislative Budget Board: "Nearly one-half of the increase in Texas' population since 1994 has occurred in the over-45 age group, which grew by 46.2 percent during the decade.

expensive age group for long-term care is much faster for Texas (82 percent) than it is for the United States (60 percent) during the same time period.[2] In gross numbers, Texas' elderly population (over age 65) is expected to grow from 2.1 million in 2002 to 3.7 million in 2020. That's an extra 1.6 million people for Texas to worry about providing and funding long-term care starting in just another 14 years.

Moreover, Texas has special LTC challenges with its aging population. Women tend to outlive men and are more likely than men to need long-term care late in life, and the poor are most likely to need state assistance funding their long-term care. Texas ranks fifth in the nation for "Minority/Ethnic Population Age 65+ (29.3 percent); 12th and 18th respectively for elderly in poverty (12.2 percent) and between 101 percent and 200 percent of poverty (25.6 percent); and 18th for women over age 80 in poverty (17.2 percent). Texas also ranks relatively high in its percentage of "Persons Age 65+ with Activity Limitations," including Self-Care Limitations (14th at 9.7 percent), Mobility Limitations (20th at 18.8 percent), Self-Care or Mobility Limitations (18th at 20.6 percent), Sensory Limitations (23rd at 17.4 percent) and Cognitive/Mental Limitations (17th at 11.9 percent).[3]

All of this means more people living longer and likely to need long-term care.

No wonder Texas is worried about long-term care and how to pay for it.

What role does Medicaid play in financing long-term care?

Medicaid is a means-tested public assistance program jointly funded by the federal government (55 percent on average nationally, 60.78 percent in Texas) and state governments (45 percent on average nationally, 39.22 percent for Texas).[4] It has been called the 800-pound gorilla of long-term care, because of its huge influence on service delivery and financing. At the national level, Medicaid paid 43.9 percent of nursing home costs in 2005 or $53.5 billion, but that number vastly understates the program's impact on nursing home care. Roughly two-thirds of all nursing home residents rely on Medicaid. Because Medicaid recipients tend to be long-stayers, Medicaid reimbursements, usually very low compared to private-pay rates, touch nearly 80 percent of all nursing home patient days.

Much of the difference between Medicaid's relatively low dollar investment in nursing home care and its much larger impact on nursing home reimbursements is made up by the fact that Medicaid nursing home recipients have to contribute most of their income (largely but not exclusively their Social Security income) toward their cost of care. Whether Medicaid or the Medicaid recipients' personal income predominates in paying the cost of nursing facility care, the nursing home only receives the relatively low Medicaid level of reimbursement.

The picture is very similar for home care on which America spent $47.5 billion in 2005 of which Medicaid and Medicare paid 70.3 percent, private insurance paid 12.2 percent, and personal out-of-pocket expenditures were only 10.7 percent or one dollar out of nine.

In Texas too, Medicaid is the predominant source of funding for nursing facility and home and community based long-term care. "In FFY (federal fiscal year) 2002, Medicaid funded long-term care services for approximately 878,000 Texans. . . . In Texas, long-term care services account for approximately 30 percent of the overall Medicaid budget. In FY 2003, ap-

proximately 234,000 clients per month received long-term care services: 69,000 in nursing facilities or receiving hospice care; 13,000 in ICFs/MR; 103,000 receiving primary home care, attendant care, and day activity/health services; 49,000 receiving 1915(c) waiver services (includes STAR+PLUS 1915(c) waiver)."[5]

The cost of long-term care is staggering already and set to grow steeply. Medicaid carries most of the financial cost and it is strained already. Policy makers despair for the program's ability to meet growing demands as its center of fiscal gravity changes from relatively inexpensive acute care for poor women and children to relatively expensive long-term care for the elderly. According to the Texas Legislative Budget Board, "This trend [toward funding more health care for the young and poor] will likely reverse itself in future biennia as the 'baby boomer' generation begins to turn age 65 in 2011, resulting in a rapid increase in the number of aged enrollees."[6]

Are there other sources of funding for long-term care and how much do they contribute to the cost?

Of course there are other funding sources for long-term care but they're relatively problematical (Medicare and Social Security) or insignificant (out-of-pocket, LTC insurance, or reverse mortgages), especially in Texas.

Other than Medicaid at 43.9 percent, the biggest funding source for nursing home care nationally is Medicare which paid 15.7 percent of the cost in 2005. Medicare nursing home payments are important because Medicare reimbursement rates are relatively high and help to make up for shortfalls in Medicaid rates. Because of Medicare's critical importance to long-term care financing today, the program's $71 trillion "infinite-horizon" unfunded liability is a serious concern for the future.[7] If Medicare should become insolvent or no longer able to contribute as much toward nursing home and home health care costs as in the past, how would the difference be made up?

Most people assume that out-of-pocket costs for nursing home care are very high. But in fact, they accounted for only 26.5 percent of all nursing home expenditures in 2005. Even that percentage is misleadingly high, however, because nearly half of the so-called "out-of-pocket" costs for nursing home care are really just "spend through" of Social Security income by people already on Medicaid.[8] People on Medicaid are required to contribute most of their income, including Social Security, toward their cost of care thus offsetting the cost to Medicaid. Because Social Security plays such a critical, albeit indirect, role in funding long-term care, its $15.2 trillion unfunded liability raises serious concerns about what will happen to Medicaid and its ability to fund long-term care if Social Security is someday unable to make full payments to its beneficiaries.[9] Annual notices to beneficiaries already warn that Social Security may someday be able to pay only 74 percent of the benefits it currently tells people to expect.

Other important sources of income that currently offset Medicaid long-term care costs are also at risk of declining over time. Retrenchment of private corporations' retiree pensions and health benefits is well known. *USA Today* reported on December 17, 2006 that state and local governments are beginning to "address a liability of more than $1 trillion for providing medical care promised to about 25 million current and future retired state and local civil servants." Changes in retiree pensions and health benefits, particularly in transition from a defined

Talking*Point:*

Because Social Security plays such a critical, albeit indirect, role in funding long-term care, its $15.2 trillion unfunded liability raises serious concerns about what will happen to Medicaid and its ability to fund long-term care if Social Security is someday unable to make full payments to its beneficiaries.

FIGURE 1: PAYOR MIX AND CENSUS BY OWNERSHIP CONTROL, STATE OF TEXAS DATA AS OF SEPT. 2006

Ownership Control	Medicare Census	Medicare Percent	Medicaid Census	Medicaid Percent	Other Census	Other Percent	Total Census
Total Texas	11,926	13.33%	59,795	66.84%	17,737	19.83%	89,548
For-Profit	9,959	13.39%	50,792	68.31%	13,604	18.30%	74,355
Government	98	6.06%	905	55.93%	615	38.01%	1,618
Non-Profit	1,869	13.86%	8,098	60.05%	3,518	26.09%	13,485

Source: CMS OSCAR data arrayed by Cowles Research Group.
Note that the Texas Association of Homes and Services for the Aging reports that its membership, comprised principally of non-profit nursing facilities, has a much lower census of Medicaid residents than the federal data indicate.

benefit to a defined contribution, can be expected into the future in both private corporations and the public sector. Because of the requirement that people on Medicaid contribute personal income toward the cost of their care, such changes also impact Medicaid and how it funds long-term care.

The Centers for Medicare and Medicaid Services report that private health insurance funds 7.5 percent of nursing home costs, but this number is highly dubious because it is derived by backing out known sources of nursing home funding and does not reflect contributions by specialized private long-term care insurance policies. As explained above, home care is also predominately funded by Medicaid and Medicare.

We lack comparable state-specific data on long-term care funding sources for Texas, though **Figure 1** shows the payor mix and census by ownership control in the state. We do know that Medicaid (66.8 percent) and Medicare (13.3 percent) are the dominant payers of nursing home care in the state. Other nursing home funding sources total only 19.8 percent and a large proportion of those would include Social Security and other income contributed to their cost of care by Medicaid recipients as explained above. Furthermore: "Long-term care caseloads are also projected to grow in the 2006-07 biennium. Nursing facility-related caseloads (includes Medicaid, Medicare co-pay, and hospice) are projected to grow by 4.3 percent from an estimated average of 69,256 in fiscal year 2005 to a projected average of 72,206 in fiscal year 2007. Community care Medicaid non-waiver (entitlement) caseloads are projected to grow by 18.3 percent from an estimated average of 124,971 in fiscal year 2005 to a projected average of 147,874 in fiscal year 2007. Community care client caseloads are projected to grow at a faster rate than nursing facility caseloads due to legislative policy that expands waivers and reduces waiting lists and an assumed continued preference of clients to receive services in a community setting."[10]

Clearly Medicaid and other public funding sources account for the vast majority of all long-term care financing in the state of Texas. Private out-of-pocket expenditures are minimal and limited mostly to income, not asset spend down. Moreover, potential alternative funding sources such as private long-term care insurance (LTCi) and reverse mortgages (RMs) to tap home equity contribute very little. Our interviews with nursing home and home health care providers

in Texas indicated that neither LTCi nor RMs contribute significantly to their revenue. Our interviews with long-term care insurance agents indicated that the market for that product, while growing, is still undeveloped and difficult. Our interviews with reverse mortgage lenders suggested that the market for RMs is growing rapidly but that reverse mortgages are rarely used to finance long-term care or to help home-owners afford the premiums for private LTC insurance. We'll explain the roles of LTCi and RMs in more detail later in this report when we discuss why they play such a small part in financing long-term care in Texas.

