THE JERSEY SHARE:

HOW TO PAY FOR LONG-TERM CARE WITH LESS FEDERAL MONEY

A Case Study in New Jersey

Presented

to

THE STATE OF NEW JERSEY
DEPARTMENT OF HEALTH AND SENIOR SERVICES

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by

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EXECUTIVE SUMMARY

New Jersey is caught in a vise. One jaw of the vise is demographics, an aging population with expensive health care needs. The other jaw is limited revenue, the necessity to constrain taxes to achieve a healthy economy. The screw is turning. The vise is closing. A bad recession now would cause a terrible squeeze. The aging of the baby boom portends a fatal fiscal crunch for the state.

New Jersey is very vulnerable to the rising pressure of aging demographics. The state already ranks eleventh in population over the age of 65. Its 75 to 84 age group is bigger than the national average and its health-cost-critical over-85 age group is only slightly below the national average. If population growth among New Jersey's elderly begins to move upward faster, the demographic pinch in the state will come even sooner than otherwise expected.

Recent state budgets already justify a strong sense of foreboding. Nursing home expenditures in New Jersey almost tripled between 1986 and 1996 from $362 million to over $1 billion. By comparison, the total state budget less than doubled (from $8.7 billion to $16.1 billion) in the same period. Perhaps even more worrisome, however, is the growth in the Medicaid program's share of New Jersey's budget. Medicaid grew from 6.8 percent of the state budget in Fiscal Year (FY) 1988 to 11.8 percent in FY 1997 squeezing out other important state priorities. In the meantime, the average cost of a Medicaid recipient in New Jersey has increased to $4,573, fifth highest in the nation, as compared to a national average of $3,080. This does not bode well for the future.

Making matters worse is the reality that New Jersey is not alone in its bind. The state relies heavily on financial participation from the United States government. This financing source, however, is highly vulnerable to big reductions in the near future. The Congressional Budget Office pins the blame for America's escalating deficits on entitlements, especially Medicare and Medicaid. Over the long-run, the CBO's biggest worry is long-term care costs for the elderly under Medicaid. Therefore, the CBO has Medicaid_including New Jersey's share of the program_squarely in its sights.

In response to the state's rapidly aging population and fiscal squeeze, New Jersey has implemented several measures to redress the imbalance between over-reliance on nursing home care and under-utilization of home and community-based services. The

assumption is that services provided at a lower level of care will save money. Ironically, however, redirecting limited public assistance resources toward home and community-based services and away from nursing home care may only increase utilization, inflate costs, and exacerbate the fiscal problem because of induced demand. Thus, New Jersey may be on the brink of implementing a solution that could be worse, *i.e.* far more expensive, than the problem itself.

As New Jersey's fiscal difficulties worsen, some of the state's public policies seem inadvertently to be adding to the problem. Medicaid estate planning, the practice of artificial self-impoverishment to qualify for public benefits, has contributed in no small measure to the state's Medicaid crisis. Mass market "how-to" books, magazine and newspaper articles, seminars, advertisements and internet sites all promote the ease and affordability of creating an illusion of poverty. The state has offered little opposition or defense toward this highly questionable method of Medicaid qualification.

While public outrage tends to focus on big ticket Medicaid estate planning techniques like spousal income trusts, life estates, and family limited partnerships, the little leaks in the eligibility system also cause an enormous loss of program resources. Perhaps the best example is prepaid burial trust funds which federal law permits with no limit on the amount. As the fiscal pressures continue to close in on New Jersey's public assistance programs, policy makers may soon have to choose consciously between indemnifying middle class heirs against the risk of paying for their parents' funerals or financing prenatal and basic health care for poor women and children.

One way to mitigate the enormous cost of generous and elastic Medicaid eligibility criteria is to recover from the estates of deceased Medicaid recipients. New Jersey has operated a small Medicaid estate recovery program since the 1970's. Although the estate recovery program is cost-effective already, it could generate far more non-tax revenue to the state than it does. In addition, long-term care insurance, which can be an effective weapon in the fight to control Medicaid growth, has not significantly penetrated New Jersey's insurance market. When people can ignore the risk of long-term care, avoid the premiums for private insurance, have the government pay for their nursing home care if the need arises, and avoid estate recovery with little legal effort, no one should be surprised that so few people purchase insurance or pay privately for long-term care.

While the stage is clearly set for a major long-term care financing crisis in New Jersey, a sensible solution can avert

this prospect. The secret is to remove the perverse incentives in the current system that (1) discourage families from preparing for the risk of long-term care and (2) reward them for ignoring the problem until Medicaid nursing home care is the only viable alternative. Therefore, to facilitate universal access to top quality long-term care for all of New Jersey's citizens, certain actions listed in this report's recommendations need to be taken. By preserving the social safety net for the truly needy, restraining Medicaid estate planning, making security of collateral a condition of Medicaid eligibility, implementing a comprehensive Medicaid estate recovery program, and educating the public about the risks of long-term care, New Jersey will be able to meet the needs of its aging population while promoting a robust economy at the same time.

Inaction or misguided efforts, on the other hand, will cause New Jersey's fiscal vise to close sooner or later, creating severe consequences, especially for the state's most vulnerable populations. The time to act is now. A solution exists. All that is needed is the vision and political will to act.

The analysis, conclusions and recommendations presented in this report are those of the author alone and do not reflect the official position or policy of any department or official of the State of New Jersey.

ACKNOWLEDGEMENTS AND DISCLOSURES

This project was funded under contract with the New Jersey Department of Health and Senior Services. The Department assisted the project by facilitating access to private long-term care experts, legislators, public and private senior advocates, elder law attorneys, long-term care provider associations, key state administrative staff, and essential legal, regulatory and administrative documents. The Department also arranged conference space, photo-copy support, and local telephone service.

LTC, Incorporated, the contractor, is a private firm specializing in long-term care financing and insurance. The company markets private home health and nursing home insurance throughout most of the United States. LTC, Incorporated is also active in the public policy debate on long-term care financing and publishes a national newsletter_*LTC News & Comment*_on these subjects. **LTC, Inc.'s World Wide Web page address is http://www.ltci.com/.**

Stephen A. Moses, the author, is Director of Research for LTC, Incorporated. He writes, speaks and consults extensively on the subjects of Medicaid nursing home eligibility, Medicaid estate planning, liens, estate recoveries, and public/private long-term care financing partnerships. He was previously a Medicaid State Representative (nine years) for the federal Health Care Financing Administration (HCFA) and Senior Analyst (two years) for the Office of Inspector General of the U.S. Department of Health and Human Services (IG). He directed and authored three national studies for HCFA and the IG on Medicaid estate planning. **Steve Moses's e-mail address is 102334.3446@compuserve.com or steve_moses@compuserve.com.**

We would like to express our appreciation to the 80 respondents and interviewees who provided the information on which this report is based. We particularly appreciate the guidance and support provided by Commissioner Len Fishman and Deputy Commissioner Susan Reinhard of the New Jersey Department of Health and Senior Services as well as by Brian Baxter, Senior Policy Advisor in Governor Whitman's Office of Policy and Planning. Finally, a very special thanks to William M. Caldwell, Jr., Health Data Specialist in the Department of Health and Senior Services, who organized, scheduled, and attended all of the interviews conducted for this project and who contributed invaluable insights and knowledge about long-term care financing and delivery in New Jersey.

INTRODUCTION

The purpose of this study was to begin the process of producing a step-by-step plan to save the State of New Jersey $200 million per year in Medicaid nursing home expenditures while simultaneously assuring universal access to top quality long-term care for rich and poor citizens alike across the whole spectrum from home and community-based to nursing home care. LTC, Incorporated originally submitted a proposal for a three-month project to achieve this goal. (See Appendix A for the full project proposal.) The current project is a three-week mini-version of the full project designed instead to evaluate the potential and point to the general public-policy direction needed to move forward.

In pursuit of this objective, the contractor (LTC, Incorporated in the person of the company's Research Director, Stephen A. Moses) visited New Jersey during the week of July 29 to August 2, 1996 and conducted a series of interviews and discussions. Specifically, he met with long-term care policy makers and stakeholders including representatives of the Medicaid program, members of the state legislature, health care providers, senior advocates and others. A complete list of respondents and interviewees for the project is provided at the back of this report.

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

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

Given the severely limited scope of this project_one week of field work, one week for research and documentation review, and one week to write the report_we probably raise more questions

herein than we answer. Therefore, when additional work or research is needed to identify a problem or craft a solution, the report recommends how this might be done.

THE PROBLEM

New Jersey is caught in a vise. One jaw of the vise is demographics, an aging population with expensive health care needs. The other jaw is limited revenue, the necessity to constrain taxes to achieve a healthy economy. The screw is turning. The vise is closing. A bad recession now would cause a terrible squeeze. The aging of the baby boom portends a fatal fiscal crunch for the state.

Nevertheless, according to most of the respondents interviewed for this study, New Jerseyans do not understand or appreciate the gravity of this demographic and fiscal problem. Repeatedly, politicians, administrators, providers and senior advocates urged me to convey the enormity of the crisis before addressing proposed solutions. To define the problem fairly and frankly is the purpose therefore of this section of the report.

Aging Demographics

New Jersey is very vulnerable to the rising pressure of aging demographics. The state already ranks eleventh in population over the age of 65.[1] Its 75 to 84 age group is bigger than the national average, 4.4 percent compared to 4.2 percent. The health-cost-critical over-85 age group is only slightly below the national average, 1.3 percent compared to 1.4 percent.[2] Furthermore, up to now, population growth among New Jersey's seniors has been relatively slow. From 1984 to 1994, the over-age-65 population increased only 15.1 percent compared to 18.9 percent for the United States as a whole[3] and the over-age-85 group increased only 26.1 percent compared to 34.9 for the U.S.[4]

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[1] Amanda H. McCloskey, Jennifer Woolwich, and Danielle Holahan, *Reforming the Health Care System: State Profiles 1995*, American Association of Retired Persons, Washington, D.C., 1995, p. 216.

[2] Erwin Brown, Jr., *Facts and Trends: The Nursing Facility Sourcebook, 1996*, American Health Care Association, 1996, p.5.

[3] David Baer and Lee Cohen, *The State Economic, Demographic & Fiscal Handbook, 1996*, American Association of Retired Persons, Washington, D.C., 1996, p. 344.

[4] Amanda H. McCloskey, Jennifer Woolwich, and Danielle Holahan, *Reforming the Health Care System: State Profiles 1995*, American Association of Retired Persons, Washington, D.C., 1995, pps. 128 and 217. The comparison cited here is actually between

If population growth among the elderly begins to move upward in the direction of the national average, the demographic pinch in New Jersey will come even sooner than otherwise expected.

Recent state budgets already justify a strong sense of foreboding. For example, nursing home expenditures in New Jersey almost tripled between 1986 and 1996 from $362 million to over $1 billion. By comparison, the total state budget did not even double (from $8.7 billion to $16.1 billion) in the same period.[5] The rapid increase in nursing home expenditures caused this critical line item in the budget to grow alarmingly from 2.1 percent to 3.3 percent of the total.[6]

Perhaps even more worrisome, however, is the growth in the Medicaid program's share of New Jersey's budget. Nationally, less than one-third of Medicaid recipients are elderly, but they (plus the blind and disabled) consume almost three-fourths of program resources.[7] The bigger Medicaid's share of its budget, therefore, the sooner aging demographics will catch up with a state. In New Jersey, Medicaid grew from 6.8 percent of the state budget in Fiscal Year (FY) 1988 to 11.8 percent in FY 1997. During the same time period, the state's investment in higher education declined from 8.7 percent to 7.2 percent of the budget. Human services other than Medicaid went down from 12.5 percent to 11.0 percent; transportation dropped from 6.5 percent to 4.4 percent; and "other" services were reduced from 18.2 percent to 16.2 percent.[8] In the mean time, the average annual cost of a Medicaid recipient in New Jersey has increased to $4,573, fifth highest in the nation, as compared to a national average of

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1985 and 1995.

[5] Source: Data provided by the State of New Jersey, Department of Health and Senior Services, August 16, 1996.

[6] Source: Data provided by the State of New Jersey, Department of Health and Senior Services, August 16, 1996.

[7] "Although more than two-thirds of Medicaid recipients in fiscal year 1990 qualified because they were members of an AFDC family, they consumed only one-fourth of program benefits. Conversely, the aged, blind and disabled, who represent less than one-third of Medicaid recipients, consumed nearly three-fourths of Medicaid benefits." (Levit, *et al*., 1991, p. 36)

[8] Source: Data provided by the State of New Jersey, Department of Health and Senior Services, August 16, 1996.

$3,080.[9] This does not bode well for the future.

Leaving the Comfort Zone

Arguably, New Jersey has had a false sense of security up to now about these issues. Numerous respondents in this study told us variations of the theme that the state has been "able to paper over problems with money" up to now. In fact, New Jersey remains a very prosperous state: third highest in the nation for *per capita* income[10] and 47th lowest for elderly poverty rate[11]. Fully 57.8 percent of New Jerseyans have household incomes in excess of $35,000 per year as compared to 42.4 percent for the country as a whole. The state's senior home owners enjoy a median home value of $136,559[12] while the national average for net home equity held by seniors is only $61,750.[13]

New Jersey is relatively generous with its wealth too. The state's Medicaid program covers 51.1 percent of its poverty population (ranking it 16th in the U.S.) as compared to the national average of 49.0 percent.[14] The program also covers

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[9] Amanda H. McCloskey, Jennifer Woolwich, and Danielle Holahan, *Reforming the Health Care System: State Profiles 1995*, American Association of Retired Persons, Washington, D.C., 1995, pps. 129 and 230.

[10] Amanda H. McCloskey, Jennifer Woolwich, and Danielle Holahan, *Reforming the Health Care System: State Profiles 1995*, American Association of Retired Persons, Washington, D.C., 1995, pps. 128 and 218.

[11] David Baer and Lee Cohen, *The State Economic, Demographic & Fiscal Handbook, 1996*, American Association of Retired Persons, Washington, D.C., 1996, p. 332.

[12] 1990 U.S. Census of Population and Housing, SSTF8, HA32A, "Median Value by Age of Householder," supplied by the New Jersey State Law Library, July 30, 1996.

[13] U.S. Bureau of the Census (T.J. Eller), Current Population Reports, Series P-70, No. 34, *Household Wealth and Asset Ownership: 1991*, U.S. Government Printing Office, Washington, D.C., 1994, p. xi.

[14] Amanda H. McCloskey, Jennifer Woolwich, and Danielle Holahan, *Reforming the Health Care System: State Profiles 1995*, American Association of Retired Persons, Washington, D.C., 1995, pps. 242 and 131.

nearly all of Medicaid's 31 optional services. This good news, however, masks New Jersey's vulnerability to the demographic and fiscal realities of the future. Ironically, the more prosperous a state's citizens and the more generous its publicly financed long-term care programs, the more susceptible the state is to Medicaid estate planning, the practice of artificial self-impoverishment to qualify for public benefits.

Furthermore, evidence abounds that New Jersey cannot expect to spend its way out of future crises. New revenue to finance increased spending is currently very hard to find. New Jersey was 14th in the nation in state and local taxes as a percentage of personal income in 1992.[15] Governor Whitman has tried to spur the economy by cutting taxes, but tax cuts inevitably constrain revenue growth and future spending. Economist Mark Zandi concluded recently in the *New York Times*, that "New Jersey is still going to be a below-average economy....While New Jersey may be a low-cost state in a high-cost region, the state is in no way competitive, even after tax cutting, with the South or parts of the West."[16] Thus, economic growth will remain a challenge even assuming stringent tax and spending restraint.

New Jersey is already having to make tough decisions. Assemblyman Kavanaugh, Chairman of the Assembly's Appropriations Committee, told us that the state is "going to be short next year between 1.2 and 2 billion dollars." A member of the Governor's staff lamented: "We almost had to drop pregnant women from 185 percent to 100 percent of poverty to qualify for Medicaid eligibility." Another *New York Times* article reported that: "The budget for the Division of Youth and Family Services was reduced from $296 million to $290 million this year...."[17] Several respondents interviewed for this study concluded that New Jersey's fiscal choices are gradually narrowing down to a "crunch between spending for poor women and children or for seniors." As one administrator stated the situation: "We need to see the stark reality in bold relief. There will be no choices after a very few years."

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[15] David Baer and Lee Cohen, *The State Economic, Demographic & Fiscal Handbook, 1996*, American Association of Retired Persons, Washington, D.C., 1996, p. 349.

[16] Richard W. Stevenson, "On Tax Cuts, a Dole Model is New Jersey," *New York Times*, August 22, 1996, p. A12.

[17] Jennifer Preston, "New Jersey Says it Will Add 120 Children's Caseworkers," *New York Times*, September 19, 1996, p. A19.

Federal Financial Assistance at Risk

New Jersey is not alone in this bind. The state relies heavily on financial participation from the United States government. But here again, a major financing source for the state is highly vulnerable to big reductions in the near future. According to an August 1996 report of the Congressional Budget Office (CBO):

> Under current policies, the deficits that...long-term demographic trends suggest would easily dwarf even the largest deficits experienced to date. Indeed, by the middle of the next century, they threaten to drive the federal debt to levels that the economy could not possibly sustain...[G]iven current spending and revenue policies and CBO's current assumptions about the economy, 1996 will be the last year of dwindling deficits."[18]

The CBO pins the blame for these insupportably escalating deficits on entitlements, especially Medicare and Medicaid. Over the long-run, their biggest worry is long-term care costs for the elderly under Medicaid. Therefore, the CBO has Medicaid squarely in its sights.