Who provides long-term care for the elderly and what difficulties do they face?

Most formal, paid long-term care in Texas is provided by nursing homes or home health companies. We interviewed representatives of both service delivery modalities and here's what they told us.

Nursing homes. We spoke with the presidents of the nursing home trade association representing mostly for-profit facilities (Texas Health Care Association) and the one representing mostly non-profit nursing homes (Texas Association of Homes and Services for the Aging). While there were nuances of difference in their opinions, they agreed entirely on several key points:

- Medicaid reimbursement levels are too low and fail even to cover the cost of providing the care. Even with a recent 12 percent increase, Medicaid nursing home reimbursements are still as much as 20 percent short.
- Direct care staff are difficult to find, hire and retain at the level of compensation Medicaid financing allows.
- Regulatory oversight is complex and tends to focus on process compliance rather than quality outcomes.

Although non-profit nursing homes have considerably more private payers than do for-profit nursing homes, both associations report that residents with private long-term care insurance are only 1 percent to 5 percent of their census, which comports with estimates published by the national insurance trade association America's Health Insurance Plans (AHIP).[11] Neither of the nursing home associations report any revenue from reverse mortgages, the other major potential source of private LTC funding.

This dearth of private financing for nursing homes is very important. On average Medicaid's daily rate is around $106 and includes ancillary costs. Private pay rates are closer to $140 to $150 per day *plus* ancillary costs making the total private pay rate, which would be comparable to Medicaid, around $175 per day or two-thirds higher than what Medicaid pays. BDO Seidman, the national accounting and consulting firm, reports that the shortfall in Texas between allowable Medicaid costs and actual reimbursement for nursing homes was $4.69 per bed day in 2003; $7.83, in 2004; and is projected to be $4.92 for 2006 despite the fact that "[a] 2006 rate increase of almost 12 percent in Texas comes after almost three years of no rate increases . . .."[12]

State staff dispute such claims and complaints but the basic fact that Medicaid is the predominant payer for nursing home care and pays at a rate considerably lower than nursing homes charge private payers is indisputable.

Talking*Point:*

Clearly, Texas serves the long-term care needs of more people through Medicaid and increasingly serves more of them in the home and community-based settings they usually prefer. But has the state saved money? Is the strategy of funding more and more desirable long-term care to more and more Texans viable for the future as the demographic "age wave" mounts?

Home Care. We interviewed representatives of the Texas Association for Home Care (TAHC) and one of its member companies, Outreach Health Services, a large home health company with offices around the state. Here again the facts and complaints were very similar and parallel to those of the nursing home interviewees. Medicaid is the prime payer for long-term home health care in Texas. Medicaid reimbursement rates are very low compared to private pay rates. For example, Outreach said Medicaid pays $10.81 per hour for attendant services whereas the going private pay rate is $16 per hour. TAHC said the base Medicaid rate is $8.36 an hour whereas the private pay rate is $12 to $15 per hour.

"Bill Miller Bar-B-Q pays $7.00 per hour, but the highest wage home health workers can get is $6.50 per hour" and "In Texas we're already at the bottom of the barrel. No state pays less," were two particularly discouraging remarks by TAHC.

Quick*Fact:*

According to the Texas Health and Human Services Commission: "Home and community-based care can be a cost-effective alternative to care in a nursing facility or ICF/MR. In 2003, the average monthly cost of a Medicaid nursing facility resident was $2,377, compared to $1,263 for an adult receiving Community Based Alternatives (CBA) waiver services as an alternative to nursing facility care."

Both the TAHC representatives and Outreach agreed funding home health care instead of nursing home care could save the state enormous sums of money. But the Outreach representatives lamented Medicaid's failure to prevent fraud and abuse by home care workers who often claim more hours than they actually worked. Outreach also noted that not all people on Medicaid are necessarily indigent, that some people move money and hide assets, and even some nurses have observed that "some of these people [on Medicaid] have more money than I do."

How have policymakers in Texas approached the challenge of financing long-term care?

Texas policymakers have approached long-term care financing creatively, ingeniously, and compassionately. Their strategy has been to make the most desirable, least expensive long-term care services (especially home and community-based care) available to as many state citizens as possible. They've pursued this strategy by resourcefully utilizing state and federal Medicaid funds, taking advantage of federally authorized Medicaid waivers, and making use of state-only money to support programs Medicaid will not cover. As a result, it has expanded publicly financed long-term care to more and more Texans.

According to the Legislative Budget Board: "Texas focuses on developing long-term care services that are provided in home and community settings. The availability of these services has significantly reduced the number of persons who otherwise would be cared for in a nursing home."[13]

According to the Texas Health and Human Services Commission: "Home and community-based care can be a cost-effective alternative to care in a nursing facility or ICF/MR. In 2003, the average monthly cost of a Medicaid nursing facility resident was $2,377, compared to $1,263 for an adult receiving Community Based Alternatives (CBA) waiver services as an alternative to nursing facility care."[14]

Texas has operationalized these principles by providing "Primary Home Care," "Community Attendant Services," "Home and Community Based Waivers," "Money Follows the Person" strategies, and "Real Choice Systems Change Grants." In fact, the number of Texans cared for in community settings, which was roughly equal to the number served in nursing facilities in 1997 (approximately 70,000), has skyrocketed to more than 150,000 expected in 2007. During the same period, the number of clients served in nursing facilities has remained between 60,000 and 70,000.[15]

Clearly, Texas serves the long-term care needs of more people through Medicaid and increasingly serves more of them in the home and community-based settings they usually prefer. But has the state saved money? Is the strategy of funding more and more desirable long-term care to more and more Texans viable for the future as the demographic "age wave" mounts?

Does funding more home and community-based services (HCBS) and less nursing home care through Medicaid really save money?

Certainly, when one compares the $2,377 average monthly cost of a Medicaid nursing facility resident in Texas to the $1,263 it costs for an adult receiving Community Based Alternatives (CBA) waiver services, it seems obvious that HCBS costs less than nursing home care. But now consider some countervailing factors.

According to CMS, Medicaid nursing home expenditures in Texas increased from $602 million in 1980 to $2.7 billion in 2004, an average annual increase of 6.4 percent, somewhat less than the average increase for the whole United States, which was 6.9 percent. During the same 25-year period, Medicaid home care costs in Texas increased from $11 million to $819 million, an annual increase of 19.8 percent, much faster than the 17.6 percent national rate. Combined, during the period since 1997 when Texas began diverting Medicaid recipients from nursing homes to home care in earnest, Medicaid nursing home and home care costs have increased from $2.2 billion to $3.5 billion in 2004, a 59 percent increase in eight years.[16] Clearly, the transition from a focus on nursing home care to a focus on home care has not reduced Medicaid long-term care costs for Texas in absolute terms.

Continuing cost increases could simply be a function of serving more people for a longer period of time. When people are able to live at home instead of going to a nursing facility, they tend to be happier, healthier, and live longer. Of course, as people live longer, it becomes more likely they will return to a nursing home later when their physical condition worsens.

The dominant professional opinion among scholars on this subject was solidly established decades ago. For example:

> *When compared to an elderly population for whom traditionally available care is offered, recipients of expanded community-based services do not use significantly fewer days of nursing home care. (1982)*[17]

> *An increasingly large number of studies, including the results of a national channeling demonstration program, have shown that noninstitutional services typically do not substitute for nursing home care, but, rather, represent additional services most often to new populations. (1986)*[18]

> *Given a choice between nursing home care and nothing, many elderly will choose nothing. But when the choice is expanded to include home care, many will choose home care. Thus, the costs associated with large increases in home care more than offset small reductions in nursing home use. (1990)*[19]

Quick*Fact:*

According to CMS, Medicaid nursing home expenditures in Texas increased from $602 million in 1980 to $2.7 billion in 2004, an average annual increase of 6.4 percent, somewhat less than the average increase for the whole United States, which was 6.9 percent.

Although community-based LTC programs proved beneficial to both clients and informal caregivers in the LTC demonstrations, they did not prove budget neutral or cost effective. (1991)[20]

Increased financing for HCB services may be desirable but will not significantly influence nursing home expenditures. . . . We must seek to justify HCB on grounds other than cost effectiveness or clinical efficacy: the debate should focus on how much community care we are willing to purchase as a society, rather than how much money we can save by purchasing these services. (1993)[21]

Talking*Point:*

The idea that funding home and community-based care instead of nursing home care saves money is a pervasive and persistent myth. Funding a full continuum of long-term care for everyone clearly costs more than funding nursing home care for those who choose it or have no other choice medically.