Three cost-reduction strategies are under serious consideration. They are (1) block grants which would "abolish the current federal entitlement to medical benefits for eligible individuals;" (2) per capita caps which would "generate $35 billion in savings over six years;" and (3) lower federal matching rates which could eliminate the 50/50 floor on New Jersey's federal medical assistance percentage (FMAP).

> Without the floor, the District of Columbia, for example, would have a 1996 matching rate of 12 percent, Connecticut's would be 18 percent, **New Jersey's [FMAP] would be 25 percent**, and New York's would be 36 percent."[19][emphasis added]

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[18] Congressional Budget Office, *Reducing the Deficit: Spending and Revenue Options*, Congress of the United States, U.S. Government Printing Office, Washington, D.C., August 1996, p. 1.

[19] Congressional Budget Office, *Reducing the Deficit: Spending and Revenue Options*, Congress of the United States, U.S. Government Printing Office, Washington, D.C., August 1996, pps. 433-443.

The CBO concludes with this understatement: "The three possible approaches to restructuring Medicaid financing... would expose the states to greater financial risks and would give them incentives to manage their programs more efficiently."[20] Although states dodged the bullet of Medicaid block grants this year, welfare reform is already a costly, time-consuming, and ominous reality. Medicaid is the next logical candidate for fiscal reform, *i.e.* federal funding cuts.

New Jersey's Long-Term Care Infrastructure

Meanwhile, long-term demographic and fiscal issues are not the only problems New Jersey needs to face. The state's long-term care infrastructure is biased toward institutional care. Home and community-based services have been slow to develop. This situation is not only expensive for the state, it is anathema to seniors who would rather receive long-term care in non-institutional settings. For example, New Jersey has a dearth of home health agencies with only .16 agencies per thousand persons over the age of 65 as compared to a national average of .41 agencies per thousand.[21] The state is also low in Medicare home health visits per user, ranking 40th nationally, with only 37 visits per user as compared to the national average of 57.4 visits per user.[22]

Nevertheless, New Jersey's nursing home residents are less disabled than residents in other states. They are below average on four objective indices of nursing home resident acuity (ADLINDEX, ACUINDEX, PROPAC, AND ADLSCORE).[23] A smaller percentage of them than the national average experience limitations on their activities of daily living (ADL's). This is

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[20] Congressional Budget Office, *Reducing the Deficit: Spending and Revenue Options*, Congress of the United States, U.S. Government Printing Office, Washington, D.C., August 1996, p. 445.

[21] Marion Merrell Dow Inc., *Marion Merrell Dow Managed Care Digest Series, Institutional Digest, 1995*, Kansas City, Missouri, 1995, p. 45.

[22] Amanda H. McCloskey, Jennifer Woolwich, and Danielle Holahan, *Reforming the Health Care System: State Profiles 1995*, American Association of Retired Persons, Washington, D.C., 1995, pps. 128 and 223.

[23] C. McKeen Cowles, *Nursing Home Statistical Yearbook: 1995*, Johns Hopkins University Press, Baltimore, Maryland, 1995, p. 20.

true for all five ADL categories: bathing, dressing, toileting, transferring, and eating.[24] A higher percentage of nursing home residents in New Jersey are not dependent at all for assistance with individual ADL's. This is also true for all five ADL's.[25] Finally, the average number of ADL's per resident in New Jersey's nursing homes is below the national average, 3.78 as compared to 3.87.[26] These facts suggest that New Jersey could manage very well with lower nursing home and higher home care utilization.

Curiously, however, New Jersey is also low compared to national standards on number of nursing home beds. The state ranks 33rd with only 45.8 beds per thousand aged persons compared to the national average of 53.1.[27] The relative scarcity of nursing home beds in New Jersey may be accounted for by the state's strong certificate of need (CON) program which has severely restricted the construction of new beds since 1970, ostensibly as a means of Medicaid cost control. Restrictions on nursing home bed growth, however, have had the side effect of causing very high occupancy. The American Health Care Association, a national trade association for the nursing home industry, reports that New Jersey's nursing homes are 95.9 percent occupied as compared to the national average of 92.0 percent.[28] High nursing home occupancy can create access problems especially for Medicaid recipients on whose behalf payments to nursing homes are considerably below payments required of private payers. Study respondents did not report serious access problems

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[24] C. McKeen Cowles, *Nursing Home Statistical Yearbook: 1995*, Johns Hopkins University Press, Baltimore, Maryland, 1995, p. 48.

[25] Erwin Brown, Jr., *Facts and Trends: The Nursing Facility Sourcebook, 1996*, American Health Care Association, 1996, pps. 11-15.

[26] Erwin Brown, Jr., *Facts and Trends: The Nursing Facility Sourcebook, 1996*, American Health Care Association, 1996, p. 10.

[27] Amanda H. McCloskey, Jennifer Woolwich, and Danielle Holahan, *Reforming the Health Care System: State Profiles 1995*, American Association of Retired Persons, Washington, D.C., 1995, pps. 130 and 235.

[28] Erwin Brown, Jr., *Facts and Trends: The Nursing Facility Sourcebook, 1996*, American Health Care Association, 1996, p. 33. Data provided by the Department of Health and Senior Services show nursing home occupancy in New Jersey staying around 90 percent to 91 percent with little change since 1987, still high but not as high as the AHCA data suggest.

for Medicaid recipients in New Jersey, however, possibly because the state maintains relatively high Medicaid nursing home reimbursement rates. The average reimbursement rate of $113.90 per day in New Jersey is the sixth highest in the nation and compares very favorably to the national average of $87.81 per day.[29]

Relatively high reimbursement rates may also account for the excellent showing of New Jersey's nursing homes on measures of quality. The state received only 3.57 survey deficiencies per nursing home as compared to the national average of 7.18 on Level A and Level B deficiencies combined, ranking it eighth in the nation. On nursing deficiencies, New Jersey averaged only 1.65 as compared to the national average of 3.57, ranking the state fifth in the nation.[30] New Jersey is also much lower than the national average in deficiency citations for all medical areas including incontinency, 2.13 compared to the national average of 11.49; pressure sores, 9.12 compared to 14.62; and physical restraints, 7.29 compared to 17.1.[31] This objective data confirms the consensus of most study respondents that nursing home quality is relatively high in New Jersey for Medicaid and private-pay residents alike.

Summary

Thus, with regard to long-term care service delivery and financing, perhaps the state's biggest social and financial liability over the long run, New Jersey finds itself in the following condition. A rapidly aging population has already driven up state Medicaid costs in general, and Medicaid nursing home expenditures specifically, to the breaking point. No end is in sight for this trend and it is more likely to increase than decrease. At the very time when extra spending for long-term care is needed, however, traditional revenue sources, such as state tax revenues and federal financial participation, are diminishing. The state has invested heavily in a high quality nursing home industry, but still has an underdeveloped home and community-based services infrastructure. Political pressures

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[29] Erwin Brown, Jr., *Facts and Trends: The Nursing Facility Sourcebook, 1996*, American Health Care Association, 1996, p. 57.

[30] C. McKeen Cowles, *Nursing Home Statistical Yearbook: 1995*, Johns Hopkins University Press, Baltimore, Maryland, 1995, p. 118.

[31] Erwin Brown, Jr., *Facts and Trends: The Nursing Facility Sourcebook, 1996*, American Health Care Association, 1996, p. 25.

abound to expand publicly financed long-term care services while fiscal pressures demand greater restraint.

Corrective Actions

Given this demographic and historical context, what is the state of New Jersey actually doing to control future long-term care costs? According to the Department of Health and Senior Services, the state has taken the following measures:[32]

- Development of lower cost home and community based alternatives to nursing home care: Assisted Living and Alternate Family Care (adult foster care).
- Development of Medicaid waivers to pay for lower cost home and community based alternatives to nursing home care.
- Loosened certificate of need regulations for long-term care alternatives.
- Restrict the growth of nursing home beds through certificate of need.
- Consolidate senior services and programs at the state level and develop single entry systems at the local level...Any cost savings realized from state consolidation and single entry systems development will be used to expand home and community-based long-term care alternatives.

All of these measures are intended to encourage home and community-based long-term care services and to reduce reliance on institutional nursing home care. The explicit assumption underlying this strategy is that the state of New Jersey can save money by providing services at a lower level of care with more efficient care management. If this assumption proves wrong or overly optimistic, the state may experience rapid increases in overall long-term care costs, exactly the opposite result of the one intended by the policy and at the worst possible time.

There is strong reason to worry about the possibility of this unintended consequence coming true. For the past ten years, a growing number of empirical studies and the scholars who report

[32] Source: Quoted from information provided August 16, 1996 by the State of New Jersey Department of Health and Senior Services.

them have undermined the idea that state Medicaid programs can save money by diverting recipients to publicly financed home and community-based care. Seniors prefer receiving care in less institutional surroundings and everyone agrees that this preference should be honored and encouraged, but the data show that it does not save the government money. For example:

> Evaluations of community care programs...tend to show not only that expansion of community care has little effect on nursing home use, but that it raises, rather than lowers, total expenditures.[33]
>
> 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.[34]
>
> Increased financing for HCB services may be desirable but will not significantly influence nursing home expenditures. The underlying assumption is that the delivery system is correct, but funding is inadequate ...We must seek to justify HCB on grounds other than cost effectiveness or clinical efficacy: the debate should focus on how much community care we are willing to purchase as a society, rather than how much money we can save by purchasing these services.[35]
>
> 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.[36]

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

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

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

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

The tragic irony supported by these scholars' conclusions is that Medicaid expansion into home and community-based services may not only increase overall long-term care costs for the state, it may also undermine the Medicaid program's most effective current control on expenditures. Because the public perceives nursing home institutionalization to be a catastrophic event, people tend to avoid it as long as possible which relieves the pressure on public financing of nursing home care. According to the U.S. Department of Health and Human Services, "for every person in a nursing home, there are two people outside with an equal level of disability."[37] In fact, one scholar says "...75% of LTC is given by family members, and...one-half of the patients so helped are bedbound or incontinent or both."[38] The more attractive Medicaid makes public financing of home and community-based services, the less incentive families will have (1) to provide long-term care themselves, (2) to help seniors purchase home care services in the private marketplace, or (3) to seek out private long-term care insurance for long-term care expenses. *(I should observe that to the extent New Jersey's single-point-of-entry program, i.e. NJ-EASE, directs seniors in the community to attractive, private-pay, home and community-based care options instead of state-financed programs, this new ease of access system will make an important, positive contribution to solving the long-term care financing problem_neither discouraging advance planning and private financing nor rewarding failure to plan and public dependency. Also, it is difficult to say at this stage of our knowledge what impact public financing of assisted living facilities will have on induced demand for Medicaid services. If people have to give up their homes to obtain Medicaid-financed assisted living benefits, they may be more reluctant to do so and the potential savings may be greater than studies have shown for home care options.)*

Thus, New Jersey may be on the brink of implementing a solution that could be worse, *i.e.* far more expensive, than the problem itself. Before we can analyze this situation and propose another strategy to enhance home and community-based services without exploding program costs, it remains to examine New Jersey's nursing-home-based system in more detail. How has the

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

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

current system contributed to the service delivery and financing problems described above?

Medicaid Eligibility Bracket Creep

New Jersey faces a rapid increase in Medicaid dependency, a kind of eligibility bracket creep. Between 1989, in the wake of the Medicare Catastrophic Coverage Act's broadening of Medicaid long-term care coverage, and 1996, Medicaid occupancy in New Jersey's nursing homes jumped from 56.5 percent to 69.9 percent.[39] The direction and magnitude of this trend (far greater than in most other states) is very important for two reasons. First, according to the Department of Health and Senior Services, a 10 percent increase in Medicaid nursing home patient days would increase New Jersey's nursing home expenditures by $119 million per year from under $1.2 million to over $1.3 billion. Thus, if the current trend continues, any increase in Medicaid nursing home census will immediately impact the bottom line of the state budget very negatively.

The second reason this trend is so critical is that increases in Medicaid nursing home census severely impair the nursing home industry's ability to provide access to quality care for both publicly and privately financed residents. According to industry representatives, the average differential between New Jersey's Medicaid reimbursement rate and the rate charged to private payers is between $40 and $50 per day.[40] If the Medicaid rate is $114 per day as documented above, then cost-shifting has already driven up the private pay rate to over $150 per day in New Jersey. "The Medicaid rate does not cover costs or produce a profit," said respondents from the New Jersey Association of Health Care Facilities. Representatives of the New Jersey Association of Non-Profit Homes for the Aging agreed. Thus, further increases in Medicaid census (more residents paying less) or future reductions in Medicaid reimbursement (lower rates for most residents) could soon endanger access to and quality of nursing home care for elderly Medicaid recipients in New Jersey. Moreover, the higher private-pay rates rise to compensate for

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[39] The national average percent of residents whose primary payor source is Medicaid is 68.7 percent according to Erwin Brown, Jr., *Facts and Trends: The Nursing Facility Sourcebook, 1996*, American Health Care Association, 1996, p. 35.

[40] Source: August 6, 1996 letter from William R. Abrams, Vice-President of the New Jersey Association of Health Care Facilities. This estimate was based on a poll of 15 facility members of the Association.

lower Medicaid rates, the more attractive qualifying for Medicaid becomes for current private payers.

Generous Medicaid Eligibility

No one knows for sure what accounts for the long-sustained increase in Medicaid eligible nursing home residents in New Jersey. One interesting speculation is that competition for certificate of need (CON) authorizations contributed to the increase because nursing homes believed they had a better chance to win CON competitions if they had higher Medicaid censuses. A more common and stronger explanation is that generous and elastic Medicaid eligibility rules, combined with very high private-pay reimbursement rates, enticed more and more potential private payers onto Medicaid sooner than otherwise would have occurred. Study respondents, almost without exception, believed that the legal practice of Medicaid estate planning (artificial self-impoverishment) also contributed significantly to the increase in Medicaid census.[41]

Most people still think that because Medicaid is a means-tested welfare program, it must therefore require catastrophic spend down into financial destitution before a person can qualify for benefits. Of course, this is not true. Income is rarely an obstacle to Medicaid nursing home eligibility in New Jersey because of the state's "medically needy" eligibility system. If you do not have enough income to pay your medical bills (including nursing home expenses; Medicare and private insurance premiums, deductibles and co-insurance; and costs not covered by Medicare such as pharmaceuticals, vision and foot care), you will probably qualify for Medicaid nursing home benefits in New Jersey immediately.[42]

Nor must Medicaid applicants deplete their assets to the poverty level in order to qualify. Despite the *de jure* limit of $2,000 on liquid assets, Medicaid nursing home recipients can

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[41] Virtually the only respondents who did not hold this view were elder law attorneys who denied that Medicaid planning is commonplace.

[42] According to a New Jersey Medicaid eligibility policy specialist, the public is still not attuned to the state's medically needy system which was only implemented in 1995. Before then, income was a much bigger obstacle to eligibility. Therefore: "A lot of the population that might be doing sophisticated Medicaid planning are not doing so yet." He said this with some foreboding.

retain a home,[43] car, term life insurance and a burial trust of any value in addition to numerous other possessions such as home furnishings, a business, certain trusts, and annuities. If the Medicaid applicant has a healthy spouse who will remain in the community, even more income and assets are protected from Medicaid spenddown. Up to $1,919 of income can be shifted to the spouse at home plus half the couple's joint assets not to exceed $76,740. These amounts increase every year with inflation. Most families are not aware of Medicaid's generous eligibility rules until they begin paying $3,000 to $5,000 per month for a loved one's nursing home care. Then they tend to become savvy very fast. This is especially true of the heirs.

Medicaid Estate Planning

Once the need to know exists, access to information on how to qualify for Medicaid without spending down is readily available in New Jersey. Mass market "how-to" books such as Harley Gordon's *How to Protect Your Life Savings From Catastrophic Illness and Nursing Homes* and Armond Budish's *Avoiding the Medicaid Trap: How Every American Can Beat the Catastrophic Costs of Nursing Home Care* are available in major bookstores throughout the state. Magazine and newspaper articles on the subject abound. Seminars for seniors on Medicaid planning are commonplace and, according to several interviewees, they are often advertised on the radio.

Study respondents also reported seeing numerous advertising flyers and newspaper ads promoting Medicaid planning. They provided several examples. One such ad for a program featuring "some of the state's leading elder law practitioners" promised to cover "Medicaid planning to maximize the amounts available through commercial annuities, private annuities, and spousal annuity trusts." Another advertising piece offered

> planning techniques available regarding transfers for medicaid eligibility...to protect the family "home"...for maximizing the community spouse resource allowance including enhancement and shifting of income

[43] New Jersey is tougher than most states regarding retention of a home. If a Medicaid applicant is not expected to recover and return to the home within a limited length of time, the state compels the person either to sell the home or lose eligibility. The recipient may use the proceeds of the sale of a home to repay the Medicaid program for costs previously incurred in order to retain ongoing eligibility. This is a source of significant (and potentially much greater) revenue to the state.