The idea that funding home and community-based care instead of nursing home care saves money is a pervasive and persistent myth. Funding a full continuum of long-term care for everyone clearly costs more than funding nursing home care for those who choose it or have no other choice medically.

Over the past decade, private long-term care insurers have learned this lesson. When LTC insurance was primarily "nursing home" insurance, most policy holders were reluctant to file claims because they preferred to delay nursing home institutionalization. When LTC insurance began covering home care, adult day care, respite care and assisted living—services people want much more than nursing home care—claims and utilization skyrocketed forcing insurance carriers to raise premiums on new business and in some cases on business already in place. Those higher costs and resulting premium increases meant tougher sales, loss of profitability, and terrible publicity for the private long-term care insurance industry.

State governments that emphasize funding HCBS for more people through Medicaid will have the same experience. As public payers of long-term care follow the same course as private insurers—funding home and community based-care instead of only nursing home care—demand will spike and costs will explode. The difference is, unlike private insurers of long-term care, Medicaid will not have cash reserves to meet future claims costs. Thus the pain for public LTC payers when this trend plays out may well be far worse than the private insurers' experience, with at least a foundation of collected reserves upon which to rebuild.

Therefore, the most important questions to ask are:

Who will pay for a full spectrum of long-term care and where will the money come from?

As Executive Commissioner Albert Hawkins of the Texas Health and Human Services Commission told us: "When I look forward to the future aging of the population, especially the growth of the oldest old, I see us straining even to cover the [the relatively lower] cost of HCBS. The problem is the gross numbers, not just the per-recipient costs. It's just the raw number of people getting older in Texas."[22]

If Texas' Medicaid program is straining even now—with a good economy, Medicaid rolls down, tax receipts up, and the "age wave" only starting to build—what will happen if another recession comes, Medicaid rolls go up, and tax receipts go down at a time when the inevitable aging of the baby boom generation places strains on the system far exceeding anything we've ever seen before? The budget struggle Texas faced in 2003 may seem like the good old days when the next recession arrives.

The only way out of this conundrum is to find new funding sources for long-term care to supplement what can reasonably be expected to come from taxpayers by way of the Medicaid program. So, let us ask now why so many Texans depend on Medicaid for their long-term care, why so little long-term care financing comes from private rather than public sources, and whether changes in public policy might relieve the fiscal burden on Medicaid by attracting more long-term care financing from private sources.

How difficult is it for frail or infirm elderly citizens to become eligible for Medicaid long-term care benefits?

Conventional wisdom holds, and federal and state rules seem to confirm, that eligibility for Medicaid long-term care benefits requires almost total impoverishment: income at or near the poverty level and no more than $2,000 in assets. But the truth is far more complicated. In actuality, there is no hard limit on how much income and how many assets a Medicaid LTC recipient may have and still get the program to pay for his or her long-term care. When examining how the system really works, evidence shows that qualifying for government-financed long-term care benefits is so easy there is little wonder why so few people pay privately or plan early for long-term care expenses.

Medicaid long-term care income eligibility is slightly tighter in Texas than in most other states because Texas uses an "income cap" eligibility system. That means anyone with income over 300 percent of the Supplemental Security Income (SSI) monthly allowance isn't eligible. The limit is $1,869 per month in 2007. That's not enough to pay privately for nursing facility care, but it's too much to qualify for Medicaid—unless one sets up a Qualified Income Trust (QIT).

QITs allow Medicaid applicants to divert excess income into the trusts in order to become eligible. The excess income has to be used to offset Medicaid's cost for the trustor's long-term care, but the trustor becomes Medicaid eligible not just for long-term care but also for Medicaid's other acute care benefits which supplement what Medicare covers. In other words, with or without a QIT, no one has to be at a poverty-level of income in Texas to qualify for Medicaid LTC benefits, they only need a cash flow problem, i.e. too little income to pay privately for nursing home care.

What about assets? Some argue that the state's $2,000 limit on cash assets is too draconian, but this limit must be considered along with the unlimited exempt assets provided for under federal law. The exempt assets under federal law include:

- A home and all contiguous property is exempt up to $500,000.
- One business including the capital and cash flow of unlimited value is exempt.
- One automobile of unlimited value, and two cars under certain circumstances in Texas are not counted.
- Prepaid burial funds for the Medicaid recipient and the recipient's whole family are exempt up to any amount.
- Home furnishings and personal property are rarely tracked but even when they are, unlimited amounts are exempt as long as they are not held as investment property.
- Term life insurance is exempt in any amount.
- Many other assets are exempt in limited amounts.

Quick*Fact:*

Medicaid long-term care income eligibility is slightly tighter in Texas than in most other states because Texas uses an "income cap" eligibility system. That means anyone with income over 300 percent of the Supplemental Security Income (SSI) monthly allowance isn't eligible. The limit is $1869 per month in 2007.

The bottom line is that any amount of assets can easily be preserved in exempt assets.[23]

In addition to these already very generous income and asset eligibility rules, a special practice of law called Medicaid estate planning helps Texans with even higher income and assets reconfigure their wealth in order to qualify for Medicaid LTC benefits by means of artificial self-impoverishment. An internet search for "Medicaid planning in Texas" turned up 1.2 million hits on December 14, 2006. Here are some examples of the Medicaid planners' sales pitches:

> *With the establishment of a Miller Trust, a person can obtain Medicaid nursing home coverage despite having too much income to qualify for such coverage. . ..*[24]
>
> *[A] skilled Medicaid planning lawyer can minimize the impact of nursing home costs and Medicaid eligibility income levels while preserving assets and the estate.*[25]
>
> *We specialize in helping single patients qualify for Texas Medicaid assistance, while preserving most of their assets and savings for their families. . . . We show you how to transfer assets and qualify for Texas Medicaid sooner. Medicaid eligibility is no secret . . . you just need to know how it works. This easy-to-understand Medicaid information is what you've been looking for. How do we know? Because* ***we've helped thousands of families qualify for Medicaid while saving millions of dollars****—people just like you. . . . FACT: Single Texas Residents can legally transfer up to 100 percent of their assets to their family and still quickly qualify for Medicaid to pay for Nursing Home or other long term care expenses—no matter what you've been told—even if you are already in care?*[26] *[Emphasis added.]*

Talking*Point:*

Based on state and federal Medicaid long-term care eligibility rules and on the published opinions of professional legal and financial advisers in the state, qualifying for public assistance to pay long-term care bills without significantly spending down one's own wealth is very easy to do.

It's not just lawyers who practice Medicaid planning. This offer was made by an insurance agent:

> *With proper Medicaid Planning, you and your loved one can keep either all or most of your assets and still qualify for Medicaid. We NEVER charge a fee!! We have helped families save hundreds of thousands of dollars each year, keep their assets, keep their homes and ranches, keep their rental properties, pass their property on to their kids and grandkids AND STILL qualify for Medicaid in a Nursing Home or an Assisted Living Community in Texas!!*[27]

Clearly, based on state and federal Medicaid long-term care eligibility rules and on the published opinions of professional legal and financial advisers in the state, qualifying for public assistance to pay long-term care bills without significantly spending down one's own wealth is very easy to do. But is it actually being done in Texas?

Do people actually qualify for Medicaid long-term care benefits in Texas while preserving significant income and assets?

For this study, we interviewed a group of 16 Medicaid long-term care financial eligibility workers and supervisors representing local offices from throughout the state of Texas. They reached a consensus estimate from their professional experience that 15 percent to 20 percent of the entire elderly, long-term care Medicaid caseload in the state uses Qualified Income Trusts to achieve eligibility despite having incomes in excess of Texas "income cap" of $1,869 per month. In wealthier areas of the state, QITs are much more common. For example:

"We have certain nursing homes where three out of five Medicaid residents have QITs, such as in Dallas and Fort Worth." And "In Austin, 60 percent of nursing home applications include QITs." Although estimates of the proportion of recipients on the Community Based Alternatives program with QITs are lower, the workers said that 75 percent to 80 percent of CBA participants come into the program by qualifying first for nursing home care in order to bypass the long waiting list for CBA. They can use the QIT to qualify at the nursing home level and retain it when they transfer to the CBA. Estimates of the incidence of QITs by Medicaid LTC financial eligibility specialists working at the agency's offices in Austin were much lower, but they clarified that they only see the most complex or unusual cases and that field eligibility staff would be more likely to know what is happening in the general caseload.

On the asset side of the ledger, field eligibility workers commented about the Extended Protected Resource Amount (EPRA) for community spouses of institutionalized Medicaid recipients. To prevent "spousal impoverishment," the well or community spouse (usually but not always the wife) may retain all of her own income plus enough of the Medicaid spouse's income to bring her up to the federally mandated Minimum Monthly Maintenance Needs Allowance (MMMNA) which is $2,541 for 2007. If after transferring the Medicaid spouse's income (which would otherwise have offset Medicaid's cost of his care) to the community spouse, she still has less than the MMMNA, she can then receive enough of the Medicaid spouse's assets, that would otherwise have to have been spent down or sheltered, so that the interest on the extra assets will bring her up to the MMMNA.

Now, here's what concerns the eligibility workers. Under federal rules, couples with one spouse on Medicaid for LTC may retain half their joint assets not to exceed $101,640 in 2007. Assets over that limit are supposed to be spent for the infirm spouse's care before Medicaid starts paying. But when the community spouse's income is low enough to justify an EPRA, as it frequently is, the couple is allowed to transfer assets from the ill spouse to the community spouse in excess of the $101,640 limit as described in the preceding paragraph. The amount of extra assets that can be retained by the community spouse is based on the current interest rate for a $1,000 Certificate of Deposit (CD). According to the state staff, the problem is that "attorneys have a worksheet and will show you the lowest rate possible. They shop for the lowest possible interest rate available in the marketplace and provide this evidence to the worker who must accept it."

The net effect is that many thousands of extra dollars can be protected in this way. For example, assume the community spouse has $500 per month of her own income (mostly Social Security). The Medicaid spouse has $1,000 per month of income all of which is transferred to the community spouse instead of offsetting his cost of care. That still leaves the community spouse nearly $1,000 per month short of the MMMNA. So, she's able to retain extra assets above the limit of $101,640 sufficient to generate $1,000 per month of income. With a 5 percent CD, she could retain only $240,000 extra. With a 3 percent CD, however, she could retain $400,000, making the total protected amount in excess of half-a-million dollars. Workers spoke of one Medicaid disability case that was able to protect a million dollars in this way. Medicaid planners and their clients are incentivized by Medicaid eligibility rules to shop for the lowest possible interest rates on the clients' capital, allowing them to shelter an indeterminate amount, but possibly tens of millions of dollars statewide, from private-pay long-term care spend down.

Quick*Fact:*

Under federal rules, couples with one spouse on Medicaid for LTC may retain half their joint assets not to exceed $101,640 in 2007. Assets over that limit are supposed to be spent for the infirm spouse's care before Medicaid starts paying.

How common is this EPRA method of protecting extra assets? Workers estimated that it affects around three percent of the entire elderly nursing home and CBA caseload. But for spousal cases only, which are about 30 percent of the caseload, they said around half of the nursing home cases have EPRAs. This is one complicated example of how middle class families preserve substantial assets while qualifying for Medicaid, and how Medicaid planning specialists earn substantial incomes helping them do so.

There are many other methods to protect assets by means of Medicaid planning, such as the purchase of exempt resources with otherwise countable assets, the use of annuities to convert countable assets into non-disqualifying income, transfers of assets before the five-year look back period, and even divorce. Are such techniques actually used? Does the public get advice on how to qualify for Medicaid LTC benefits? Here's a sampling of what the field eligibility workers told us:

"Estate planners and their assistants contact us frequently with eligibility questions. Often, they are former Health and Human Services Commission employees." "We are treated like their free paralegals." "When we close one loophole, the elder law attorneys just open three new ones." "They are always three steps ahead of us." "If you have one legislator with a mother who got in this way [using an EPRA], there goes any possibility for reform." "If you have a large concentration of elder care attorneys in your area, you get a lot of calls; NAELA [the National Academy of Elder Law Attorneys, the Medicaid planners' trade association] is really active in some communities. There are huge groups of [Medicaid planning] attorneys from Houston to Dallas to Austin." "Among our spousal nursing home eligibility cases, at least half have attorneys involved or an estate planner."

Talking*Point:*

Capping Medicaid's home equity exemption at $500,000, excludes few people from eligibility when the median home value in Texas is only $82,500.

Didn't the Deficit Reduction Act of 2005 put a stop to this kind of thing? Has Texas implemented the DRA?

The *Deficit Reduction Act (DRA)*, enacted February 8, 2006, included several measures to discourage the overuse of Medicaid by people with substantial income and assets. To its credit, Texas has already implemented most of these provisions in the DRA. Unfortunately, the DRA's changes in Medicaid eligibility rules and its provisions to encourage more private long-term care insurance have not solved the problem of excessive dependency on Medicaid LTC financing. In fact, some of the DRA's provisions may make Medicaid more attractive than ever to the public as a long-term care funder. Here's what the DRA has done and why it matters.

The DRA's measures to place stricter limits on Medicaid LTC eligibility are a step toward protecting the program as a safety net for the poor, but they are unlikely to prevent most people from qualifying easily for the program. For example, capping Medicaid's home equity exemption at $500,000, excludes few people from eligibility when the median home value in Texas is only $82,500.[28] The rule still allows billions of dollars to be protected from private-pay long-term care expenses. It leaves Medicaid in the role of free "inheritance insurance" for baby boomer heirs against the risk their parents' real estate wealth would be used for long-term care.

The DRA extended the Medicaid transfer of assets look-back period from three to five years. That's the period of time during which assets transferred for less than fair market value for the purpose of qualifying for Medicaid are supposed to cause an ineligibility penalty equal in months to the amount of assets so transferred, divided by the average monthly cost of a nursing home in the state. But few people plan for long-term care that far in advance anyway, so the impact of this change on Medicaid expenditures is unlikely to be very great.

More significant is the DRA rule that changes the date a transfer of asset penalty begins from the date of the transfer to the date a person applies for Medicaid or enters a nursing home. That change was intended to eliminate the most common Medicaid planning gimmick previously in use. The "half-a-loaf" strategy called for people to give away half their countable assets, shelter the rest, and avoid spending any of their own money for long-term care by waiting for the shortened penalty period to expire. Since the DRA, the penalty period has been changed to begin when it would previously have expired, thus effectively eliminating the "half-a-loaf" strategy. This change worried nursing homes and senior advocates that it would result in many people ending up in need of nursing home care, without any assets remaining and ineligible for Medicaid because of the later penalty date. Such a result was unlikely to happen because the new rule eliminates the incentive to transfer assets in the first place and prevents Medicaid planners from recommending "half-a-loaf." In fact, neither Medicaid eligibility workers nor nursing home representatives interviewed for this study reported that this problem has occurred to any significant extent.

The DRA also put an end to rounding down monthly asset transfers, a technique that used to allow people to give away one dollar less than double the average monthly cost of a nursing home without incurring an eligibility penalty beyond the single month of the transfer. But Texas had already implemented that change before the DRA was passed. Likewise, the DRA stopped the strategy of transferring assets before income to bring community spouses up to the MMMNA, but again Texas had made that change already. Texas was also ahead of the DRA curve in partially curbing the use of annuities to qualify for Medicaid. In fact, the DRA implemented Texas' strategy in that regard.

Although the DRA made these changes to control excessive utilization of Medicaid and Texas implemented them, all the techniques to qualify for Medicaid LTC benefits without spending down that were described in the previous section remain in effect. The DRA's provisions allowing the implementation of "Long-Term Care Partnerships" are also unlikely to make much difference. The Partnerships allow people to be excused from Medicaid spend down liability in an amount equal to the total value of the LTC insurance they purchase and use. Texas is considering the implementation of a long-term care partnership program. But as long as Medicaid spend down remains so easy to avoid, the Partnership's spend down exemption is unlikely to incentivize many people to buy LTC insurance who would not have done so otherwise. Another consideration is whether or not Medicaid, already strained financially by long-term care costs, will be able to meet commitments made today to fund long-term care decades in the future for people with substantial assets protected by LTC partnership policies.

Despite these reservations about its likely efficacy, however, Texas would be well advised to implement the LTC Partnership program. The program will help educate the public about the need for long-term care planning and engage the public and private sectors in a cooperative effort to ensure the availability of high-quality insurance products. To maximize the LTC Partnership's impact, however, the state must also curb the easy access to Medicaid-financed long-term care by people with sufficient income and assets to insure privately.

A final observation about the DRA is that it actively encourages more of the same strategy Texas is already pursuing to divert as many people as possible from nursing homes to home and community-based care. The DRA allows states to pursue HCBS through the state plan process instead of forcing them to pursue complicated waivers. A $1.75 billion grant fund has been established to encourage "Money Follows the Person" to rebalance long-term care systems, a strategy Texas pioneered. The risk in all this, as we've already explained, is that making Medicaid long-term care benefits ever more attractive before curbing the easy access to such benefits inherent in the eligibility system even after the DRA, runs the risk of overwhelming Medicaid and crowding out alternative, private sources of LTC financing by discouraging the public from worrying about and planning for long-term care. A public anesthetized to the risk of long-term care by over 40 years of Medicaid and Medicare financed care will not accurately and objectively assess the future risk of long-term care as demographic pressures impede those public programs' ability to continue covering LTC costs.