> possibilities, spousal refusal, and gift planning ...trust planning techniques...new estate recovery law, including restrictions and planning opportunities to avoid the state Medicaid lien...estate planning options for the "healthy spouse," including the effect of "disinheriting" a Medicaid recipient... "bread and butter" planning techniques, including handling life insurance, payment of expenses, and transferring the home into the name of the community spouse...

This particular seminar was available to members of the New Jersey State Bar Association for a discounted fee of $89. Optionally, one could purchase the 758-page seminar handbook and cassette recordings for the same price.

One should never underestimate the Internet's reach. Information on Medicaid estate planning available through the World Wide Web has exploded in the last few months. For example, at **http://www.mvp.net/gate/nurse.htm**, you should be able to find ordering information for a $29.95 publication that promises "nearly a dozen, perfectly-legal ways to protect your assets" and concludes: "Many of us will end up spending our nest egg in a nursing home. But some others will avoid the Medicaid trap. They'll get the government to pick up the tab while keeping their assets for their children." No wonder syndicated columnist Jane Bryant Quinn once penned a column on these practices entitled "Do Only the Suckers Pay?"[44]

Formal legal scholarship on Medicaid estate planning in New Jersey is bountiful also. A quick visit to any law library will reveal a voluminous literature spanning the past 15 years. For example, the October 1994 issue of *New Jersey Lawyer* was dedicated entirely to elder law and contained articles on "Medicaid After OBRA '93 as It Impacts on Long-Term Care Planning" and "Protecting the Home in Government Benefits Planning."[45] A book by Michael K. Feinberg, *et al*. entitled *New Horizons in New Jersey Medicaid and Elder Law Planning* contains sections on "Basic Medicaid Planning," "Planning Alternatives for Medicaid Qualifications," and "Medicaid Planning Opportunities under HCFA Transmittal No. 64."[46] Several New Jersey elder law

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[44] Jane Bryant Quinn, "Do Only the Suckers Pay?," *Newsweek*, December 18, 1989.

[45] *New Jersey Lawyer*, No. 164, October 1994.

[46] Michael K. Feinberg, *et al*., *New Horizons in New Jersey Medicaid and Elder Law Planning*, Professional Education Systems, Inc., Eau Claire, Wisconsin, 1995.

attorneys also contribute seminars at national symposia of the National Academy of Elder Law Attorneys and the Joint Conference on Law and Aging. Two examples include "The Family Partnership Alternative to Irrevocable Trusts as a Planning Vehicle for Seniors" and "Advanced Substantive Planning Ideas for the Protection of Assets and Income for the Legal Services Attorney and the Private Attorney after OBRA '93." Clearly, New Jersey is saturated with information on and practitioners of Medicaid estate planning.

State Medicaid Eligibility Policy: Theory and Practice

New Jersey's ability to control the fiscal drain incidental to generous Medicaid eligibility rules and Medicaid estate planning is severely limited. Federal mandates prohibit stricter rules and stronger enforcement in many ways. Officials representing the U.S. government's Health Care Financing Administration frequently consult with Medicaid planning attorneys on key issues of policy interpretation and enforcement before (or without) seeking the advice of the Eligibility Technical Assistance Group (E-TAG) of which New Jersey is a practicing member. The state's dually bifurcated Medicaid program is very difficult to manage: administration of the program is shared by the state and the counties on the one hand and by the state Department of Health and Senior Services and the Department of Human Services on the other hand. Citizens of the state have come to expect easy access to publicly financed long-term care to such an extent that numerous study respondents referred to this public attitude as an "entitlement mentality." The following paragraphs give a sense of what state officials have to work with and what they are up against.

Medicaid nursing home eligibility policy is formulated and promulgated by the New Jersey Department of Human Services. To the extent that such policy affects programs or services offered by DHSS, the DHS consults with the DHSS. Department staff have made the state's policy very clear to county workers who make the individual eligibility decisions in the field. County workers are supposed to explain the rules to Medicaid applicants and their representatives in as much detail as necessary, but they are "instructed by us not to do a planning exercise." County eligibility workers have access to IEVES data, an income eligibility verification system based on Internal Revenue Service information derived from IRS-1099 forms. This data tends to be very old, but it does turn up a lot of valuable information and state and county staff believe that the very fact that it is collected and reviewed has a strong chilling effect on concealment and misrepresentation of income and resources.

When county staff encounter complicated Medicaid planning devices such as trusts and annuities, they are authorized and instructed to refer such cases to Trenton for review. This is a "best practice" that relieves pressure on the field and fosters awareness of creative planning techniques by and uniformity of response from headquarters. Unfortunately, state administration of Medicaid eligibility rules has not been as attentive to other important policy areas. Several provisions of the Omnibus Budget Reconciliation Act of 1993, federal legislation intended to close certain eligibility loopholes, have still not been incorporated into state administrative rules or promulgated to the field. As a consequence, for example, county eligibility workers continue to permit the costly practice of "multiple divestment," *i.e.*, allowing transfer of assets penalties to run concurrently, which OBRA '93 prohibited.[47]

County Administration

Despite the state's best efforts to control Medicaid eligibility inflation, county workers are under enormous pressure to expand coverage liberally in each individual situation. The following quotations from Medicaid nursing home eligibility workers and supervisors in Ocean County give a vivid sense of the influences they confront daily.

- We see Medicaid planning every day. Each time the law changes, the lawyers scramble to adjust. Frequently, it is the people with the most assets who are able to shelter them.

- The vast majority of our cases with excess assets do some form of Medicaid planning. This is a county with seniors who have money and a lot of home ownership.

- Ninety-five percent of our cases involve some form of Medicaid planning. Twenty-five percent involve attorneys. We know most of the really high-tech attorneys.

- We are all sickened by a lot of stuff that goes on. There have been occasions where clients could pay privately without using any of their capital, but they have transferred assets instead.

[47] State eligibility policy staff explain that time constraints and other priorities caused the delay in implementing OBRA '93 and that most Medicaid planners abide by the new federal rules even though they are not yet reflected in state administrative procedures.

- We have seen country club memberships, jewelry, diamonds, and even Victoria Secret garments [purchased to convert countable assets into exempt assets].

- Applicants can protect $3,376 times 12 months each year. $3,376 is the average cost of nursing home care as determined by the state of New Jersey. They start with that figure and multiply by the penalty period. It comes out to $121 thousand that they can transfer within 36 months [without violating eligibility rules].

- A disabled child can take everything [without an eligibility penalty]. If mom is 96 and son is 76, and fits disability criteria [including old age], there is no transfer of assets penalty at all. It does not matter how rich the children already are, they can get everything. Recently, a daughter had Multiple Sclerosis. She had too much income to be eligible for state programs herself, [but she was able to take her parent's money so s/he qualified for Medicaid]. This involved $160,000. The public is not aware of this. They don't realize how common it is. Another case involved over $200,000 transferred without penalty to a son who was 70 years old, ambulatory, reasonably healthy and in our office with his attorney.

- What is hard for us to pick up is tax deferred bonds. IEVES is based on IRS [data for interest bearing accounts such as] bank accounts, stocks, *etc*. But tax deferred bonds are hard to find. We find them usually only if there are family disputes [that give us a clue].

- We have a great deal of trouble getting help from banks. It is not mandatory that they help us. Now they want to charge [for account verifications] and we cannot afford to pay. They even charge the families who are applying for assistance and that is a hardship for them.

- We allow the community spouse to transfer the house into their name and then will it away when they die. They can give it away while they are still living too. We would not know because we do not track this. I have no example because we would not know if it happened, but I am very confident that it is going on.

- We have some attorneys who have not been very ethical.

- Atlantic City is the place to go if you have mom and dad's money. One woman took over $100,000 [from the Medicaid

recipient] and when we asked what happened to the money, she said she had gambled it away. She had letters from the casinos confirming that she was a big gambler.

- Some people go to attorneys to put together elaborate deals but then they do not follow through with the asset transfers they are supposed to make. One case put the money in trust but took it out because mom did not like being without money.

- We have some very astute minds working here. You can go into any stationery store and buy forms for anything you want to set up. One guy had a whole bunch of phony liens he had paid off and said that his "no good alki brother" had ripped off mom.

- One technique is building a big home addition or pool at mom's expense. They spend all the money [on their own home] and say: "we wanted mom to stay with us." How long did she stay? Two weeks and then she had a stroke.

- I had one case where a lady called me from the nursing home. Her nephew spent all her money ($119,000) on his house and then put her in the nursing home. She wanted out. She wanted her money back.

- We are one of the good counties. We require face-to-face interviews. Even at redeterminations, we look at everything. We found out that if we don't do that, we miss things. Our county has made a commitment. We are staffed up. Not every county is in the same position.

We also interviewed eligibility workers and supervisors in Mercer County which has a much smaller population of prosperous seniors than Ocean County. Staff in Mercer County discounted the impact of Medicaid estate planning. They said, for example: "We have cases with sizable assets but this money is usually used for spend down. We don't see many cases with preplanning in advance." Staff in both counties and headquarters acknowledged, however, that they routinely advise all applicants of rules that permit them to protect assets above the ostensible limit of $2,000. For example:

- We give them all the information they should need to know to be able to protect the assets. Without telling them to go buy an oriental rug, we tell them what they need to know. We hold nothing back. It is always frustrating to decide where to draw the line. People need to be informed. (Ocean County)

- County staff tend to advise families how to navigate the system within legitimate parameters. For example, they explain burial trusts. Sometimes they are empathetic toward the little old lady who is just $8,000 over the limit. They see themselves as the keepers of the trust for those who can afford their own care, but advocates for those who cannot. (Headquarters)

- Most of the advice we give is how to set up a funeral fund. We automatically tell them about pre-paid funerals. There is no limit as long as it is irrevocable and cannot be cashed in. (Mercer County)

There is nothing whatsoever inappropriate about eligibility workers explaining program rules to applicants and their representatives. That is an important part of the worker's job. It may partially account, however, for the belief expressed by many interviewees during this study (especially provider representatives) that state and county eligibility experts routinely counsel families on how to qualify for Medicaid nursing home benefits without spending down.

Prepaid Funeral Trust Funds

The cost to the state Medicaid program of small asset sheltering methods that workers routinely explain to applicants can hardly be over-estimated. While public interest tends to focus on big ticket planning techniques like spousal income trusts, life estates, and family limited partnerships, the little leaks in the eligibility system also cause an enormous loss of program resources. Perhaps the best example is prepaid burial trust funds which federal law permits with no limit on the amount. No one begrudges Medicaid recipients a decent funeral, but indirect public financing of moderately expensive burial arrangements is big business in New Jersey.

As mentioned above, eligibility workers routinely advise seniors who have excess assets that they can invest in a prepaid burial fund to shelter their money. The funeral industry advertises this benefit widely. For example, advertising flyers collected during this study entitled "SSI, Medicaid and Prepaying a Funeral," "The New Jersey Prepaid Funeral Trust Fund," and "The New Jersey Funeral Assurance Plan" offered the following advice:

- "Are you or someone you know, applying for financial assistance under SSI/Medicaid? If so, prepaid funeral arrangements offer the opportunity to completely pay for the funeral of your choice **before** assets are used up for medical

care and **before** your assets are reduced to SSI/Medicaid eligibility levels." (Emphasis in original.)

- "Your total funeral costs may include: funeral director's professional services, funeral home facility charges, transportation charges, casket, vault, similar merchandise, and cash advances for clergy, cemetery, monument, *etc*."

- "If you are prepaying your funeral for SSI/Medicaid eligibility, your funeral director will make the necessary arrangements to ensure the agreement will be accepted."

- "**Irrevocable Trust** for your total funeral costs, provided that your trust account is equal to the specific funeral that you have selected. The future interest earnings on the original amount are exempt." (Emphasis in the original.)

- "If at the time of death the payment is larger than the actual current funeral bill, the beneficiary that you name will receive the balance of funds."

Mercer County staff indicated that the average dollar amount invested in prepaid burials is $5,000 to $7,000. Ocean County staff stated that they refer all funeral plans in excess of $9,000 to Trenton for review. Headquarters policy staff said "we have found no patterns of funerals in excess of $7,000." The *Wall Street Journal* recently cited the average cost of a funeral nationally to be $7,100.

By permitting families to prepay even moderately priced funerals instead of spending down on long-term care, the Medicaid program diverts scarce welfare resources in huge total amounts from one social objective to another. Policy makers should make such expenditures on the basis of conscious and carefully thought out decisions. In a recent expose' of the funeral industry in New Jersey, *ABC News 20/20* did not disguise its opinion of this practice. The following is an excerpt from a show that aired last year and again on August 30, 1996.[48]

> John Stossel: [*voice-over*] Finally, one other pre-payment scam_ripping off the taxpayer...New Jersey Medicaid lets you pre-pay whatever you want for a funeral. So by putting aside say $30,000 for a fancy funeral, you can make yourself look broke enough to qualify for free taxpayer-paid nursing home care...Now aren't there regulators who are supposed to watch for

[48] *ABC News 20/20* Transcript # 1636.

> this kind of thing? Well there are, but let's be realistic. They can't watch every transaction or even a fraction of them...we know more money each year gets spent for this kind of scam because more people keep learning the tricks and taxpayers pay.

State staff insist they have put an end to the more egregious abuses of funeral planning. Nevertheless, as the fiscal vise continues to close in on New Jersey's public assistance programs, policy makers may soon have to choose consciously between indemnifying middle class heirs against the risk of paying for their parents' funerals or financing prenatal and basic health care for poor women and children.

Other Opinions on Medicaid Planning in New Jersey

New Jersey Deputy Attorneys General, who are responsible for backing up state and county eligibility experts when legal challenges occur, also had some strong opinions about Medicaid estate planning. They were very frustrated that they have neither the staff nor the resources to give front line workers the level of support needed. They feel "out-gunned" by the private Medicaid planning bar. They said:

> We have a lot of areas to cover. We do not have the time or expertise to specialize in discouraging Medicaid estate planning. We do not attend the legal training seminars, nor do we have the necessary documentation. We are always playing catch up with the private bar. Everything we do is reactive. We confront the whole macrocosm of adversaries out there. They are always coming out with creative ideas to manipulate the Medicaid, tax and Social Security laws. For us to merely react, is not efficient. There have to be ways to make the litigation aspect of this process more efficient. If it were not possible for people to have a last minute fix, then we would not be always litigating over last minute fixes.

With regard to the incidence of Medicaid estate planning, the Deputy AG's had the following things to say:

- "I don't think a week goes by that someone does not ask me about Medicaid planning. People find me all the time. It is just amazing. I don't know how they find me."

- "To get a divorce is rampant in New Jersey as a Medicaid planning technique. The State Supreme Court said OK. They leave the institutionalized spouse without a penny. They

could never do this if people in the community understood. It would be considered unconscionable."

- "The problem with the superstructure is that the bench has a bias toward making the state take on the expense of health care for the elderly. We see a tremendous number of cases where the judge helped the attorneys craft an order to help protect the estate."

- "We see trusts, gifts, transfers, limited liability corporations, annuities, family limited partnerships and all the other techniques. Long term care insurance is not on the list. Not in New Jersey."

- "Everybody does some kind of money manipulation. Some do it sooner than later. Some wait until they are in the hospital. Others do it years in advance. It boils down to: those who take the advice of their children do the Medicaid planning."

- "The State of New Jersey has spent the last twenty years expanding the Medicaid program. It is hard to turn around this momentum."

Another important long-term care stakeholder group that is very conscious of and upset about Medicaid estate planning is nursing home providers. When I asked representatives of the New Jersey Association of Non-Profit Homes for the Aging how common Medicaid estate planning is, they answered: "Very common. Absolutely common. There is an elder law attorney on every block. Low income people pay their own way to the extent they can; the well-to-do pay as little as they can get away with." When I asked the same question to representatives of the New Jersey Association of Health Care Facilities, they gave this reply: "I believe it is pervasive. All you have to do is look at the New Jersey State Bar Association. The bar has had an elder law section for 10 years. They put on at least two seminars per year. Having attended one, I can say they are very comprehensive. Plus, you see ads for these seminars all the time. 'Come to this hotel and hear a lawyer teach you how to get rid of your money.'" Nursing home providers feel that they are caught in a bind. Even when they know someone has excess resources, the same person shows up eligible for Medicaid a few weeks later. They feel helpless to do anything about it and they opine that the Medicaid program is not enforcing the rules.

Even senior groups we interviewed were sensitive to the ramifications of Medicaid estate planning. They expressed opinions such as these:

- "I get requests for information on how to get rid of assets and get benefits. They ask: 'What can I leave for my family if I spend all my money on nursing home care?'"

- "The elder law section of the bar has done a really good job of propagating the idea of an individual right to protect assets in qualifying for Medicaid."

- "Members of the bar have bought into the entitlement mentality. They do not understand that Medicaid is a welfare program."

A seniors' ombudsman involved in decisions about life supports made a fascinating observation about Medicaid's influence on life and death decision-making. She said: "If someone is a private patient with endstage Alzheimer's Disease, the family is likely to request withholding of life supports. But if someone is on Medicaid, the family will request everything possible including feeding tubes." Without an empirical study to document the impact of this issue, one can hardly imagine how much it may cost the Medicaid program.