QuickFact:

Through the *Omnibus Budget Reconciliation Act of 1993* (OBRA 93), Congress required all states receiving federal Medicaid matching funds to implement estate recovery programs.

Does all this really make any difference now that Texas will recover from the estates of deceased Medicaid long-term care recipients?

Through the *Omnibus Budget Reconciliation Act of 1993 (OBRA 93)*, Congress required all states receiving federal Medicaid matching funds to implement estate recovery programs. The purpose was to ensure that people who sheltered assets while receiving Medicaid financed long-term care would pay back the cost of their care before passing their wealth unencumbered to heirs. This "pay me now or pay me later" strategy was intended to encourage people to plan early and insure for long-term care in order to protect their savings, but without forcing them to impoverish themselves before receiving help from the state if they failed to plan or insure.

Most states implemented Medicaid estate recovery as required and with varying degrees of success. Protections in the federal law made recovery quite difficult and avoidance quite easy, especially with legal advice. But in Texas' case, it was all moot, because the state did not implement Medicaid estate recoveries until recently. Thus, Medicaid remained for 12 years after OBRA '93 a wide-open, free inheritance protection system for long-term care recipients and their heirs.

That situation is finally beginning to change. The Texas Legislature authorized a Medicaid estate recovery program in 2003, and rules finalized in December 2004, became effective in March 2005. A private contractor has been hired to make the recoveries, but at the time of our interviews, no claims had been filed against any estates and Texas' Medicaid estate recovery program had collected only $325,000 in voluntary contributions. A fine feature of the program is that all proceeds will be recycled back into Medicaid to support long-term care instead of being absorbed as they are in many states into the general fund.

Once it becomes fully operational, will estate recovery in Texas contribute significant resources to offset the cost of Medicaid? Will it help to persuade the public to pay privately for long-term care and to plan early to save, invest or insure against that risk? Both points are doubtful.

The Texas Medicaid estate recovery program is mandated by state law to exempt all estates of $10,000 or less and is prohibited from pursuing state claims less than $3,000. The average estate recovery in Oregon, the state with the most successful estate recovery program in the country, is $2,500. By excluding smaller estates and lower claims, Texas has handicapped its Medicaid estate recovery program and will likely recover much less non-tax revenue to fund its program than would otherwise be the case.

Furthermore, estate recovery is a very politically sensitive issue in Texas. Long-standing constitutional homestead protections prevented creditors' claims against home equity until recently, and many object to collecting from the estates of the elderly in general. Ultimately, unless and until Medicaid estate recovery claims the moral high ground—that public assistance should be a safety net for the poor and not a financial hammock for the prosperous—it is unlikely to contribute significantly to Medicaid's coffers nor to encourage people to avoid Medicaid dependency by saving, investing or insuring for long-term care costs.

On a hopeful note, the Texas Medicaid estate recovery staff understand the challenges and are eager to make the program a positive force toward funding long-term care and encouraging responsible long-term care planning.

Does the availability and attractiveness of Medicaid-financed long-term care benefits affect the amount of private LTC financing?

First, what are the private financing alternatives that might relieve some of the financial burden of long-term care on Medicaid? There are really only three.

The first is private income and assets. We've already seen that income usually does not stand in the way of qualifying for Medicaid but that once on Medicaid, a person's income must be used to offset Medicaid's cost of care. While that private income relieves the burden on Medicaid, we've also seen how instability with both private pensions and Social Security in the future could devastate Medicaid's ability to fund long-term care. Assets, on the other hand, are exempted in practically unlimited amounts and are invulnerable to private LTC costs unless recaptured through the notoriously unreliable process of estate recovery. Thus, Medicaid has the effect of eliminating worry that long-term care costs will cause a personal shortfall of income or assets. It de-sensitizes the public to long-term care risk.

The second potential private funding source for long-term care is home equity. Nationwide, more than 80 percent of seniors own their homes and over 70 percent of them own their homes free and clear. Two trillion dollars lie fallow in the home equity of elderly Americans, mostly unused to provide access for them to quality long-term care. According to the National Council on the Aging, older American households could tap on average $72,000 each from their home equities by means of reverse mortgages to help finance their long-term care.[29] Average home equity of the elderly in Texas is somewhat less than the national average but still substantial. On the other hand, home ownership by elderly Texans is greater than the

Quick*Fact:*

Nationwide, more than 80 percent of seniors own their homes and over 70 percent of older homeowners own their homes free and clear. Two trillion dollars lie fallow in the home equity of elderly Americans, mostly unused to provide access for them to quality long-term care.

national average: 81.8 percent compared to 78.6 percent for the country as a whole, ranking Texas 18th in that category.[30]

What are reverse mortgages and what role do they play in funding long-term care for Texans? Reverse mortgages are federally insured and regulated loans that permit people 62 years of age or older to withdraw otherwise illiquid equity from their homes in lump sums, monthly payments, or through open-ended lines of credit without having to make monthly payments. The loans only come due after the borrowers die, move out, or sell their homes. It is beyond the scope of this report to describe reverse mortgages in more detail or to discuss their pros and cons.[31] However, we interviewed several reverse mortgage (RMs) lenders for this study and learned that although the market for RMs is growing very rapidly in Texas, it is extremely rare for seniors to use these loans for the purpose of financing their long-term care. Although constitutional homestead protections in Texas prevented home equity lending until 1997 and the first reverse mortgage was not funded in Texas until 2001, it is reasonable to believe that RMs would be playing a much larger part in funding long-term care by now if it weren't for Medicaid's exemption of half a million dollars of home equity. The experts we interviewed estimated that only a couple thousand reverse mortgages were funded in Texas last year for any reason and few or none for long-term care.

Talking*Point:*

Our interviewees said that Texas does little or nothing to incentivize the purchase of long-term care insurance and that, arguably, the Texas Department of Insurance over-regulates the product making it very difficult, for example, to get advertising and marketing pieces approved.

The third potential private financing source for long-term care is private insurance. Long-term care insurance (LTCi) comes in many forms and information about it is readily available from numerous books and reports. Suffice it to say that agents marketing the product in Texas told us that high quality, affordable private insurance is readily available for long-term care in Texas but very difficult to sell. They estimated that only three dozen companies sell the product in the state and that perhaps 200 agents specialize in long-term care insurance statewide. AHIP, the national insurance trade association, estimates that only one to five percent of Texans age 50 or older have purchased LTCi.[32] Our interviewees said that Texas does little or nothing to incentivize the purchase of long-term care insurance and that, arguably, the Texas Department of Insurance over-regulates the product making it very difficult, for example, to get advertising and marketing pieces approved.

Does the easy availability of Medicaid-financed long-term care further impede the market for LTCi?

Jeff Brown and Amy Finkelstein, two scholars at the National Bureau of Economic Research, answer this question with an unqualified yes. In one study, they say:

> *We examine the interaction of the public Medicaid program with the private market for long-term care insurance and estimate that Medicaid can explain the lack of private insurance purchases for at least two-thirds and as much as 90 percent of the wealth distribution, even if comprehensive, actuarially fair private policies were available.*[33]

In another study, they conclude:

> *[I]f every state in the country moved from their current Medicaid asset eligibility requirements to the most stringent Medicaid eligibility requirements allowed by federal law—a change that would decrease average household assets protected by Medicaid by about $25,000—demand for private long-term care insurance would rise by 2.7 percentage points.*[34]

As we've already explained, the "most stringent Medicaid eligibility requirements allowed by federal law" are extremely lenient, allowing Medicaid LTC recipients to qualify despite possessing very substantial incomes and while retaining virtually unlimited assets. One wonders if a slight reduction of Medicaid's asset protections of $25,000 would produce a 2.7 percent increase in LTC insurance market penetration, raising the base of 9.1 percent to 11.8 percent market penetration according to the authors, what would a more substantial reduction, such as placing the home equity exemption at $50,000 instead of $500,000, cause?

To its credit, Texas has taken some important steps toward increasing the market for long-term care insurance. Governor Perry recently sent a letter to all Texans aged 45 to 65 encouraging them to think about how they'll pay for long-term care and urging them to consult information sources like the federal government's "Own Your Future" campaign (www.aoa.gov/ownyourfuture) and the state's "Aging Texas Well" initiative (www.agingtexaswell.org). The state legislature is considering a proposal for Texas to participate in the newly revived Long-Term Care Partnership program to encourage the purchase of LTCi by forgiving some or all of the Medicaid spend-down liability in the future.

It remains doubtful, however, that any amount of education or positive financial incentives will persuade people to plan for long-term care and save, invest or insure for the risk as long as Medicaid-financed long-term care benefits are easy to obtain even after the insurable event occurs. As long as people can ignore the risk of long-term care, avoid the premiums for private insurance, wait to see if they ever need long-term care, and if they do, shift the cost to Medicaid, the public is unlikely to embrace the idea of taking early personal responsibility for this risk. The Texas Health and Human Services Commission acknowledged as much in testimony before a Joint Hearing of the Senate Committee on State Affairs and Senate Committee on Health and Human Services on October 17, 2006: "Interplay of Medicaid in the LTC system as a whole has not supported personal responsibility for future care needs planning" and "Medicaid coverage of LTC may serve as a disincentive to private purchase of LTC insurance or other financial planning options for LTC needs."[35]

Why don't legislators and public policymakers propose and implement restrictions on Medicaid long-term care eligibility?

The first reason why Medicaid long-term care eligibility rules remain so lenient and generous in Texas is that federal law prevents stricter rules in most regards. But that explanation only begs the question why federal legislators and policymakers don't tighten up the system more. The underlying reason holds equally for federal and state officials.

Medicaid long-term care eligibility rules are very politically sensitive. The public has come to expect that long-term care is not a personal responsibility. Any movement toward placing more of the responsibility for long-term care financing on individuals or families arouses strong opposition from senior advocates. Seniors carry a lot of political weight and they bring it to bear very effectively.

Most people don't know who pays for long-term care, nor do they care. Whether it is paid for by Medicaid or Medicare is less important than the fact that *somebody* pays. Often it's not until families face a long-term care crisis that they become sensitized to this issue. But once Dad has a stroke or Mom succumbs to dementia, the path of least resistance is to qualify

Talking*Point:*

Most people don't know who pays for long-term care, nor do they care. Whether it is paid for by Medicaid or medicare is less important than the fact that *somebody* pays. Often it's not until families face a long-term care crisis that they become sensitized to this issue.

for Medicaid. While few people at any given time face extreme long-term care costs, their intensity of concern and the political pressure they assert are substantial.

Not the least of the forces pushing politicians to keep Medicaid access wide open are the businesses that benefit from Medicaid financing. Medicaid estate planning is the cash cow supporting most "elder law" legal practices; Medicaid planners fight every effort to close eligibility "loopholes." Nursing homes and home health agencies struggle to manage on Medicaid's low reimbursements, but at least the public program pays reliably what it pays, unlike some private payers from whom collections may be difficult or impossible. So LTC providers sometimes oppose measures that delay or prevent eligibility for public financing.

Talking*Point:*

First, federal and state officials can recognize why they have a problem with long-term care. To wit, the government has been giving it away since 1965 and has therefore crowded out private financing alternatives like personal spend down, reverse mortgages and long-term care insurance. If they stop doing what they have always done, they will get a different result.

Public officials and state legislators are walking a professional and political tightrope when it comes to long-term care. Lean too far toward preserving Medicaid as a safety net for the poor, thus encouraging private financing alternatives for long-term care, and they risk losing their jobs or the next election. If they lean the other way, toward making Medicaid long-term care more attractive and easier to obtain, they run the risk of digging Texas ever deeper into a fiscal hole.

Is the situation hopeless?

By no means is the situation hopeless. Texas and the rest of the country will end up resolving the long-term care financing challenge in roughly the same way whether or not they do it through responsible public policy or let the current system drift toward collapse. Here are the two alternatives:

First, federal and state officials can recognize why they have a problem with long-term care. To wit, the government has been giving it away since 1965 and has therefore crowded out private financing alternatives like personal spend down, reverse mortgages and long-term care insurance. If they stop doing what they have always done, they will get a different result. Target Medicaid to the truly needy and use the savings to educate the public about long-term care and to incentivize the use of private financing alternatives. Almost immediately, the system will begin to right itself. Seniors will get better access to higher quality care across a wider spectrum of care if they pay privately. Long-term care providers will be more financially solvent when they have fewer patients on Medicaid with its low reimbursements. Medicaid will be able to do a better job for a smaller number of people who truly need it. Home and community-based services will prosper and grow because people spending their own money or their insurance benefits will seek out the lowest cost, least institutional care instead of heading straight to nursing homes to get Medicaid. The reverse mortgage and long-term care insurance industries will boom, creating more jobs and generating more tax revenue. The fiscally counterproductive business of Medicaid estate planning will decline, a benefit for tax payers and everyone else, except the Medicaid planners themselves.

Second, the other alternative is for federal and state officials to stay on the same course they're on: keep making Medicaid long-term care benefits more and more attractive without significantly cutting back on easy eligibility for those benefits. On that path lies insolvency for Medicaid in the future as current fiscal pressures become worse and worse. As the "age wave" mounts, more and more people will demand Medicaid LTC benefits. As pressures on private pensions, Social Security and Medicare grow, those sources that have traditionally

offset Medicaid's long-term care costs will wane. Texas' home and community-based services infrastructure will become ever more starved for financing as it becomes more and more obvious that the only way to control Medicaid's LTC costs is to fund nursing home care which most people would rather avoid. But even nursing home reimbursements will be too much for Medicaid to cover adequately. Access and quality to all levels of long-term care will decline for people dependent on Medicaid. In time, Medicaid will be forced to restrict access to only the neediest Texans or disappear altogether as the long-term care safety net. If Medicaid fails entirely, a lot of people will be unnecessarily hurt, especially the poor who have no other option but Medicaid. The middle class and affluent will have their home equity to turn to for long-term care so they will get good care at the expense of their legacies. The reverse mortgage industry will boom. Once home equity is at risk for long-term care, people will buy LTC to protect it. This will be especially true for baby boomer heirs who lose their own inheritances to their parents' long-term care costs and don't want the same thing to happen to their own legacies for their children. Then, the LTC industry will boom. And in time, things will sort out more or less as they would have had we followed scenario one, the more responsible public policy course.

CONCLUSION

Long-term care financing is not the enigma it's been made out to be. Over the years, people have wondered if the risk and cost of long-term care is so great, why is the public in denial? Why do so few people worry about long-term care and so many end up in nursing homes on public assistance? How can publicly financed long-term care programs survive the onslaught of aging baby boomers? What can we do to prevent the "age wave" from capsizing the ship of state? The answers to these questions are no mystery once we understand the perverse incentives within well-intentioned public policy that have caused the problems.

Medicare and Medicaid finance most of the formal, professional, paid long-term care services Texans receive. Medicare has no financial eligibility limits and is available to almost all Americans over the age of 65. Medicaid, which was intended to be a means-tested public assistance program, is actually, as we've explained, routinely available to finance the long-term care of most Texans. The average person in terms of income and assets who has a nursing home level of medical need qualifies easily for Medicaid long-term care benefits. Texans with substantially higher income and assets qualify by doing little more than purchasing exempt assets with otherwise countable resources. Citizens with even very large incomes and assets can still obtain Medicaid long-term care benefits by retaining the counsel of legal specialists in Medicaid estate planning.

Under the circumstances, there is little wonder that most Texans don't worry about long-term care, don't use their home equity to pay for it, don't purchase long-term care insurance against the risk, and end up if and when a long-term care crisis occurs dependent upon assistance from the state as the only alternative to consuming their own wealth and their heirs' inheritances. All that remains for this report is to suggest what public policymakers in Texas should do about this situation. To a large degree, the state's hands are tied by federal laws and regulations that prevent solving the problem by returning Medicaid to the poor and thus unleashing the potential financing from reverse mortgages and long-term care insurance. But even within those constraints, there are many things Texas can and should do.

Talking*Point:*

Medicare and Medicaid finance most of the formal, professional, paid long-term care services Texans receive. Medicare has no financial eligibility limits and is available to almost all Americans over the age of 65. Medicaid, which was intended to be a means-tested public assistance program, is actually, as we've explained, routinely available to finance the long-term care of most Texans.

RECOMMENDATIONS

- Realistically assess the ability of Medicaid to continue financing most long-term care in Texas. If that's not feasible, as most of our interviewees believed, focus intensely on how to target Medicaid more narrowly to the needy and encourage those who are able, to pay privately for long-term care.
- Reassess Texas' strategy to fund more and more attractive home and community-based services for more and more Medicaid recipients, prioritizing those who are truly needy and diverting others to private financing alternatives.
- Study a valid random sample of Medicaid LTC cases to estimate the incidence in the statewide caseload of income and asset preservation techniques. For example, how many nursing home and Community Based Alternatives cases utilize Qualified Income Trusts or Extended Protected Resource Amounts? How many cases involved the purchase of exempt assets, or the use of annuities, or other such methods to qualify? Ascertain the overall cost to the state of these and other similar practices.
- Require the use of the highest interest rate widely available for determining the EPRA instead of allowing the lowest rate a Medicaid recipient or legal advisor can find. Set a more rational limit on how much extra money can be protected using the EPRA to prevent cases like the Medicaid millionaire. Seek a waiver of federal rules if necessary to do this.
- Conduct a study of Medicaid estate planning techniques. What types of strategies are being used? What is their incidence? What is the cost impact to the state?
- Finish implementing any remaining provisions of the *Deficit Reduction Act* that will help discourage over-utilization and abuse of Medicaid long-term care benefits. Implement a Long-Term Care Partnership program as newly authorized by the DRA to encourage the purchase of private long-term care insurance.
- Hire or contract with additional attorneys on a contingency basis to represent the state and help eligibility staff when medicaid planners challenge state decisions on Medicaid long-term care eligibility.
- Eliminate the limits that prevent estate recoveries on estates of less than $10,000 or for state claims of $3,000 or less. Instead, let Medicaid estate recovery personnel decide what is cost-effective to recover and what isn't. Conduct a study of Medicaid estate recovery best practices.
- Openly confront the political sensitivity of controlling Medicaid long-term care eligibility. Publicly emphasize that the sentiment "I paid my taxes, I'm entitled to Medicaid" is a recipe for fiscal disaster. Underscore the benefits of being able to pay for one's own long-term care in terms of better access, quality and choice.