The only stakeholder group interviewed for this study that downplayed the pervasiveness and financial impact of Medicaid estate planning was the elder law attorneys. We met with three of them. They claimed that most of the talk about Medicaid planning was "hyperbole." They said that hundreds of thousands of dollars were usually not involved. Their clients average only $150,000 to $200,000. They said: "The family is working together as a unit. The goal is to get the highest quality and best level of care for the parents. The question is: how can we assure quality with limited resources?" Even when people pre-plan, they do not want to do the things necessary to get on Medicaid, the elder law attorneys told us. "If you are looking for actual experience rather than pie in the sky, that is what you will find in New Jersey." They claim that egregious Medicaid planning is not going on. "People spend more time planning their vacations than their lives. They do not call us until they are in crisis." Besides, if the government succeeds in closing all the other loopholes "people might as well throw their money away on any kind of frivolous purchases to qualify for assistance." Elder law attorneys felt very strongly that they have been left out of the process of long-term care policy making, that they should be invited to participate on a task force to assess and resolve these issues, and that, ultimately, the solution to the underlying problem is private long-term care insurance.

Medicaid Estate Recoveries

One way to mitigate the enormous cost of generous and elastic Medicaid eligibility criteria is to recover from the estates of deceased Medicaid recipients. Of course, assets divested for the purpose of qualifying for Medicaid in the first place do not remain available to be recovered from an estate. Nor do assets divested while a recipient is on Medicaid reach the estate. New Jersey does not have a TEFRA lien program[49] to secure real property during the Medicaid recipient's lifetime. Instead, the state requires recipients who are not expected medically to be able to return to their homes to place the homes up for sale. This has the effect of capturing some home value prior to estate recovery. But other sheltered property, such as a home in which a community spouse resides or other illiquid assets that are not countable for purposes of determining Medicaid eligibility, may pass unencumbered to heirs unless Medicaid recovers their value from the estate.

New Jersey has operated a small Medicaid estate recovery program since the 1970's. In calendar year 1994, the program recovered $2.2 million from the estates of deceased Medicaid recipients. The total recovered for calendar year 1995 was $2.4 million. Approximately 2.5 to 3.0 full time equivalent staff (FTE's) produced these results. The unit's manager estimates that the state collects between $20 and $25 for every dollar invested in Medicaid estate recovery. The Department of Human Services operates this program.

Additionally, the state collects approximately $3 million per year in "voluntary" recoveries. Most of this money comes from people who are permitted to repay the state for Medicaid benefits already received when they sell their homes. They make these repayments for the purpose of retaining Medicaid eligibility after converting an exempt asset (their home) into an otherwise nonexempt asset (the cash proceeds of the sale.) These voluntary recoveries are managed by the Department of Health and Senior Services. They are administered by the county eligibility workers. Because of the diffuse responsibility for voluntary recoveries, no one is able to estimate the return on investment from this program.

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[49] The Tax Equity and Fiscal Responsibility Act of 1982 authorized states to place liens on the homes of Medicaid nursing home recipients during their lifetimes to secure benefits correctly paid for later recovery. TEFRA liens have many restrictions that limit their effectiveness, but some states use them very successfully. Maryland collects over $1 million per year from TEFRA liens recoveries.

New Jersey's long-standing Medicaid estate recovery program is cost-effective. It operates in a very limited but efficient manner. The program showed foresight and initiative in advocating and successfully adopting the expanded definition of "estate" authorized in the Omnibus Budget Reconciliation Act of 1993.[50] Nevertheless, New Jersey's program has its limitations. If it operated at the same magnitude and effectiveness as Oregon's program, for example, the New Jersey estate recovery program (based on the state's larger size) would employ 68 FTE's and recover over $50 million per year. The New Jersey program has no way to track former recipients or surviving spouses for estate recovery and therefore loses a large proportion of recoveries that are captured by more aggressive states. The state's voluntary recovery program to recoup the cost of benefits paid by compelling home sales when people are too ill to return to their homes is technically impermissible under federal law and could be stopped by the Health Care Financing Administration at any time. (Besides, optimally, the state's program should help people save the family home instead of compelling them to liquidate it.) Finally, New Jersey does not have a systematic method to educate the public about the risks of estate recovery. My conclusion is that New Jersey needs to study and evaluate its Medicaid estate recovery program with an eye to increasing recoveries, relieving the impact of forced home sales, and educating the public about the importance of avoiding Medicaid dependency in order to prevent estate recovery liability.

Long-Term Care Insurance

If more people had private insurance to pay for home and community-based services or nursing home care, fewer people would need to rely on Medicaid. What is the long-term care insurance situation in New Jersey? As of 1994, between one and three percent of seniors in New Jersey had purchased private long-term care insurance.[51] Market penetration that low occurs in only nine other states. Of the 121 companies that market long-term care

[50] For example, this expanded authority empowers the state to recover assets that pass through joint tenancy with right of survivorship. Previously, recovery was limited only to assets that pass through a formal probated estate. The new authority is very important for the financial viability of a Medicaid estate recovery program.

[51] Susan Coronel and Craig Caplan, *Long-Term Care Insurance in 1994: Policy and Research Findings*, Health Insurance Association of America, Washington, D.C., 1996, p. 20.

insurance in the United States, only seven of them sell their individual products in New Jersey.[52] The New Jersey Department of Banking and Insurance does not track the number of policies sold, the value of premiums paid, or the number of agents selling long-term care insurance. Agents themselves estimate that the number of people actively marketing long-term care insurance as their primary product is under 200 in New Jersey.

The regulatory authority in New Jersey has not overburdened long-term care insurance products with excessive mandates that can drive up the cost of the coverage and imperil its affordability. On the other hand, New Jersey has not implemented policies to encourage the purchase of long-term care insurance, such as tax deductibility or "partnership" programs, as other states have done. Agents and regulators alike believe the market for private long-term care insurance in New Jersey is increasing, but not at the pace that any of them would like to see. All agreed that the easy availability of Medicaid nursing home benefits discourages the growth of the long-term care insurance market. One well-known agent observed that people would not consider private coverage so expensive if they were more likely to have to pay back the cost of their Medicaid nursing home benefits out of their estates.

Synopsis of the Problem

For many years, New Jersey has experienced rapid growth in total Medicaid rolls, general Medicaid program costs, and nursing home costs specifically. Just as Medicaid financing pressures are reaching crisis proportions, the federal government is likely to begin cutting back on its contributions to the program. Demographic trends guarantee that the need for all levels of long-term care will increase rapidly in the future. Yet, New Jersey's long-term care delivery system is heavily weighted toward expensive nursing home care and very lightly concentrated on the less expensive home and community-based services that most seniors prefer. Simultaneously, and in direct contradiction of the common sense notion that level of care should be proportionate to level of medical need, New Jersey's nursing home residents are relatively less dependent and more able-bodied than the same groups in some other states. Ironically, however, to redirect limited public assistance resources toward home and

[52] These companies are American Travellers Life, Continental Casualty, Bankers Life and Casualty, John Alden Life, John Hancock, Lincoln National Life and Mutual of Omaha. Some other companies offer individual polices under group plans approved in other states; GE Capital Assurance is an example.

community-based services and away from nursing home care may only increase utilization, inflate costs, and exacerbate the fiscal problem because of induced demand. Finally, the percent of New Jersey's nursing home residents that Medicaid pays for is increasing rapidly; Medicaid estate planning is pervasive; Medicaid estate recovery is relatively low; and long-term care insurance coverage is minimal. The stage is set for a major long-term care financing crisis in New Jersey.

THE ANALYSIS

The problems described and summarized above are not unique to New Jersey. To one degree or another, every one of the United States suffers from a similar mal-adaptation of the long-term care marketplace. The secret to solving these common problems is to understand why they have developed and how they persist. In this section, I will explain briefly how the long-term care system came to be the way it is throughout the country. Where appropriate, I will describe differences that uniquely characterize the system and problems in New Jersey. In the next section, I will describe in general terms what must be done to solve these problems in New Jersey. Finally, I will supply a series of specific recommendations necessary to actualize the proposed solution in the context of current and potential future state and federal law, regulations, and rules.

The Roots of the Problem[53]

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

Instead, with every good intention, the new federal Medicaid program offered publicly financed nursing home care. In time, New Jersey implemented Medicaid, including the program's generous nursing home benefit. This subsidy confronted families with a very difficult choice. They could pay out-of-pocket for the home care and assisted living services seniors prefer or they could accept nursing home care paid for by the government. Most people chose the safety and financial benefits of the Medicaid option. Therefore, the market for home care withered, private long-term care insurance failed to develop, and Medicaid-financed nursing home care flourished.

The nursing home industry took full advantage of this new public financing source by building many new facilities. To have failed to do so would simply have been bad business policy. As

[53] Portions of this analysis are drawn from a paper originally presented at the 22nd Annual Meeting of the American Legislative Exchange Council in San Diego on August 10, 1995. See also *The Long-Term Care Financing Crisis: Danger or Opportunity? A Case Study in Maryland*, LTC, Incorporated, Seattle, Washington, 1995.

fast as the industry could build them, however, the new nursing home beds filled with Medicaid residents. Stunned by the cost, Medicaid attempted to control the construction of new beds with Certificate of Need (CON) programs on the principle that "we cannot pay for a bed that does not exist." By the mid-1970's, health planning for nursing homes was in full swing. New Jersey's strong CON program, in effect since 1970, has severely restricted the construction of new nursing home beds and fits perfectly into this mold.

Capping bed supply, however, predictably drove up price and demand. The nursing home industry merely raised charges to compensate for the limitation on new beds. Government costs grew faster than ever. So Medicaid capped reimbursement rates too. This move compelled the nursing home industry to increase private-pay reimbursement rates to compensate. So began the highly problematical differential between Medicaid rates and private-pay rates. Today, Medicaid pays only 80 percent of private-pay rates on average nationally. The Medicaid rate in New Jersey is closer to 75 percent of the private-pay rate.

Eligibility Inflation

Higher private rates made Medicaid more attractive to private payers and this led to pressure on legislators to liberalize Medicaid eligibility. A long process of eligibility expansion gradually made Medicaid nursing home benefits available even to upper middle class people who had or could obtain the expertise to manipulate Medicaid's highly elastic eligibility rules. A whole sub-practice of law_Medicaid estate planning_ developed to take advantage of this new opportunity. Medicaid estate planning has permeated New Jersey as explained above.

With the supply and price of nursing home beds capped by government fiat and with Medicaid eligibility increasingly generous, nursing home occupancy skyrocketed to an average of 95 percent nationally. New Jersey, with its 95.9 percent nursing home occupancy rate, did not escape this trend.[54] With high demand and severely limited supply, nursing home operators could fill their beds easily with low-paying Medicaid patients. To achieve adequate operating margins, however, nursing homes had to attract a sufficient supply of full-paying private patients or they had to cut costs drastically.

The Origin of Quality and Discrimination Problems

[54] Erwin Brown, Jr., *Facts and Trends: The Nursing Facility Sourcebook, 1996*, American Health Care Association, 1996, p. 33.

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

Such trends have not developed as far or as fast in New Jersey as they have in other states. Almost everyone we interviewed for this study, inside and outside the nursing home industry, indicated that quality of care in the state's nursing homes is good.[55] As described above (pps. 10-11), some objective outside evidence supports this judgment. The reason that quality and discrimination problems have not yet become as severe in New Jersey as elsewhere is probably that the state has maintained comparatively high Medicaid reimbursement rates heretofore. Fiscal pressures to restrict rates more severely in the future, however, could give rise to the same kinds of problems that have plagued other states already.

Boren Battles

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

Soon, the Boren issue will be moot anyway. Everyone expects the law to be repealed in the near future. Unfortunately,

[55] There was a single exception to the otherwise universally favorable evaluation of New Jersey's nursing homes. One senior advocate said: "Go to a 95 percent Medicaid nursing home vs. a 45 percent Medicaid facility. You will know by the smell as soon as you walk through the door...To be put on Medicaid in this state is dehumanizing and demoralizing. There is a clear differentiation between the 30 percent who are private pay and the 70 percent who are public."

however, Congress cannot repeal the underlying problem any more than it can repeal the law of gravity. "You cannot get a silk purse out of a sow's ear." If New Jersey tries to solve the long-term care financing problem by capping or cutting Medicaid nursing home reimbursements and bed supply, the state will pay the price in quality and discrimination problems sooner or later as so many other states already have.

Home and Community-Based Services Waivers

In the meantime, a wave of academic speculation in the late 1970's indicated that paying for home and community-based services (HCBS) instead of nursing home care could save a lot of money. For years, therefore, Medicaid experimented with HCBS waivers as a cost-saving measure. In time, however, hard empirical research showed that (desirable as they may be) home and community-based services do not save money overall. Today, institutional bias remains Medicaid's strongest cost containment tool and one of its gravest deficiencies.

New Jersey has not created a large, publicly financed home and community-based services (HCBS) program yet. As Medicaid financing pressures continue to mount, this will probably prove to have been wise public policy. The more a state (like New York, for example) spends on publicly financed HCBS, the less incentive the public has to insure or pay privately for long-term care and the greater the pressure becomes to provide ever more expansive and expensive public long-term care services. Nevertheless, the ready availability of high-quality, affordable home and community-based services is a key component of any long-term care system. The proposed solution and recommendations offered below acknowledge this fact and provide for enhanced HCBS.

Summary

In a nutshell, just as heavy demand was building for a private seniors housing market in the 1960's, Medicaid co-opted the trend by providing easy access to subsidized nursing home care. Confronted with a choice between paying out-of-pocket for a lower level of care or receiving a higher level of care at much less expense, seniors and their families made the predictable economic choice. Not surprisingly, Medicaid nursing home caseloads and expenditures increased rapidly and drastically. In response, Medicaid capped bed supply and reimbursement rates, which led inevitably to excessively high occupancy, private-pay rate inflation, discrimination against low-paying Medicaid patients, and increasingly serious quality problems.

In time, Medicaid nursing home care acquired a national reputation (though less so in New Jersey) for impeded access, doubtful quality, inadequate reimbursement, widespread discrimination, pervasive institutional bias, and excessive cost. Medicaid remains, however, the only way middle class people can pay for long-term care after the need arises without spending their savings. That is why so many otherwise independent and responsible Americans fail to plan ahead or buy insurance and end up looking to Medicaid planning as the only way to save their estates or their inheritances. That is also why a huge proportion of America's glorious World War II generation is dying in nursing homes on welfare. Sadly, this analysis and conclusion applies also to New Jersey in principal part.

THE SOLUTION[56]

If the foregoing analysis of the Medicaid malaise in the United States and in New Jersey is accurate, a sensible solution comes easily into focus. The secret is to remove the perverse incentives in the current system that (1) discourage families from preparing for the risk of long-term care and (2) reward them for ignoring the problem until Medicaid nursing home care is the only viable alternative. Therefore, to facilitate universal access to top quality long-term care for all of New Jersey's citizens (rich and poor alike), any future, publicly financed long-term care program should have the following characteristics:

- It should save taxpayers money while improving access to quality long-term care for all citizens;
- It should encourage, instead of discourage, private financing of home and community-based services and assisted living;
- It should encourage, instead of discourage, the purchase of private long-term care insurance to pay for all levels of extended care;
- It should combine generous eligibility criteria to protect the unprotected (including the family home) with strong incentives for everyone to plan ahead for self-protection;
- It should pay market-based reimbursement rates to assure access to quality care for all participants and to eliminate discrimination;
- It should promote strong market competition between providers of all levels of care; and
- It should maximize the number of consumers in the marketplace who have a pecuniary interest in getting the best possible care at the lowest possible price.

[56] This section is borrowed substantially from a recent report on a similar study for the state of South Dakota. Circumstances unique to New Jersey have been reflected here when necessary. By using that portion of the analysis that remains the same between the two states, however, I was able to spend more time analyzing and describing New Jersey's unique characteristics elsewhere in this report.

Is a single program that combines all of these features possible? Could it be implemented under current state and federal law? Does New Jersey's existing long-term care system provide any kind of a foundation on which to build? What, in general, are the concrete steps the state needs to take to achieve this objective? These are the questions that the remainder of this report will attempt to answer. This section addresses the solution in broad scope. The Recommendations section provides somewhat more detailed guidelines.

Preserve the Social Safety Net

The solution to New Jersey's long-term care financing problem has five main steps. First, the state must continue to provide a viable social safety net for citizens who are already too old, too sick, or too poor to protect themselves from the ravages of old age and the expense of long-term care. Fortunately, New Jersey has an excellent base on which to build. The state's Medicaid program offers generous nursing home eligibility criteria and provides almost all of the 31 optional medical services available under federal law. New Jersey's Medicaid nursing home program has not deteriorated in terms of access, quality, reimbursement, and discrimination to anything approaching the extent common in many other states. Medicaid reimbursement rates also remain reasonable. It is not too late to save the program.

Therefore, the challenge in New Jersey is to preserve, and hopefully improve on, the existing long-term care system by eliminating the financial pressures that threaten it. To achieve this objective by raising state taxes, however, is not a likely or viable alternative according to the public officials and private citizens interviewed for this study. Likewise, slashing Medicaid coverage and reimbursements to save money is not a satisfactory or politically feasible solution either. Instead, New Jersey needs a more thoughtful and creative approach.