Talking*Point:*

There is little wonder that most Texans don't worry about long-term care, don't use their home equity to pay for it, don't purchase long-term care insurance against the risk, and end up if and when a long-term care crisis occurs dependent upon assistance from the state as the only alternative to consuming their own wealth and their heirs' inheritances.

- Review Medicaid long-term care cases to determine the level of billing fraud and consider ways and means to stop it. Use sampling techniques to estimate error rates and require vendors to lower the incidence in their caseload to within tolerance levels.
- Study reverse mortgages and long-term care insurance as potential private long-term care financing alternatives to offset Medicaid expenditures. Make information available to the public about these products. Incentivize the use of RMs and LTCi with tax incentives such as a sales tax rebate for people who pay for their own LTC with a RM or who purchase LTCi against future costs.
- Seek a waiver from the federal Centers for Medicare and Medicaid Services to allow the state of Texas, at least in a portion of the state, to experiment with more rational Medicaid eligibility rules such as a $50,000 cap on the home equity exemption, a ten-year look back period for asset transfers done to qualify for Medicaid, stronger authorities to pursue liens on real property and estate recovery, etc.

In general, remember Lincoln's advice in his "House Divided" speech: "If we could first know where we are and whither we are tending, we could better judge what to do and how to do it." Find out, then do it. 

ENDNOTES

[1] Legislative Budget Board, "Fiscal Size Up: 2006-07 Biennium," http://www.lbb.state.tx.us/Fiscal_Size-up/Fiscal_Size-up_2006-2007_0106.pdf (last accessed Dec. 11, 2006) 37.

[2] Source of statistics in this section is Mary Jo Gibson, Steven R. Gregory, Ari N. Houser, Wendy Fox-Grage, "Across the States: Profiles of Long-Term Care 2004: Texas" (AARP Public Policy Institute, Washington, D.C., 2004) http://assets.aarp.org/rgcenter/post-import/d18202_2004_ats_tx.pdf, last accessed Dec. 13, 2006.

[3] Ibid.

[4] Federal Financial Participation in State Assistance Expenditures, FY 2007, http://aspe.hhs.gov/health/fmap07.htm, last accessed Dec. 20, 2006.

[5] Texas Health and Human Services Commission, "Texas Medicaid in Perspective: Fifth Edition" (June 2004) http://www.hhsc.state.tx.us/medicaid/reports/PB5/PinkBookTOC.html (last accessed Dec. 11, 2006) 4-18 to 4-19, footnotes omitted.

[6] Legislative Budget Board, op. cit., 111.

[7] "Facing Facts Quarterly: A Report about Entitlements & the Budget from The Concord Coalition, Volume II, Number 3, New Series (Oct. 2006) 4, http://www.concordcoalition.org/facing-facts/2006/FacingFacts-061012.pdf?emc=intellicontact&m=3461186&v=1003173080&l=2, last accessed Dec. 18, 2006.

[8] Although Social Security is not usually considered to be a financing source for nursing home care, the fact is that it contributes very significantly albeit indirectly as "spend-through." Social Security spend-through refers to income most seniors collect in the form of Social Security benefits that must be contributed toward their cost of care when they receive nursing home services paid for by Medicaid. According to the Health Care Financing Administration (since renamed the Centers for Medicare and Medicaid Services): "An estimated 41 percent . . . of out-of-pocket spending for nursing home care was received as income by patients or their representatives from monthly social security benefits." Helen C. Lazenby and Suzanne W. Letsch, "National Health Expenditures, 1989," *Health Care Financing Review* 12, no. 2 (Winter 1990) 8. Later research confirmed that Social Security spend-through in 1997 was almost half (49.4 percent) of nursing home out-of-pocket costs and fully 15.3 percent of total nursing home expenditures. Nelda McCall, "Long Term Care: Definition, Demand, Cost, and Financing," in Who Will Pay for Long-Term Care? ed. Nelda McCall (Chicago: Health Administration Press, 2001) 19.

[9] "Facing Facts Quarterly," op. cit., 4.

[10] Legislative Budget Board, op. cit., 111.

[11] Susan Coronel, Research Findings: Long-Term Care Insurance in 2002 (America's Health Insurance Plans, Washington, D.C., 2004) 29, http://www.ahip.org/content/default.aspx?bc=39|341|328|454, last accessed Dec. 18, 2006.

[12] BDO Seidman, LLP, "A Report on Shortfalls in Medicaid Funding for Nursing Home Care," prepared for the American Health Care Association (June 2006) 14, http://www.ahca.org/brief/seidmanstudy0606.pdf.

[13] Legislative Budget Board, op. cit., 119.

[14] Texas Health and Human Services Commission, "Texas Medicaid in Perspective: Fifth Edition," op. cit., 4-18 to 4-19.

[15] Legislative Budget Board, op. cit., Figure 60, 120.

[16] Office of the Actuary, Centers for Medicare and Medicaid Services (May 2006) Tables for 2004 State Estimates - Medicaid - Home Health Care (Millions of Dollars) and 2004 State Estimates - Medicaid - Nursing Home Care (Millions of Dollars) http://www.cms.hhs.gov/NationalHealthExpendData/downloads/nhestatesummarymcaid2004.pdf, last accessed Dec. 19, 2006.

[17] General Accounting Office, "The Elderly Should Benefit From Expanded Home Health Care But Increasing Those Services Will Not Insure Cost Reductions" (Dec. 7, 1982) 43.

[18] John F. Holahan and Joel W. Cohen, Medicaid: The Trade off Between Cost Containment and Access to Care (The Urban Institute Press, Washington, D.C., 1986) 106.

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

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

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

[22] Interview with Mr. Hawkins on Dec. 6, 2006.

[23] For hyperlinks to the federal rules requiring all these exemptions, see Stephen A. Moses, "Aging America's Achilles' Heel: Medicaid Long-Term Care," Cato Institute (2005) http://www.cato.org/pubs/pas/pa549.pdf.

[24] Law Office of Christina Lesher, PC, http://www.lawlesher.com/, last accessed Nov. 27, 2006.

[25] Stephen J. Livens, PC, http://www.stephenlivens.com/PracticeAreas.shtml, last accessed Nov. 27, 2006.

[26] The Financial Aid Center for Long Term Care, http://medicaidhelp.com/tx/, last accessed Nov. 28, 2006.

[27] Sunny Hoppe, http://www.medicaidadvisors.com/, last accessed Nov. 27, 2006.

[28] Table 1: Median Home Values for the United States, Regions, and States, and for Puerto Rico: 1990 and 2000, http://www.census.gov/prod/2003pubs/c2kbr-20.pdf, last accessed Dec. 15, 2006.

[29] Barbara Stucki, "Use Your Home to Stay at Home: Expanding the Use of Reverse Mortgages for Long-Term Care: A Blueprint for Action," National Council on the Aging (2005) iv, http://www.ncoa.org/attachments/ReverseMortgageReport3%2Epdf, last accessed Dec. 18, 2006.

[30] Mary Jo Gibson, Steven R. Gregory, Ari N. Houser, Wendy Fox-Grage, "Across the States: Profiles of Long-Term Care 2004: Texas" (AARP Public Policy Institute, Washington, D.C., 2004) http://assets.aarp.org/rgcenter/post-import/d18202_2004_ats_tx.pdf, last accessed Dec. 18, 2006.

[31] For an excellent and comprehensive discussion of reverse mortgages as a potential long-term care financing source, see Barbara Stucki, "Use Your Home to Stay at Home: Expanding the Use of Reverse Mortgages for Long-Term Care: A Blueprint for Action," op. cit., http://www.ncoa.org/attachments/ReverseMortgageReport3%2Epdf.

[32] Susan Coronel, Research Findings: Long-Term Care Insurance in 2002 (America's Health Insurance Plans, Washington, D.C., 2004) 29, http://www.ahip.org/content/default.aspx?bc=39|341|328|454, last accessed Dec. 18, 2006.

[33] Jeffrey R. Brown and Amy Finkelstein, "The Interaction of Public and Private Insurance: Medicaid and the Long-Term Care Insurance Market," NBER working paper (Dec. 2004) http://www.nber.org/papers/w10989, last accessed Dec. 18, 2006. This quote is from the paper's abstract.

[34] Jeffrey R. Brown, Norma B. Coe, Amy Finkelstein, "Medicaid Crowd-Out of Private Long-Term Care Insurance Demand: Evidence from the Health and Retirement Survey," National Bureau of Economic Research, NBER Working Paper Series, Working Paper 12536 (Sept. 2006) http://www.nber.org/papers/w12536, last accessed Dec. 18, 2006. This quote is from the paper's abstract.

[35] Texas Health and Human Services Commission, Joint Hearing of the Senate Committee on State Affairs and Senate Committee on Health and Human Services, Long Term Care Partnership Programs (Oct. 17, 2006) http://www.hhsc.state.tx.us/news/presentations/LTC_101706.pdf, last accessed Dec. 18, 2006.

RESEARCH AND INTERVIEWS

This report recounts the findings, conclusions and recommendations of a study of Medicaid and long-term care financing in Texas conducted by Stephen Moses of the Center for Long-Term Care Reform for the Texas Public Policy Foundation.

Field work consisted of a single week of interviews mostly in Austin, Texas from December 4-8, 2006. A list of individuals interviewed for this study is shown at right.

We thank everyone who shared their time and expertise on Texas Medicaid and long-term care financing in Texas. In particular, we would like to offer special thanks to the state government staff who contributed generously of their time. Public officials in Texas at all levels have been thoughtful, creative, and resourceful in their approach to long-term care financing and it shows.

Steve Abshier, Chief Operating Officer, Outreach Health Services, Garland, TX
David Allen, Agent, Allen Financial Services, Austin
Janis Ambs, Director, HHSC (HHSC) Medicaid for the Elderly and People with Disabilities, Dallas
Gary Anderson, Regional Manager, Financial Freedom, Austin
Leah Auricchio, CSA, CPA, Texas Director, First Continental Reverse Mortgage, Houston
William E. "Buddie" Ball, Outreach Health Services, Garland, TX
Leticia Caballero, Director of Government Relations, Texas Health Care Association, Austin
Bob Callanan, Genworth, Dallas
Margaret (Christine) Cervera, Temp Supervisor, HHSC, Medicaid for the Elderly and People with Disabilities, San Antonio
Dee Church, Manager, Texas HHSC, Medicaid for the Elderly and People with Disabilities Policy, Austin
Nora Cox, Assistant Director for Budget, Planning and Policy, Office of the Governor, Austin
Julia Davis, ARTS Lead Worker, HHSC, Medicaid for the Elderly and People with Disabilities, Beaumont
Travis Davis, Owner, LTC Advisors, Austin
Flora A. Fearon, Litigation Unit Attorney, Texas Department of Aging and Disability Services, Austin
Tonya Felan, Temp Supervisor, HHSC, Medicaid for the Elderly and People with Disabilities, Lubbock
Marc Gold, Manager, Department of Aging and Disability Services, Austin
Tim Graves, President, Texas Health Care Association, Austin
Diane Hall, Program Manager, HHSC, Medicaid for the Elderly and People with Disabilities, Houston
Rachel Hammon, BSN, RN, Director of Clinical Practice and Regulatory Affairs, Texas Association for Home Care, Inc., Austin
Albert Hawkins, Executive Commissioner, HHSC, Austin
Brenda Hellie, Temp Supervisor, HHSC, Medicaid for the Elderly and People with Disabilities, Tyler
Amy Lindley Herzog, Director, Senate Committee on Health and Human Services, State of Texas, Austin
David Holt, self employed, Austin
Jason Jenkins, Reverse Mortgage Specialist, Financial Freedom, Austin
Kristi Jordan, Governor's Advisor for Budget, Planning and Policy, Austin
Kenneth Kapelka, CEO, Insurance Associates of the Southwest, Houston
Anne Kimbol, Policy Analyst, Senate Committee on Health and Human Services, State of Texas, Austin,
Aldonna Kroeker, Program Specialist, HHSC, Medicaid for the Elderly and People with Disabilities, Beaumont
Harriet "Honey" Leveen, LTC insurance, Houston
George Linial, RHP, CAE, President and CEO, Texas Association of Homes and Services for the Aging (TAHSA), Austin
Dr. Forrest Lowry, Reverse Mortgage Branch Manager, Wells Fargo Home Mortgage, Austin
Maureen Milligan, Deputy Chief of Staff, HHSC, Austin
Kay Nobles, CLTC, Regional Sales Consultant, AssistGuide, Fort Worth
W. Scott Norman, Vice President for Government Relations, Financial Freedom, Austin
Craig Olson, Owner, LTC Advisors, Austin
Isela Ortez, Temp Supervisor, HHSC, Medicaid for the Elderly and People with Disabilities, El Paso
Brian Partin, Chief Operating Officer, Outreach Health Services, Garland, TX
Clint Perrin, LTC Insurance, self-employed, Austin
David Pfleeger, Assistant Director, HHSC, Medicaid for the Elderly and People with Disabilities, Dallas
Gloria Robinson, Assistant Director, HHSC, Medicaid for the Elderly and People with Disabilities, Tyler
Matt Robinson, Chairman, Texas Health Care Association and owner of HealthMark a company with seven nursing homes, The Woodlands, TX
Marie Roche, General Director, John Hancock Life Ins. Co., Boston, MA
Stephanie Ryan, Medicaid Estate Recovery Program Specialist, Texas Department of Aging and Disability Services, Austin
Daphne Shaw, Acting Program Manager, HHSC, Medicaid for the Elderly and People with Disabilities, Dallas
Nadine Slayter, Temp Supervisor, HHSC, Medicaid for the Elderly and People with Disabilities, Abilene
Charlene Sparks, Temp Program Manager, HHSC, Medicaid for the Elderly and People with Disabilities, Austin
Dahlia Sylva, Acting Supervisor, HHSC, Medicaid for the Elderly and People with Disabilities, Edingberg
John Stockton, Texas HHSC, Medicaid for the Elderly and People with Disabilities Policy, Austin
Mary Katherine Stout, Director of Center for Health Care Policy Studies, The Texas Public Policy Foundation, Austin
Peter Strong, Long Term Care Agent, Genworth Financial, Houston
Mimi Sutherland, LTC Insurance, self employed, San Antonio
David Thomason, Ph.D., Vice President of Public Policy, Texas Association of Homes and Services for the Aging (TAHSA), Austin
Chris Traylor, Associate Commissioner for Medicaid and CHIP, Health and Humans Services Commission, Austin
Heather Vasek, Director of Public Policy, Texas Association for Home Care, Inc., Austin
Jeff Warren, President, Markman, Dallas
Chuck Williams, Systems Analyst, Department of Aging and Disability Services, Austin,
Arlene Wohlgemuth, Three Point Strategies, Austin
John Young, Owner, Senior Strategies, San Antonio

About this Report

Across the country, lawmakers are increasingly sensitized to the growing demand on long-term care services and the significant cost of providing these services as the "Baby Boomers" age on to their expected benefits from Medicaid, Medicare, and Social Security. For the states, Medicaid already carries a significant financial cost, which will grow even more steep as Medicaid shifts from covering comparatively inexpensive acute care for poor women and children to covering the more expensive long-term care services for the elderly. As a result, states are desperate to identify reforms that will hold the aging onslaught at bay by directing people away from reliance on government programs and into private sector solutions to long-term care. But what can the state do and will there be time to put the needed reforms into place?

The Foundation asked Stephen Moses of the Center for Long-Term Care Reform to assess the Lone Star State's Medicaid long-term care program and identify potential solutions that can help relieve the increasing pressure on the state budget through reform. This report is an examination of the state's current Medicaid long-term care program, its prognosis, and areas for possible reform.

About the Texas Public Policy Foundation

The Texas Public Policy Foundation is a 501(c)3 non-profit, non-partisan research institute guided by the core principles of individual liberty, personal responsibility, private property rights, free markets, and limited government.

The Foundation's mission is to lead the nation in public policy issues by using Texas as a model for reform. We seek to improve Texas by generating academically sound research and data on state issues, and recommending the findings to policymakers, opinion leaders, the media, and general public.

The work of the Foundation is primarily conducted by staff analysts under the auspices of issue-based policy centers. Their work is supplemented by academics from across Texas and the nation.

Funded by hundreds of individuals, foundations, and corporations, the Foundation does not accept government funds or contributions to influence the outcomes of its research.

The public is demanding a different direction for their government, and the Texas Public Policy Foundation is providing the ideas that enable policymakers to chart that new course.

900 Congress Ave., Ste. 400 • Austin, TX 78701 • P: 512.472.2700, F: 512.472.2728 • www.TexasPolicy.com

RR05-2007