The answer is to discourage reliance on Medicaid nursing home care by the middle class and to attract private dollars and services into the long-term care marketplace. If we can keep enough people off of Medicaid who would have otherwise ended up on the program by default and empower them to pay privately for their care, we can relieve the fiscal pressure on the government, improve access to quality care for the public, and supercharge the private market for long-term care providers and insurers. Public policy has a critical role to play in achieving this objective.

Restrain Medicaid Estate Planning

The second step, therefore, is to prevent middle class people who suddenly confront a long-term care crisis from jettisoning their wealth to qualify for Medicaid nursing home care. New Jersey needs longer and stronger transfer of assets restrictions that will encourage seniors to retain their resources and pay for their own care as long as possible. The state needs to eliminate the existing incentive under Medicaid for heirs to expropriate their parents' assets in order to qualify them for publicly financed nursing home care.

Under current federal law, anyone can give away any amount of money (even millions of dollars) and become eligible for Medicaid nursing home benefits after a 36-month waiting period. The average period of time from onset to death in Alzheimer's disease, however, is eight years. Thus, anyone who chooses to do so has plenty of time to qualify for Medicaid benefits easily and without expensive legal assistance. Dozens of mass-market books and magazine articles explain this technique and many other similar methods to the general public. This study established that Medicaid planning of this kind is commonplace in New Jersey.

Unfortunately, despite good intentions and considerable effort, New Jersey has not enforced such rules and restrictions as are available under current law to control asset transfers and shelters, including the new authorities contained in the Omnibus Budget Reconciliation Act of 1993, as thoroughly as it might. As explained above, limited resources and other workload priorities have interfered. Furthermore, the biggest problem is that federal law still restricts the state's ability to establish and enforce asset control methodologies that will actually achieve the objective of preventing excessive asset transfers and shelters. The primary focus of reform must be to plan for the opportunity to lengthen and strengthen the transfer of assets rules either under a federal waiver or under a block grant. In the meantime, there are still many measures New Jersey can take under existing law to enhance this area of eligibility control. We will explore measures New Jersey can take under a waiver, block grant or existing law in the Recommendations section. Further study and research is necessary, however, to assure that the state does everything reasonably and cost-effectively possible to control the spread of Medicaid planning.

Security of Collateral as a Condition of Eligibility

The third step to reform New Jersey's long-term care system is to assure that people receiving assistance, who have retained income or assets protected by the system's generous eligibility

rules, do not divest this wealth while they are receiving publicly financed benefits. The principle here is that people who have wealth to protect, but who need Medicaid to help them finance long-term care because their monthly cash flow is inadequate to pay for their care, should receive public benefits as a loan, not a give-away or welfare. Those who care to may liquidate their wealth and purchase red-carpet access to top-quality care in the private long-term care marketplace until they have nothing left of their estates. But those who choose to retain a home, car and other assets exempted by the Medicaid program for the benefit of their immediate dependents (such as a healthy spouse or disabled child) should expect to repay Medicaid for benefits received after the assets are no longer needed to support these dependents.

The Medicaid program often pays for years and years of expensive, custodial long-term care for recipients who own many thousands of dollars worth of exempt assets. It is very appropriate for the program to require legal security for this expenditure of public funds, just as any other financial institution would require a mortgage to secure a loan used to purchase a property. This objective is achieved by instituting a lien as a condition of eligibility. The lien would only be obligatory if the person chooses to take advantage of Medicaid benefits while preserving and sheltering assets. It does not prevent transfer of a home or other property. The lien merely assures that the creditors, in this case the state and federal governments who finance Medicaid, are notified if the liened property is to be sold or transferred. This method assures that an equitable arrangement can be reached which protects any legitimate dependent's interest in the property but also protects the interest of the tax payers who are financing the long-term care of the ill spouse under Medicaid.

Although current federal law does not permit the use of liens as a condition of eligibility, it does allow the placement of liens on real property under certain circumstances while a Medicaid recipient is receiving benefits. Unfortunately, New Jersey does not take advantage of TEFRA liens (as described in footnote number 49 above), but rather compels the family to liquidate the home when the recipient is unable medically to return and no exempt dependent remains in the home. Premature liquidation of residences is harsh public policy. It is technically impermissible under federal regulations. It is also very costly in that the state could often collect more money by allowing families to retain homes and pay back the cost of Medicaid from rental income or family contributions. Thus, in the area of liens, New Jersey's objective should be, first, to expand the state's authority to use liens more fully either under

a federal waiver or a block grant. Second, the state should explore ways to assure that Medicaid recipients do not divest homestead property before it can be secured by a lien.

Medicaid Estate Recovery

Step four is to implement a comprehensive, universal, failsafe system of Medicaid estate recovery. The principle here is that people who receive Medicaid nursing home benefits while preserving a home, business, or other property have the moral and legal obligation, and deserve the right and the dignity, to pay back the cost of their care. "It isn't welfare if you pay it back" is how many proud seniors look at the issue according to a Medicaid eligibility worker interviewed for a previous study. By sending the message that Medicaid is a loan and not a grant, a strong estate recovery program can begin to reverse the culture of dependency and entitlement that threatens to swamp America's public assistance programs. Estate recoveries also generate non-tax revenue to support the Medicaid program. Potentially, up to five percent or more of the cost of the Medicaid nursing home program can be recovered from lien and estate recovery efforts. Most such programs recover at least $10 for every dollar invested in the cost of recovery and New Jersey is currently recovering at a rate of $20 or more to $1.

The primary contribution of Medicaid estate recoveries to an efficient long-term care system, however, is not revenue, but rather to send a strong message to the public that long-term care financing is a genuine risk. This is the message that a strong estate recovery program sends to the general public: You either "pay now or pay later." That is, plan ahead, buy insurance, or pay privately for home and community-based services. Otherwise, if you take advantage of the publicly financed program, you absolutely, positively will pay every nickel back before any remainder value in your estate passes to your heirs. This is not bad. This is very good. It means you can protect your home from the immediate ravages of catastrophic long-term care costs, because the government has a wonderful new program to lend you a hand. But it also means that over time, your heirs will have to pay back the state for the cost of your care (up to the value of your estate which they otherwise would have received intact). Without this requirement, the government program could not remain solvent financially. If you or your heirs do not want to have to pay back the cost of your care, then you have a strong incentive to seek alternatives to relying on Medicaid to pay your long-term care costs.

Once again, it is good to report that New Jersey has laid a fine foundation on which to build in the area of estate recovery

as described above (see pps. 40-41). The Recommendations section of this report will offer several additional suggestions to enhance the recovery potential from liens and estates. Further study is necessary and warranted, however.

Public Education

In the meantime, the most important measure New Jersey can undertake with regard to estate recoveries is step five in the reform of the state's long-term care system: educate the public about the risks of long-term care. No degree of tightening Medicaid eligibility criteria or enforcing liens and estate recoveries will have any effect on individual behavior unless the public knows what the state is doing. People will not become concerned about long-term care, seek out insurance protection, or pay privately for home and community-based services to avoid Medicaid dependency and eventual estate recovery **unless they know they are at risk**. For this reason, the state of New Jersey should earmark a significant portion (at least ten percent) of the revenue generated by the lien and estate recovery programs to finance a major public education campaign.

This public education campaign should (1) explain the risk of long-term care, *i.e.*, a nine percent probability that a person will spend five years or more in a nursing home after age 65 at a cost of $40,000 or more per year in New Jersey; (2) describe the difficulties associated with qualifying for and receiving Medicaid nursing home benefits including (a) income and asset restrictions, (b) lien and estate recovery requirements, and (c) the possibility that future financial crises may limit access to and quality of care for public welfare recipients; and (3) elaborate the alternatives that families have available to finance long-term care privately including (a) home and community-based services to help the elderly remain at home as long as possible, (b) long-term care insurance to spread the risk of catastrophic costs widely among eligible (*i.e.*, relatively, younger and healthier) policy holders, and (c) home equity conversion to tap seniors' primary source of wealth by generating a cash flow from an otherwise illiquid asset to help pay for HCBS and insurance premiums.[57]

[57] Research shows that 57 percent of home owners could purchase long-term care insurance with nothing more than the proceeds of a reverse annuity mortgage. (Aldo A. Benejam, "Home Equity Conversions as Alternatives to Health Care Financing," *Medicine and Law*, Vol. 6, No. 4, May 1987, p. 340.) The main reason home equity conversion has lagged as a source of long-term care funding throughout the United States is that Medicaid exempts the home and all contiguous property, regardless of value, whether

Once the public understands these risks, and once the risks are backed up by strong enforcement of the new state program, the public will gradually change behavior. Instead of ignoring long-term care, people will worry, plan, and prepare for this risk the way they do for any other genuinely catastrophic risk. If any doubt remains, ask yourself how many people would buy fire insurance if the government rebuilt every house that burned down. For that matter, consider why so few people purchase flood insurance, when every politician within a thousand miles shows up after every major inundation to declare an emergency and distribute checks.

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or not the home is occupied, and whether or not the Medicaid recipient can reasonably be expected ever to return to the home. Why tap the equity in the home to pay for long-term care or insurance when the government will pay and protect the home as well (as long as one legally avoids estate recovery which is still relatively easy to do)?

CONCLUSION

New Jersey faces a very challenging future. Demographic and fiscal forces are closing in on the state. A rapidly aging population guarantees increasing health care costs, especially for long-term care. Economic exigencies at the state and federal level threaten revenue growth and inhibit public spending on health care priorities. Already, nursing home costs are very high and Medicaid has nearly doubled as a percentage of the state budget in the past few years. Ironically, state plans to enhance publicly financed home and community-based services_for the purpose of spending scarce resources more wisely_may exacerbate the spending problem. By making Medicaid eligibility even more attractive than it already is, the state runs the risk of unleashing a huge induced demand for government services.

Despite this looming crisis, however, New Jersey is only beginning to recognize and face the problem of hemorrhaging long-term care costs. The state has very generous Medicaid eligibility rules which allow most seniors to qualify quickly for nursing home benefits. Medicaid estate planning, the practice of sheltering or divesting assets to qualify for publicly financed nursing home benefits without spending down, is pervasive in the state. New Jersey has no lien program to secure sheltered assets while recipients receive Medicaid benefits. The state's Medicaid estate recovery program is very limited in scope and the public is practically unaware of this liability. Divided administration of the program, split between two state departments and the counties, complicates operations and hamstrings corrective action. With Medicaid nursing home benefits easy to obtain and the public largely unaware of Medicaid's potential downside risks, New Jersey has inadvertently deflated demand for private financing alternatives such as home equity conversion and private long-term care insurance.

New Jersey faces another problem which, if not unique, is more pronounced here than elsewhere. The state's economic prosperity has contributed to a sense of security that may no longer be warranted. Repeatedly, study respondents told us New Jersey has deferred confronting the challenge of long-term care financing by spending more and more money in a futile attempt to keep all interest groups content. According to one state official: "New Jersey has had enough money to buy its way out of this problem up to now. We spend money like crazy because everyone wants to be nice." As a consequence: "Seniors have an entitlement mentality because politicians have been pandering to them," according to another official. One particularly discouraged and cynical state legislator said: "Seniors will not

give up their entitlement; the nursing home industry is powerful enough to avoid cuts; so the poor will bear the burden." Fortunately, the senior representatives interviewed for this study had a very different view. When presented the problems and the options, they were eager to understand the issues and work together with others to find solutions even if their own benefits are at risk.

I conclude that nothing is more important in New Jersey for solving this problem than public education. In the words of Bill Caldwell, who coordinated this project on behalf of the state Department of Health and Senior Services: "Most people really don't believe the government is going to run out of money. We have to educate them and bring home the fiscal reality." Finally, another important piece of advice that we heard from numerous public policy makers during this study is that we have to keep solutions positive and emphasize what any new changes or programs have to offer seniors. Therefore, the focus of the following recommendations is to promote discussion of these issues by the key stakeholder groups, to empower win/win solutions that leave no one behind, and to educate the public about the need to plan ahead for long-term care.

RECOMMENDATIONS

The objective of the following recommendations_assuming they are first refined into a well-researched, highly coordinated, and aggressively enforced plan of action_is to reduce Medicaid nursing home utilization in New Jersey from almost 70 percent of all residents to 60 percent (the actual level as recently as 1992) over a period of three to five years. This is a conservatively achievable goal and could save the state of New Jersey as much as $200 million per year or approximately 20 percent of the Medicaid nursing home budget (in combination with enhanced lien and estate recoveries). If the state does nothing and Medicaid nursing home utilization continues to creep up to 80 percent,[58] New Jersey will need to spend at least an extra $119 million per year for nursing home care not counting annual inflation adjustments.[59]

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

The recommendations are presented in two groups. Those actions that do not require either a waiver of federal law or the wider state authority anticipated under a block grant are presented first. These recommendations come first because they are easier to implement and because discussion among long-term care interest groups and education of the public are so critical to making progress in New Jersey that more aggressive measures

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

[59] This estimate is based on data provided by the Department of Health and Senior Services which indicate that a ten percent increase in Medicaid patient days would increase total expenditures by $119 million. An increase in Medicaid census from 70 percent to 80 percent would actually increase total patient days by much more than 10 percent, resulting therefore in an even higher increase in state expenditures than $119 million per year.

are impractical at this stage. Nevertheless, to achieve a fully successful reform of the long-term care system in New Jersey will probably be impossible without seeking either a federal waiver or wider state authority under a future block grant. Fortunately, the Health Care Financing Administration and the Clinton Administration have become much more amenable to creative ideas and experimental waivers recently. The immediate likelihood of the block grant option has declined in recent months, but will likely increase again because it is driven by the federal Medicaid financing crisis which shows no signs of mediating. For more detail on one possible block grant approach, see Appendix C entitled "Model State Statute Explained: Long-Term Care Financing Under a Medicaid Block Grant."

Finally, before presenting these recommendations, I must remind the reader that a three-week project, including only five days of field work and five days of literature review, is completely inadequate to plot a course for long-term care reform in New Jersey. Therefore, most of these recommendations are cast in very general terms and many of them are similar (sometimes nearly identical) to recommendations made to other states in earlier reports by the same researcher. There are two reasons for this fact. First, New Jersey faces many of the same problems that other states face and the appropriate solutions are often the same also. Second, in a study of this small scope, we are flying at tree-top level. To provide ground-level, operational, politically feasible, New Jersey-specific recommendations would require weeks of intense research into the laws, regulations, administrative rules, agency practices, public policy and political climate of the state.

Therefore, many of these recommendations are qualified by a call for further study and analysis. Most of the additional research that needs to be done can and probably should be done on contingency so that the state of New Jersey can preserve scarce program resources for their originally appropriated purpose. To conduct these studies, in other words, the state should contract with vendors who are confident enough in the success of their work to take their fees from actual, documented recoveries or savings that occur as a direct result of their recommendations. Included as Appendix A at the back of this report is a proposal for a broader project designed to fill many of the gaps that remain in our knowledge of the problem and the solutions.

I. **RECOMMENDATIONS ACHIEVABLE UNDER CURRENT FEDERAL LAW**

1 Retain a Generous Public Long-Term Care Financing Program

1.1 Resist the temptation to solve Medicaid financing problems by drastically cutting eligibility, coverage or reimbursement. Such draconian measures are unnecessary if the state implements the recommendations in this report. They would only exacerbate other problems such as catastrophic spend down, neglect of the frail elderly, and discrimination against Medicaid nursing home residents.

1.2 Consider adopting the federal maximum spousal impoverishment standards which allow all community spouses to retain $76,740 instead of half of the joint assets up to that amount as currently applies. Review and consider other measures to make Medicaid more "user friendly" for middle class families who lack the cash flow to pay for long-term care. Such program improvements will be affordable if the state implements the asset control methods recommended below.

1.3 The state of New Jersey needs to listen to what seniors and all other long-term care stakeholders have to say about the problems discussed and the solutions proposed in this report. The state should convene a conference to discuss this study's findings and recommendations. Invite senior advocates, provider representatives, legislators and staff, the Governor and her staff, DHSS and DHS representatives, county managers and eligibility workers, long-term care insurance regulators and sales agents, and any other groups with a stake in long-term care. Because of the extreme political sensitivity of these issues, however, this meeting should be a "Brainstorming Conference" carefully designed to foster the open expression of ideas, but also to discourage criticism and judgmental attacks between interest groups.

1.4 Implement the recommendations in this report for controlling Medicaid estate planning, enhancing liens and estate recoveries, and encouraging private financing alternatives before continuing with state initiatives to expand public financing of adult foster care homes and other forms of home and community-based services. To proceed with current plans without initiating appropriate asset control methodologies could run the risk that induced demand will drive up costs insupportably before the necessary controls are

in place.

1.5 The state of New Jersey should commission a much more comprehensive study of long-term care financing based on the guidance and direction received from the brainstorming conference recommended above. One possibility is the project described in Appendix A. Another model is the task force in New York state which produced a report to the governor and the state legislature in May 1996 entitled "Securing New York's Future: Reform of the Long-term Care Financing System."[60] Recommendations in the New York report closely parallel the strategy and specific recommendations made herein and in other reports by the author.

2 Control Divestiture and Medicaid Estate Planning

2.1 The Department of Health and Senior Services should work closely with the Department of Human Services and representatives of the counties to develop and implement a training program for field eligibility staff to discourage inappropriate Medicaid planning. The state should further strengthen training, procedures and legal support to assist field eligibility staff in dealing with Medicaid estate planning attorneys, general practitioners, and other representatives of Medicaid applicants who seek "loopholes" in current law.

2.2 Develop a pamphlet to be distributed to all Medicaid long-term care applicants by field eligibility staff explaining the fact that Medicaid is having severe financial problems, that Medicaid recipients may encounter difficulties in accessing quality care, that these problems may become much worse in the future, and that healthy friends, relatives and spouses of current Medicaid recipients should explore private insurance for their long-term care needs instead of expecting Medicaid to be there in the future as it has been in the past.

2.3 Conduct a valid random sample of Medicaid nursing home eligibility cases in New Jersey to determine the

[60] Task Force on Long-term Care Financing, *Securing New York's Future: Reform of the Long-term Care Financing System*, State of New York Department of Health, Albany, New York, May 1996.

incidence and cost of asset divestiture and other techniques of Medicaid estate planning (such as trusts, annuities, purchase of exempt assets, life estates, abusive divorces, dubious claims of exempt transfers, *etc*.). Compensate the contractor for this study on contingency from the savings incidental to its findings so that the state has little or no cost. To date, no such study has been done and the state has no estimate of program losses caused by the legal stretching or illegal breaking of nursing home eligibility rules by applicants or their representatives. A good model is the systematic quality control study conducted by Minnesota which "found asset transfers of $2,101,250, of which $1,747,852 was attributed to improper asset transfers and $353,398 was attributed to permissible asset transfers."[61] Inasmuch as Minnesota's Medicaid nursing home program is smaller than New Jersey's, potential savings could be even greater here.

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

2.5 Clamp down on the use of annuities and life estates to shelter excess resources. According to state eligibility staff, these loopholes are wide open in New Jersey. The subject is extremely complicated, affected by guidelines published by the Health Care Financing Administration (HCFA), and requires extensive further study. There may be much more New Jersey can do than it already is doing. A review of federal policy and restrictions utilized by other state Medicaid programs is needed.

2.6 Establish safeguards to assure that seniors get the

[61] Minnesota Department of Human Services, *Medical Assistance Quality Control Long Term Care Client Asset Review*, St. Paul, Minnesota, April 22, 1996, quote is from the executive summary, page unnumbered.

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

2.7 New Jersey should take full advantage of the legal interpretation that Medicaid estate planning may violate the common law of fraudulent conveyances. In other words, a transfer in contemplation of avoiding a future possible creditor, *i.e.* Medicaid, may be a fraudulent conveyance even if it otherwise complies with Medicaid rules. This idea is fertile with potential, but will require considerable additional research. A Deputy Attorney General representing the state could pursue this work or a private contractor might do the job. Huge savings to the Medicaid program could accrue.

2.8 To educate and empower eligibility policy staff, the Deputy Attorneys General, and hearings and appeals personnel, the New Jersey Medicaid program should subscribe to and carefully review elder law publications such as John Regan's Tax, Estate and Financial Planning for the Elderly and Clark Boardman Callaghan's *Advising the Elderly Client*. These publications are full of Medicaid estate planning techniques that lawyers are using to circumvent Medicaid eligibility rules. Publications like these supply vital clues on where to focus efforts to control and contain Medicaid estate planning abuses.

2.9 State eligibility staff should attend all major elder law conferences including the annual Joint Conference on Law and Aging held in Washington, D.C. and the semi-annual symposia and institutes of the National Academy of Elder Law Attorneys (NAELA) held at various locations throughout the United States. Join NAELA and

participate so you know what the Medicaid planners are planning. This is an excellent way to monitor old and new Medicaid estate planning techniques. It also provides an opportunity to convey the Medicaid program's point of view on Medicaid estate planning to professionals in the field and to enlist their help in correcting problems. Alternatively, the Medicaid program can obtain advice from consultants or attorneys who attend these meetings and study the Medicaid planning literature.

2.10 County eligibility staff should have better access to good professional legal assistance and representation in hearings and appeals. Greater efforts should be made to educate the judiciary in New Jersey regarding the cost to the state of overly generous interpretations of the laws and regulations intended to control access to public financing.

2.11 New Jersey should form a special team of state staff attorneys, eligibility experts, and Medicaid estate recovery specialists to work with a public relations expert on a public action program to encourage advance planning for long-term care and discourage reliance on Medicaid by default.

3 Enhance Asset Security

3.1 New Jersey should stop compelling nursing home residents to list their homes for sale in violation of federal eligibility rules. As long as the Medicaid recipient expresses an intent to return to the home, the family should be allowed to keep and maintain it as required by federal law. Forced sales are disruptive to families and often result in lost revenue to the state.

3.2 Instead of compelling premature liquidation of family homes, the state of New Jersey should implement a TEFRA lien program. The state of Maryland, whose Medicaid nursing home program is less than half the size of New Jersey's, collects over $1 million per year from its TEFRA lien program with only nominal administrative costs. (Maryland also recovers additional real estate value through its Medicaid estate recovery program.)

3.3 The opportunity to save the family homestead is very beneficial to seniors. The fact that the home becomes security for repayment of Medicaid benefits impresses

on families the need to buy insurance or purchase home and community-based services in order to avoid the lien liability on their homes incidental to receiving Medicaid nursing home benefits. To maximize such cost avoidance savings, the state should publicize its lien program as widely and promptly as possible.

4 Strengthen Estate Recovery

4.1 Conduct a comprehensive study of the Medicaid estate recovery program in New Jersey to identify ways to increase recoveries. As explained in the text of this report, the state recovers only a fraction of the revenue that could be expected based on the performance of other states. Several recommendations to enhance estate recoveries are included below, but further study and analysis is critical.

4.2 New Jersey should either staff up its estate recovery program or retain a private contractor on contingency to capture potential recoveries that are being lost. If the state continues to run this program, then a method should be developed to direct a portion of all recoveries toward growth and enhancement of the program. For example, for every additional $250,000 that the program recovers, one additional staff member might be added until the total recovery potential is achieved.

4.3 New Jersey currently pays a "county bounty" bonus to counties administering the Medicaid program when they discover and recover benefits improperly or illegally paid. A similar system should be developed to reward counties for their help on lien and estate recoveries. If New Jersey continues to compel home sales, the county bounty should be expanded (although perhaps at a smaller percentage) to cover voluntary recoveries. Furthermore, the voluntary recovery program should be expanded, enhanced, and encouraged. When it becomes permissible under federal law, recovery of Medicaid costs from the proceeds of the sale of a recipient's home should be mandatory unless the proceeds are used to purchase another exempt residence or unless recapture would produce a legitimate hardship.

4.4 Lien and estate recovery staff should train county field eligibility staff in techniques to identify unreported property or asset transfers. New Jersey cannot collect liens or estate recoveries from property

that was divested by Medicaid recipients to qualify for assistance in the first place. Integrating the front-end eligibility process with the back-end lien and estate recovery program is absolutely essential but largely unachieved at present.

4.5 Draft and pass state legislation to require nursing homes to remit the proceeds of personal needs accounts of Medicaid recipients who die directly and immediately to the state. The current system whereby nursing homes notify the Medicaid program upon the death of a resident receiving benefits works fairly well. Nevertheless, states that require nursing homes actually to remit the personal needs accounts directly to the state upon the death of a Medicaid recipient have found that the system saves a lot of time and money and prevents heirs from diverting resources to themselves that should be used to reimburse the state for the cost of care already provided.

4.6 New Jersey should add to its estate recovery efforts a program to collect hard assets such as antiques, jewelry, vehicles, guns, investment grade collections, *etc*. Obviously, such assets should be collected only if doing so is cost-effective. Currently, hard assets drift out of estates or are cashed out for pennies on the dollar with the result that thieves, heirs, or investors prosper from Medicaid subsidies. Only objects of real sentimental value such as original wedding rings should be exempted. If taxpayers are willing to protect all of a family's possessions from long-term care costs, why should the family pay its own way rather than relying on Medicaid?

4.7 New Jersey should begin a systematic and comprehensive system of accounts receivable. For example, the state could avoid liquidating certain illiquid assets in the probate process in order to preserve more of their value and in order to help families retain the assets (such as homesteads or family farms) by repaying the Medicaid program over time. Oregon recovers more than $85,000 per month from accounts receivable of this and many other kinds. If occasionally it becomes necessary to receive real property that will not sell quickly in a down market, consider placing the property in management by a private real estate manager with fees paid by rental income until the real estate market improves.

4.8 Implement a method to track former Medicaid recipients and spouses predeceased by Medicaid recipients. Recover Medicaid benefits previously paid from the estates of former recipients and spouses up to the limit of the law. Spousal recoveries are an enormous source of non-tax revenue currently lost by the state. By not pursuing spousal recoveries, New Jersey allows substantial wealth to pass unencumbered to heirs regardless of how much money Medicaid contributed toward the recipient's care.[62] By not pursing estates of former recipients, the state has inadvertently created an incentive for families to remove nursing home residents from Medicaid eligibility immediately before death to avoid estate recovery.

5 Educate the Public About and Actively Encourage Long-Term Care Financing Alternatives

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

5.2 Draft an executive proclamation for Governor Whitman to deliver at a press conference declaring that the official policy of the state of New Jersey is to target Medicaid resources to those who need them most. In other words, Medicaid in New Jersey is for the genuinely needy, measures are being taken to discourage Medicaid estate planning, restrictions on divestiture of assets are being tightened, a strong estate recovery program is in effect and expanding, and seniors and heirs should carefully examine private long-term care financing options. Those who retain exempt or sheltered assets while receiving Medicaid benefits should anticipate the certainty that such assets will reimburse Medicaid for benefits paid before any remainder passes to heirs.

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[62] A recent court case in Wisconsin has brought the practice of spousal recoveries into question under federal law. This is a legal matter that should be watched very closely. States that continue to recover from spousal estates should be contacted for advice on the issue and to develop a state legislative strategy. In any case, spousal recoveries will be much easier to achieve under waiver or block grant authority.

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

5.4 Design a campaign_using flyers, white papers, and video-tapes_to educate the media, the public, attorneys, judges, eligibility workers, hearings officers, seniors and their advocates, nursing homes, home health agencies, insurance agents and other long-term care interest groups concerning the issues explained in and the public policy changes delineated in this report.

5.5 Inform the state elder law bar that efforts to stretch Medicaid eligibility rules beyond the limits intended by federal and state lawmakers will not be permitted without a legal fight. Mobilize to back up that resolve with action whenever Medicaid estate planning rears up. Seek the assistance and cooperation of the elder law bar to notify their clients that state and federal Medicaid laws change frequently, that Medicaid estate plans designed today may be totally unusable in the future, and that long-term care insurance and private payment for home and community-based care are important options to consider. Recommend to elder law attorneys who engage in Medicaid planning that they obtain signed waivers from every client relieving them of malpractice liability if their Medicaid plans fail because of changes in the law and confirming that their client was presented the alternative of purchasing a long-term care insurance policy when and if this is a viable alternative.

5.6 Send a mailing to all citizens of the state advising them of provisions in the new health reform act signed by President Clinton on August 21, 1996 to the effect that beginning January 1, 1997, under certain circumstances, long-term care insurance premiums will be tax deductible and transfer of assets to qualify for Medicaid will be a crime. The federal government could not send the message to the middle class any more clearly: buy private insurance and stay off Medicaid. The state of New Jersey should make sure that this message gets through to the intended audience.

5.7 Develop a systematic, statewide, well-financed initiative to educate the public about the risk of long-term care, the cost of institutionalization, and

the availability of private long-term care insurance to prepare in advance. If necessary, tap a percentage of lien and estate recovery revenues to finance this initiative. Seek and obtain the cooperation and assistance of the Chamber of Commerce and the various public and private employee unions in this effort. The Medicaid program and the long-term care insurance industry should find ways to work together in their common interest and in the common interest of their mutual clients. This is not a conflict of interest. It is a confluence of interests.

5.8 Initiate similar education campaigns to promote awareness of home equity conversion options, home and community-based services, and family subsidization plans. If families know they stand to lose estates and inheritances to Medicaid liens and estate recoveries, they will pull together, help each other out, defer expensive institutional care, and look creatively for ways to finance cheaper, more desirable levels of care.

5.9 Examine state insurance regulations on long-term care insurance to assure that they encourage the availability of affordable products. First impressions based on this study suggest that long-term care insurance regulation in New Jersey is very reasonable, protecting consumers without unduly hampering the marketability of the product. Nevertheless, the state Medicaid program and the Department of Banking and Insurance should work together very carefully to assure that their efforts in public and private long-term care financing are complementary and not mutually defeating.

5.10 Explore the possibility of encouraging the purchase of private long-term care insurance by granting state tax deductibility. This is not a high priority. People rarely fail to buy long-term care insurance because it is not tax deductible and deductions constitute a tax expenditure that negatively impacts the bottom line in the state budget. Nevertheless, on the margin, if affordable, and especially in the context of recent federal initiatives to make premiums tax deductible, state tax deductibility should be considered.

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

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

5.12 The Department of Health and Senior Services should seek out elder law attorneys and private long-term care insurance agents and attempt to integrate the interests of all three groups. New Jersey has a reputation for reaching out to industry and this is a perfect opportunity to do so. For example, elder law attorneys might do less Medicaid planning if they fully understood the damage it does to the state's ability to provide benefits to the needy. Attorneys might be more apt to recommend long-term care insurance to their younger, healthier clients if they understood the product better. Perhaps insurance agents would refer their clients to elder law attorneys for legitimate estate planning and vice versa if they understood each other's services better. The Medicaid program could save tax payers a lot of money by facilitating cooperation and concord between attorneys and insurance agents toward the goal of preparing everyone who qualifies and can afford long-term care insurance to buy it and stay off Medicaid.

II. RECOMMENDATIONS THAT WOULD REQUIRE A WAIVER OR BLOCK GRANT[63]

1 Retain a Generous Public Long-Term Care Financing Program

[63] See Appendix C entitled "Model State Statute Explained: Long-Term Care Financing Under a Medicaid Block Grant" for the public policy rationale for these recommendations.

1.1 Adopt the "Senior Financial Security Program" (SFSP) outlined in Appendix C entitled "Model State Statute Explained: Long-Term Care Financing Under a Medicaid Block Grant." The SFSP assures access to high quality, publicly financed long-term care while retaining strong incentives for families to plan ahead for private financing of home, community-based, and nursing home services.[64]

2 Control Divestiture and Medicaid Estate Planning

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

2.2 Limit the amount that Medicaid applicants can shelter in prepaid burial accounts to no more than the cost of a decent disposal of remains and a simple service, perhaps $2,500. Currently, there is no effective limit on how much money can be sheltered in this way and nearly all Medicaid nursing home recipients in New Jersey take advantage of this loophole. The public policy issue involved here is whether scarce welfare resources are appropriately used to subsidize expensive funerals for people who could otherwise have afforded to pay longer for their own long-term care. Is it proper, in other words, to use money appropriated for public assistance to indemnify heirs against the cost of burying their parents? The state should study (or retain a private contractor on contingency to examine) this issue. New Jersey should also monitor and insure that the state's funeral homes refund excess prefunded burial costs that are eventually unspent, instead of refunding this money to the heirs. (Such a policy eliminates the incentive for heirs to minimize burial or cremation costs and pocket the difference which had been exempted as a funeral cost for purposes of

[64] The American Legislative Exchange Council recently endorsed a minor variation of the model state statute described here.

determining Medicaid eligibility.)

2.3 Determine whether or not "wholesale" Medicaid estate planning is a problem in New Jersey and, if so, prohibit the practice. Wholesale Medicaid estate planning is the practice by large (often charitable) organizations or retirement centers of requiring donation of all assets to qualify for their program by which means they insure that all participants are eligible for Medicaid nursing home benefits within 36 months. The state or a contractor should conduct a study to determine if this practice occurs today and whether or not it is growing.

3 Enhance Asset Security

3.1 Formally require a lien on all property real and personal as a condition of receiving public long-term care benefits. Liens do not prevent property-owners from selling or transferring their property. They only assure that the creditor, in this case the taxpayers, are privy to the transaction and have an opportunity to protect their security.

4 Strengthen Estate Recovery

4.1 Require all recipients to agree in writing as a condition of eligibility that all proceeds from the sale of everything they own[65] will go to pay for the cost of their care upon the death of their last, surviving exempt dependent relative and that all property of a predeceased Medicaid recipient will be encumbered by a lien until such time as it is recoverable from the estate of a dependent relative.

5 Educate the Public About and Actively Encourage Long-Term Care Financing Alternatives

5.1 All of the actions necessary under this category may be accomplished under existing federal law. Nevertheless, the additional state authority potentially available under a waiver or block grant would empower any public education program enormously.

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

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Appendix A

Project Proposal: Controlling Medicaid Long-Term Care Costs

Submitted to the State of New Jersey
by
Stephen A. Moses, Director of Research
LTC, Incorporated

I. **Objective**: Produce a step-by-step plan to save the State of New Jersey $200 million per year in Medicaid nursing home expenditures while simultaneously assuring universal access to top quality long-term care for rich and poor citizens alike across the whole spectrum from home and community-based to nursing home care.

II. **Problem**: Medicaid nursing home expenditures in New Jersey nearly doubled from $630.2 million in 1989 to over $1 billion in 1994. This rapid cost increase severely impairs the state's ability to maintain generous Medicaid nursing home eligibility criteria, to expand the home and community-based services often preferred by seniors, and to sustain adequate financing for other critical state services such as corrections, education, and highways.

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

IV. **Treatment**: The solution to this quandary, proposed in a long series of reports by the DHHS Inspector General, the General Accounting Office, and LTC, Incorporated, is to retain generous Medicaid eligibility criteria while restricting asset transfers and shelters, enhancing estate recoveries, and encouraging private long-term care financing alternatives. The difficulty with this solution, however, is that it is complicated to achieve and it is often opposed by various long-term care interest groups. Therefore, a two-fold public policy intervention is needed: the Medicaid program must assure that (1) every federal and state statutory, regulatory and administrative remedy is

fully employed to target public assistance resources to the most needy while diverting more prosperous people to private financing options and (2) every stakeholder in the long-term care financing issue understands the benefit to its constituency of implementing the necessary measures. These are the specific goals that this project would seek to achieve.

V. **Work Plan**: To achieve the objective and goals of this project, we propose the following activities (estimated hours by project staff in parentheses):

A. Examine Medicaid nursing home eligibility criteria in New Jersey with attention to federal and state statutory, regulatory and policy guidelines. Thoroughly study and review all relevant state and federal statutes, regulations and policy manuals and compare them to eligibility policies in other states. Provide recommendations for state legislation, program policy changes and federal waivers to achieve a stronger and tighter asset control methodology. (40 hours Moses; 10 hours Tjelle)

B. Review the state's implementation of OBRA '93 (Omnibus Budget Reconciliation Act of 1993) authorities. Interview responsible state staff and study existing plans, proposed legislation, and policy options under consideration. Recommend ways that the State of New Jersey can take full advantage of this powerful federal legislation. (30 hours Moses; 6 hours Tjelle)

C. Appraise the status of Medicaid estate planning (the artificial impoverishment of frail seniors to qualify them for publicly financed nursing home benefits) throughout the state. Review the legal literature on Medicaid planning in New Jersey and interview five or more key, influential elder law attorneys. Recommend measures to control Medicaid estate planning and to encourage attorneys, financial planners, accountants and other senior advisers to suggest private long-term care financing alternatives while their clients are young and healthy enough to afford them. (60 hours Moses; 8 hours Tjelle)

D. Plan and conduct site visits to at least four local Medicaid nursing home eligibility local offices (urban, suburban, and rural). Interview supervisors and eligibility workers; review eligibility policies and procedures; examine a judgmental sample of Medicaid nursing home eligibility case records; compile examples of Medicaid estate planning techniques; explore the potential impact of possible alternative solutions on affected field staff; and obtain ideas and recommendations from front line workers. (48 hours Moses; 10 hours Tjelle)

E. Analyze New Jersey's lien and estate recovery statutory

authorities, regulations, administrative policies, program activity, and collections. Interview key program staff; analyze procedures; examine the integration of front-end eligibility controls with back-end collection efforts; estimate maximum recovery potential; research best practices from other states and explore the possibility of applying them in New Jersey. Recommend initiatives to maximize non-tax revenue to the State of New Jersey from lien and estate recovery programs. (48 hours Moses; 12 hours Tjelle)

F. Study long-term care insurance regulation in New Jersey. Interview representatives of the State Insurance Commissioner's office; review laws, regulations and policies governing the content and sale of long-term care insurance products in the state; interview agents and brokers who market home health and nursing home insurance policies concerning the obstacles they face; compare policies and practices in New Jersey with other states; and analyze the chilling effect of easy Medicaid eligibility on the marketability of private insurance alternatives. Recommend statutory, regulatory and policy changes to enhance early planning for private long-term care insurance as an affordable, high quality alternative to reliance on Medicaid nursing home benefits by default. New Jersey's long-term care insurance market penetration is only 1-3 percent, among the lowest in the country. Therefore, this part of the project is very important. (30 hours Moses; 6 hours Tjelle)

G. Interview and brief key long-term care stakeholders: e.g., senior and consumer advocates, Governor's staff, key legislators and staff, proprietary and non-proprietary nursing home and home health providers, long-term care insurers, Medicaid planners, taxpayer representatives, the Chamber of Commerce and other business interests, Medicaid management, line and legal staff, and any other group which the Department believes would be appropriate. It is critical to meet with each group separately to avoid adversarial confrontations between groups and to target each group's special interests. The purpose of these meetings is to discern the prevailing attitudes of the various interested parties, both public and private, in the long-term care area and to introduce them to the consensus strategy described in the Inspector General's reports and LTC, Incorporated's Florida, Montana, Wisconsin, Illinois and Maryland reports. We will conduct two-hour presentations for each interest group with a stake in the long-term care financing issue. Presentations will include a summary of the problem, an historical perspective on how we got into the fiscal and political predicament we are in, a summary of recommendations from the DHHS Inspector General and other government agencies on how to resolve the situation, and an explanation of why it is in the best interest of each group to

work cooperatively with the others on the proposal under consideration to the mutual benefit of all. Each respondent will receive an information pack of articles and reports on the topic similar to the one enclosed herewith. (80 hours Moses; 20 hours Tjelle)

H. Examine the overall social impact (upon the elderly population, families, *etc*.) from the transfer of resources and assets. We propose to explore every aspect of the potential ramifications for seniors of the transfer of assets and resources issue and to provide relevant recommendations on each. For example, what effect does Medicaid estate planning have on the state's ability to finance and the nursing homes' ability to provide access to quality long-term care? Will closing loopholes discourage vulnerable seniors from seeking needed care? Does the easy availability of Medicaid benefits discourage advance planning and purchase of private long-term care insurance products or continuing care retirement community contracts? To what extent are middle class people on Medicaid consuming state tax revenues needed to fund other public needs such as education, highways, and prisons? Are there ways to divert the middle class to other financing mechanisms while making Medicaid benefits more readily available to the poor than ever before? We will address all of these questions and many more similar ones in the final report of this project. (28 hours Moses; 6 hours Tjelle)

I. Prepare and submit an interim report mid-way through the project summarizing current status, problems encountered, solutions proposed, work remaining, preliminary findings, *etc*. (24 hours Moses; 8 hours Tjelle)

J. Analyze all data; write the final report including the action plan implementation strategy; and submit five original bound copies to the state. The final report will be entirely substantive, clear and readable as evidenced by our previous work products, samples of which are available upon request. The goal is to prepare a document suitable for presentation to the State Legislature as a game plan to improve long-term care access and quality, benefit seniors, reduce Medicaid expenditures and enhance the fiscal responsibility of state government. (120 hours Moses; 16 hours Tjelle)

K. Subsequent to publication of the final report, the author will be available in New Jersey for one week at the Legislature's convenience to present state legislative testimony, advise on implementation strategy, conduct media briefings, present findings to key interest group representatives, and provide any additional follow-up work desired by the state. (40 hours Moses)

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

VI. **Site Visits**: We anticipate the need to spend approximately 20 work days in New Jersey during this project for the purpose of conducting interviews and briefings, visiting local eligibility offices, analyzing current policies and procedures, conducting legal research, *etc*. In addition, we have allowed and budgeted for a post-project trip of five days for follow-up, testimony, briefings, *etc*.

VII. **Schedule**: We recommend beginning this project by August 1, 1996 and completing it by January 1, 1997.

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

IX. **Business Proposal**: We propose to conduct the work described in this proposal for the following compensation:

Moses: $175 per hour times 548 hours equals $95,900

Tjelle: $75 per hour times 102 hours equals $7,650

Travel expenses: 25 days times $350 (inclusive of all travel expenses including air and ground transportation) equals $8,750

Total: $112,300

This bid covers all costs to the State of New Jersey incidental to this project.

X. **Experience and Credentials**: All tasks related to this project will be performed by Stephen A. Moses or Kathryn J. Tjelle of LTC, Incorporated (unless another arrangement is requested by LTC, Inc. and accepted by the State of New Jersey) as delineated below:

A. LTC, Incorporated is a private firm specializing in

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

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

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

Since leaving federal service in 1989, Mr. Moses has published over four dozen articles on Medicaid estate planning, nursing home eligibility, transfer of assets, liens and estate recoveries; he has consulted on these subjects in over 25 states and spoken at innumerable national conferences; and he has testified before two dozen state legislatures. As Director of Research for LTC, Inc., Mr. Moses has directed and authored studies on Medicaid nursing home eligibility, asset and resource transferring techniques, methods to control divestiture, estate recoveries, and how to implement OBRA '93 in numerous states, e.g.: *Medicaid Estate Recoveries in Massachusetts: How to*

Increase Non-Tax Revenue and Program Fairness, December 1990; *The Senior Financial Security Program: A Plan for Long-Term Care Reform in Wisconsin*, June 1992; *Medicaid Estate Planning in Kentucky: How to Identify, Measure and Eliminate Legal Excesses*, March 29, 1993; *Long-Term Care in Montana: A Blueprint for Cost-Effective Reform*, September 23, 1993; and *The Florida Fulcrum: A Cost-Saving Strategy to Pay for Long-Term Care*, April 21, 1994; *The Magic Bullet: How to Pay for Universal Long-Term Care, A Case Study in Illinois*, February 1, 1995; *The Long-Term Care Financing Crisis: Danger or Opportunity? A Case Study in Maryland*; September 15, 1995. Of closely related significance is *Medicaid Loopholes: A Statutory Analysis with Recommendations*, which Mr. Moses presented to the minority staff of the United States Senate Committee on Finance in 1991 and *Medicaid Estate Planning: An Analysis of GAO's Massachusetts Report and Senate/House Conference Language*, presented to The United States Senate Committee on Finance and Special Committee on Aging, July 30, 1993. Any or all of these reports and publications are available for review upon request.

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

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

A. Maryland Project Coordinator: Joe Coble, Director of Legislative and Government Relations, Health Facilities Association of Maryland, 229 Hanover St., Annapolis, MD, 21401, 410-269-1390.

B. Illinois Contract Officer: Jan Boone, Assistant Bureau Chief, Bureau of Long-Term Care, Illinois Department of Public Aid, Third Floor, 201 south Grand Avenue East, Springfield, Illinois, 62763, 217-524-7211.

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

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

E. Wisconsin State Contact: Gene Kussart, Executive

Assistant, Department of Health and Social Services, P.O. 7850, 650 One West Wilson St., Madison, WI, 53707, 608-266-9622.

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

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

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

Appendix B:

Sample Opening Presentation

The following is a transcription of the opening presentation provided to the New Jersey Association of Non-Profit Homes for the Aging on August 1, 1996 at noon. The opening presentations provided to each of the 17 long-term care stakeholder groups interviewed for this project were almost identical. As this was an oral presentation, it does not read like a formal written document. Moreover, the transcription has been edited slightly for clarity of presentation.

My name is Steve Moses. I am Director of Research for a company called LTC, Incorporated out in Seattle, Washington. The principle business of that company is the design and marketing of long-term care insurance. I'm not much involved in that end of it, however. I work in public policy and consulting. But my background is not in the private sector or in insurance. It's with the United States government. I spent 18 years, most of it with the Health Care Financing Administration and the Office of Inspector General, and mostly in the area focused on Medicaid and long-term care. I did some of the early research that identified and investigated, if you will, this phenomenon of Medicaid estate planning, the attorneys who help people divest or shelter income and assets to qualify for Medicaid.

These are a couple of the major national studies [copies displayed] that came out of the Office of Inspector General, and they ultimately culminated into the Omnibus Budget Reconciliation Act of 1993 that attempted to close some of the so-called loopholes in Medicaid and mandated Medicaid estate recoveries. I've been doing a series of studies on these issues, very similar to what I did with the federal government with states around the country. We've worked with Montana, Illinois, Florida, Maryland, one of the recent studies is from Maryland, and the Illinois report "The Magic Bullet". I think we've got copies of the Bullet to give you. We are doing a mini-version of this study in New Jersey now. We basically do a 3 week version and we do a 3 month version. This is the 3 week version, which has me on site for one week talking to a lot of people, such as yourselves, all of the interest groups that we can get in front of: senior advocates, nursing home representatives, home health care representatives, governor's staff, legislators, administrative staff, eligibility workers out in the field, actually in the trenches talking with families trying to apply for Medicaid, and

so on.

The way I like to start off, kind of put this in some orderly arrangement, is to talk a little bit about how we tend to view the long-term care economy in this country. Traditionally, we've seen it as what I call "the welfare paradigm." And most of us who have ever read a book or a magazine article or a journal article on long-term care, we've seen it probably described something like this: you have an aging population, people are living longer, they're dying slower, often in a nursing home, at an enormous expense--$30,000 to $70,000 per year. Because of the high cost of the nursing home care, people are spending down their life-savings. According to the Congress of the United States, the average senior spends down their life savings in an average of thirteen weeks and collapses into the social safety net of Medicaid which then becomes a terrible burden on the public financing and an awful strain on the budget. And that's the problem as it's usually described.

We know for a fact, according to the *New England Journal of Medicine*, 9 percent of people over the age of 65 will spend 5 years or more in a nursing home. That's close to a 10 percent probability you will spend 5 years or more in a nursing home facility after age 65. That really is a serious risk given the cost. Now, this fact and the reality that the only option seniors have is to spend down catastrophically would seem, clearly, to substantiate the welfare paradigm. Let's ask ourselves, however: if the welfare paradigm is true, what do we know about consumer behavior, and does it make sense? Well, if you stood a 10 percent probability of basically losing everything because of a long-term stay, you would think the public would be really nervous about that; worried, planning years in advance about "how are we going to deal with Grandma going to the nursing home?" For us, for heaven's sake, is that the reality as we know it? No, people are in denial about long-term care: "It won't happen to me, never go to one of those places, I'd shoot myself first," and nobody ends up really dealing with the problem until Grandma has Alzheimer's and you have to do something. So it doesn't fit in with the welfare paradigm.

What about home care versus nursing home care? You would think that if you stood to lose everything to the cost of long-term care, the first place you'd go to look for assistance would be to the home and community-based services network. And you'd hire a chore aide, and then as necessary you might go to an adult day care center, and you'd have respite care services, ultimately into assisted living, and only nursing home care as an absolute last resort because it is so expensive. What do we know about the long-term care economy in this country? It is absolutely

upside-down from that. We are heavy into institutional nursing home care and we have a very underdeveloped home and community-based services infrastructure. We're trying to correct that now, but unfortunately all the public money has been sucked into the black hole of institutional care and there's nothing left to retrofit a home and community-based services system. The practical reality of the current system is that we are real heavy in nursing homes and real light on home and community-based care. Which is exactly what seniors don't want. They want to get the care at home. In my opinion, this imbalance just doesn't quite fit in with the welfare paradigm. Why would we go straight to a nursing home at $30,000 to $70,000 a year, when there are lower cost levels for care just as effective in the early stages of debility that are out there or could be out there?

Where does the financing from come for long-term care? If you have a $200,000 to $300,000 financial liability for long-term care, you would think that folks would look creatively for ways to generate the revenue to pay for the least expensive level of care that is appropriate at each stage of debility. In other words, what do we know about seniors' economic status? They are cash-poor but house-rich. They don't have a lot of income, so it's hard for them to afford extra expenditures. 77 percent of seniors own their homes; 83 percent of those own them free and clear. There's a trillion and a half dollars in net home equity held by seniors in the economy. The obvious solution is to tap the equity in the home. A reverse annuity mortgage will pull out a little bit of revenue and a little bit of cash flow to supplement the income so they can afford home and community-based care which is so much less expensive than nursing home care. A reverse annuity mortgage can also generate the dollars needed to buy long-term care insurance which is relatively expensive. What do we know about reverse annuity mortgages? The government realized 10 or 15 years ago that this pot of money was the solution to the long-term care financing problem, and they have pushed reverse annuity mortgages, home equity conversions aggressively. They had lots of experiments through HUD, and the VA, and so on, but nobody's interested. Banks don't want to offer them and the public hasn't created a demand. So you ask yourself: If the welfare paradigm is true, the house is in jeopardy, and you could lose everything you own, why wouldn't people tap the equity in this major resource that they own? Why is it that home equity conversion is so unpopular? It doesn't make sense under the welfare paradigm.

And finally, long-term care insurance. We have only 6 percent of seniors insured for long-term care, and yet long-term care represents 80 percent of all the catastrophic health care costs seniors face over $2,000. But 75 percent to 80 percent of

seniors have Medicare supplemental insurance, which really isn't insurance at all. It just pays those $50 to $60 doctor bills and the first day in a hospital. It does not pay most of the catastrophic health care expenses seniors face. The purpose of insurance is to replace the small risk of a catastrophic loss with the certainty of an affordable premium. And yet, our pyramid of risk in this country is absolutely upside down. You have all these seniors insured for these relatively minor doctor's bills, and practically none of them insured against the real catastrophic risks.

So, what I've done here is gone through the welfare paradigm and said let's look at consumer behavior in a whole bunch of areas, and it just doesn't seem to make sense. Either the welfare paradigm is not an accurate description of the long-term care economy, or we have a bunch of really dumb senior consumers in this country. I think we know the latter isn't true, because our senior consumers are pretty savvy. They buy insurance for every other risk, they shop around, they're careful. Thus, consumer behavior in long-term care is really peculiar. So I looked around for another paradigm that might explain consumer behavior better. I'm going to describe it now and I have to ask you, because it is so radically different from most of our understanding of how long-term care works, if you would suspend your disbelief, if you will, and just go with me there for a little bit. I'll try to back it up after we talk about the consequences in consumer behavior.

What if the real description of the long-term care economy were the entitlement paradigm instead of the welfare paradigm. I describe the entitlement paradigm this way: In America today, you can ignore the risk of long-term care, you can avoid the premiums for private insurance, even wait to see if you get sick. You die of a heart-attack or cancer, you're home free, in a manner of speaking. But if you do get one of the chronic illnesses of old age: Alzheimer's, Parkinson's, stroke, the literal reality is the median person over age 65, in terms of income and assets, if they need nursing home care, qualifies financially for Medicaid without doing any fancy planning. And virtually anyone else who gets good legal advice can be on Medicaid in 30 days. Well, I haven't proven it yet. Let's just assume for a minute that the entitlement paradigm is true and then look at consumer behavior.

Now we ask ourselves, should we be surprised that people are in denial about long-term care and they're not planning ahead years in advance about how to pay for it? I don't think so. Because for the last 30 years every time you bump into this problem, the government has been taking care of it financially.

Well, what about the fact that we are under-developed in home care and over-developed in nursing home care? Now that's not too surprising, because if you want home care, if you want assisted living, if you want anything like that, you've got to pull out the old wallet and pay for it yourself. But as long as you want to put grandma in a nursing home, the government will pay for it. The government won't pay for most other things for the simple reason that as soon as they do, everybody comes out of the woodwork and wants it, and it swamps the ship of state fiscally for the simple reason that for every person in a nursing home in America, we've got two still at home of equal disability, half of whom are bed-bound, incontinent, or both.

What about how we finance it? Should we be surprised that seniors don't tap into their single biggest economic resource, the home, to pay for home and community-based care to stay out of a nursing home? I don't think so. Medicaid exempts the home and all contiguous property, regardless of value. Why tap the equity in the home when the government will provide this care for free without requiring you to contribute the equity in the home.

And finally, long-term care insurance. Only 6 percent are insured? No big surprise! You can't sell apples on one side of the street if they're giving them away on the other.

Obviously, the entitlement paradigm, if it's true, explains consumer behavior much better than the welfare paradigm does. So that brings us to the question: is it conceivable? Is there evidence for the entitlement paradigm? I think there's a good deal of evidence, which I will now proceed to give you. In the United States, 73.7 percent of all patient days in nursing homes today are paid for by Medicaid. If you look at just the dollars that go into nursing home care in this country, you will find that roughly half of them come from Medicaid directly. Another roughly 10 percent comes from Medicare. By the way, that's quadrupled to quintupled since the Medicare Catastrophic Coverage Act of 1988. It's shooting up rapidly.

But then we get to another government source of financing in nursing home care most people aren't even aware exists. Can anybody venture a guess as to how much of the cost for nursing home care is paid for by the Social Security Administration? Most folks would say none. And it is not paid directly. But what there is, is a "spend-through" of Social Security income. It works like this: Once somebody is eligible for Medicaid, they have to contribute all of their income towards their cost of care. That's why you always see this number that Medicaid only pays 50 percent of the cost, but 70 percent of the beds are

Medicaid. That covers the differential. Social Security doesn't provide enough income to people to make them ineligible for Medicaid because there really is no limit anymore, now that you have a medically needy system in this state, to how much income you can have and qualify for Medicaid. Because you can deduct out all your medical expenses, the nursing home care, the co-insurance and deductibles on Medicare, and all the services that Medicare doesn't cover like eye care and foot care, pharmaceuticals, and your premiums for your Medicare Supplemental policy. If you still don't have enough money from your income, even though your income may be $5,000 or $6,000 dollars a month, you're eligible for Medicaid. Not just for the nursing home care, but for all the other services--that panorama of 31 optional services, most of which are offered here in New Jersey.

I digressed a little bit, let's get back on target. Social Security represents 18 percent of the entire cost of the nursing home care provided in this country, not as a spend-down of assets but as a spend-through of income. Now look, with just Medicaid and Medicare and Social Security, we're now up to 75 percent to 80 percent of the entire cost of nursing home care in the United States and we haven't touched a penny of anyone's income or assets. Seniors do have, after all, some private income. About a third of them have pensions and they've got interest on their savings. Some of them are so rich they pay for nursing home care out of pocket change. We don't know how much private income contributes to the cost of nursing home care. There haven't been any studies done. But, if it even is only 10 percent, we're now pushing 90 percent of the entire cost of nursing home care in the United States without touching a penny of anybody's assets.

If we have a problem in this country of widespread catastrophic spend down, we would expect to find data that shows that people are spending their assets for nursing home care. But we don't have any data to demonstrate that. We do have lots of data to demonstrate that we don't have much of a spend down problem. Until about 5 years ago, we had no empirical data at all. Now we have about 3 dozen of these so-called spend down studies that have been done. These studies look at how many people on Medicaid didn't start as Medicaid, but started as private payers and then converted to Medicaid. Conventional wisdom used to be, when I was first learning about long-term care, that 50 percent to 75 percent of all people in nursing homes on Medicaid began as middle-class folks, and because of the high cost of nursing homes, they spent down their life savings. They finally became eligible for Medicaid, fell into the social safety net, and were then taken care of by public assistance. Now we have 3 dozen studies that show that the actual figures are only 15 percent to 25 percent. And these are just people who

converted from private pay to Medicaid. The studies didn't distinguish between people who converted the old-fashioned way_by spending $5,000 a month for nursing home care until they were broke_and the people who spent $2,000 for an attorney who made all the money go away overnight and walked right on. So the 15 percent to 25 percent that started private pay and became Medicaid, as low as it is, includes everybody who became artificially impoverished. That's some hard empirical data to demonstrate that catastrophic spend-down isn't the problem we thought it was.

In other words, maybe we've been trying to solve the wrong problem. We've been trying to solve the welfare paradigm, and what's really going on is a much more complicated thing called the entitlement paradigm. But, let's see now if what I've said about the overall data is true. We ought to be able to account for how people qualify for Medicaid without spending down. So let me do a little bit of that now. I already talked about income: how you can have $5,000, $6,000, $7,000 per month in income in New Jersey and qualify for Medicaid easily. Income does not get in the way of eligibility for Medicaid anywhere in the country until you get up to at least the 90th percentile of income. We're talking about, by definition, the wealthy top 5 or 10 percent who might run into an income problem until they divest their assets and bring their income down by eliminating their interest or dividend income.

So we're basically talking about an asset issue for Medicaid eligibility. Of course, everybody knows you can only have $2,000 in assets in order to qualify for Medicaid. So the presumption is that people have to be spending down. Well, that's frankly complete bunk, because you can also have a home of any value and all contiguous property that's not counted; you can have unlimited household furnishings for all intents and purposes because, while technically you have a $2,000 limit, nobody checks. So therefore, like one elder law attorney in New York said once: If you had an extra million dollars and you want Medicaid to pay for your nursing home care, just buy a Rembrandt, because as soon as you hang it on the wall it becomes a personal furnishing and nobody's looking at it. You can have a car of any value, and a car is exempt. If you transfer an exempt asset, it's obviously not done for the purpose of qualifying for Medicaid, is it?, because you are already eligible because the asset is exempt. So you can transfer an exempt asset with the exception of the home. If you have an extra couple of hundred thousand dollars, buy yourself a Jaguar and give it away. I did this study in South Dakota a couple of weeks ago and they said "That's not a good example here, Steve, when we go, it's in Jeep Cherokees." So they were telling me about their Jeep Cherokee

problem. The point is, it's not a big challenge to do it.

We just came from the county offices in Ocean City and you don't have a safety net here, you have a sieve. I can't imagine anybody in New Jersey being so rich they couldn't walk right onto Medicaid if they chose to because it's wide open. The troops there in the county office are doing the best they can. It's just that they don't have the tools they need to work with to deal with the problem. The ones who have consulted with attorneys, the ones with several hundred thousand dollars, they come in with applications indexed with every "i" dotted and every "t" crossed. Then the poor folks with only $40,000 or $50,000 come in and the workers feel sick that they put the well-to-do on Medicaid, because they are lucky enough to have attorneys. Then, the workers feel they really owe it to the people who are on the borderline to show them the same information that the wealthier people get. They are not ineligibility workers, they are eligibility workers. So they help people understand the rules and they tell them about the prepaid burial trust funds, and the kinds of things it's all right to buy like home furnishings and cars and so on, and other things that it's not all right to buy.

Is that a fair representation? [Question addressed to Bill Caldwell, Project Coordinator for the state of New Jersey. He assented.] They didn't exactly say it in those words, but I'm not misleading. That's basically what goes on. Obviously, you've probably seen the ads for Medicaid planning attorneys and you know what goes on there. The family limited partnerships and all sorts of razzle-dazzle techniques. This is a book I picked up at the last National Symposium of the National Academy of Elder Law Attorneys. It's called "New Horizons in New Jersey Medicaid and Elder Law Planning," and it's got information on the techniques you can use to qualify. It's training for other attorneys who don't specialize in this area to help them help people to qualify for Medicaid. But this is going to cost you $2,000 or $3,000 if you go out and retain an attorney, which is well worth it in order to get it right if you have a big estate. But if you don't have that kind of money, you might want to look into Armond Budish's book for $15.95 called "Avoiding the Medicaid Trap."

Now, this is a good time to mention the caveat I always give. I know Armond, he's a friend of mine, we've debated at conferences, he's a good egg, he thinks he's doing the best thing for his clients and I don't hold these guys morally culpable, much less the seniors they represent for this reason: There is no reason to have to take a toll bridge when there's a free one next door. The attorney's responsibility is to the individual client, to get that client everything he's entitled to under the

law. It's not their responsibility to change public policy. Certainly the senior, who's suddenly faced with a major financial disaster, never knew anything about how to plan for it. Nobody ever said it was necessary. It wasn't necessary. You only had long-term care insurance of any quality and affordability for the last few years. Ten years ago, it wasn't all that good and wasn't all that available. They haven't had much choice. You really can't blame them. But that caveat stated, here's what Armond advises. By the way, this book contains boiler-plate trusts: just photocopy and fill in the blanks, walk onto Medicaid, step by step instructions on how to do all of these things.

> Is there any practical way to juggle assets in order to qualify for Medicaid before losing everything? The answer is yes. By adopting a Medicaid strategy that fits their needs, older Americans can avoid the Medicaid trap and keep their savings from flowing endlessly into a nursing home. What are the options? Move money into exempt assets, transfer assets directly to your children tax-free, pay children for their help, juggle assets between spouses, transfer a home while retaining a life estate, change wills and title to property, create a revocable living trust, write a durable power of attorney, set up a Medicaid trust, create a family asset protection trust, put the home in a house preservation trust, or get a divorce.

In New Jersey, divorce is one of the big ones because the judiciary is very willing to cooperate in impoverishing one spouse in order to help the family take advantage of the public financing for long-term care. In the meantime, Medicaid pays for about 80 percent of the cost of the private pay rate in the nursing home, and, according to some providers, that comes to less than the cost of providing the care. This means the private payers, the few that remain, and their families are carrying the load for themselves and the publicly financed patients.

For Jane Bryant Quinn, the nationally syndicated financial columnist, this is a real hot button of hers. Each time I do one of these studies, I send it to her, and every so often it sets her off and she'll do a column. One column she did, I think it may be in the packet I gave you, is called "Do Only the Suckers Pay?" There are people who are still paying half again as much, and after awhile they say "Why am I doing this?" The people on Medicaid are getting every bit as good care. I see all these ads in the newspapers, and you begin to feel like a sucker if you don't take advantage of the system. The irony is that it is perfectly legal and you can make a case it is completely ethical

on the basis no one has to pay any more taxes than they're responsible for. The late Supreme Court Justice Learned Hand said that once. You don't have to pay any more taxes than you are absolutely liable for and anything you can do legally to avoid taxes is perfectly appropriate, and that's the case the elder law attorneys make. It's parallel to tax planning.

The problem is, it is a little bit different. It's only in this one respect I hold the attorneys morally culpable. If I have a million dollars, I can get red-carpet access to top quality care at any level of care. I can get home care, assisted living or walk into any nursing home in the country. There is never a waiting list for someone who is private pay because of the factual reality of the fiscal pressures on the industry. There is no choice but to keep a certain percentage of private payers, so private payers are going to walk in to the best facilities always. What happens to me once, because of the public policy incentives in the system, my kids have taken away all my money? They now have all of their inheritance. They don't have to worry about me writing them out of the will. They don't even need to visit me anymore. They put me in a nursing home for whatever Medicaid will pay. It is becoming a bigger and bigger problem as Medicaid has to ratchet down reimbursement rates, as the fiscal pressures become greater throughout the country, federal deficit spending and all of that.

What's going to happen next year, or the year after when we have not only eliminated the entitlement to welfare, but there is no entitlement to Medicaid either? It almost happened this year. And when they put the squeeze on New Jersey, because it has already happened to other states, that's when the challenge of this issue is going to hit you here. It hasn't hit you yet. What's different about New Jersey is this state doesn't know it has a problem yet. The rest of the country has already figured it out and I can come in and I can give them detailed recommendations on how to fix it. But I can't do it here because I would walk right into a political windmill. The recommendations for this state are to go out and do some research and studies to identify this, and to point it out gradually over time to the citizens that you are on a collision course with a brick wall of fiscal reality and you are going to hit it sometime in the next 5 or 10 years. I can guarantee it will have happened in 20 years because that's when the baby boom generation starts to retire. Then it won't only be Medicaid that's collapsing. It will be Medicare and Social Security as well. My generation said "Hell no, we won't go;" my son's generation will say "No way, we won't pay."

My son is 19 and for him to get out of Medicare and Social

Security what his grandma and grandpa can take out right now, his payroll deductions for those two programs alone, would have to go to 42 percent to 44 percent. That's before you add in federal income taxes, state income taxes, sales taxes, sin taxes and all the other taxes that suck the wind out of the economy that, after all, has to generate the wealth to tax in the first place. We are in big trouble nationally and I think you are in even bigger trouble in New Jersey for the simple reason that this is a very prosperous state and it's been able to push some of these issues aside and cover them up with money so they don't smell so bad. But when they start coming up and there isn't enough money to cover them because the feds have cut back, that's when it's really going to hit the fan here in a few years.

What can we do about it? I'm making the same recommendations now that I made in the original study I did in 1983 that was published by the Health Care Financing Administration in 1985. They are almost identical. First of all, I will tell you what we can't do that would fix it in a minute; well, in 3 to 5 years. We could turn Medicaid into the kind of catastrophic spend down welfare program that most people think it is already. We could say if you want government help in paying for long-term care, then you must devastate yourself financially 100 percent: sell the house, sell the car, impoverish grandma. Once you are absolutely destitute, then we'll help you out. Guess what would happen right away? They'd be breaking down the doors to get to people selling long-term care insurance. You would see a sudden massive growth in home and community-based care. There already is. Look what's happening in the assisted industry right now. All that reflects is the reality that custodial nursing home care was an artifact of Medicaid financing. Medicaid financing is drying up and the industry is moving upscale to subacute and downscale into assisted living to attract private money. So you are already starting to see it, just because the system is disintegrating.

What you can't do, is just radically change Medicaid so it isn't an entitlement anymore. What we basically have in this country, frankly, is a national health insurance program for long-term care. We're doing it by putting the World War II generation into nursing homes on welfare and the program is going bankrupt. That's a tragedy. You can't solve the problem by eliminating an entitlement entirely, because it isn't politically feasible and it would really be going backwards. What we have to do is save the system we have by changing the incentives in it. What we have proposed then is to do this: Retain a generous public financing program. Whether you call it Medicaid (or as I've proposed to call it, "The Senior Financial Security Program Act," which has been endorsed through a model state statute by

the American Legislative Exchange Council) or whatever you want to call it, it should work something like this.

We have to be more financially responsible than we've been to save a publicly financed system. We need longer and stronger transfer of asset restrictions. Right now we only look back 3 years. You could give away over a million dollars 37 months ago and you're eligible for Medicaid. It doesn't cost you a nickel. But, the average period of time from onset to death in Alzheimer's Disease is 8 years. If you give away the money the first time grandma forgets to turn off the stove, you don't entail any costs. You don't even have to buy Armond's book, you're on Medicaid. If we had a longer and stronger transfer of assets restriction and we really enforced it_we don't really enforce the ones we've got now as strongly as we could_here's the message we'd send: Grandpa and Grandma, this is your money, you earned it, you struggled through the Depression, you fought World War II, you scrimped and saved, from now on we're not going to have a public policy that rewards your heirs for taking your money away from you prematurely and solving your long-term care problem by putting you into a nursing home on welfare. No more public policy like that. It's your money. You keep it. And if you don't have the cash flow you need to be able to afford the long-term care you need, we will help you. We'll give you, in essence, a line of credit on your estate. We will also give you the dignity of the expectation that you will pay it back out of your estate. It isn't welfare if you pay it back.

We have a situation now where people go to the attorney and take away all of mom and dad's life savings, put them in a nursing home on Medicaid and then beg the eligibility workers not to tell the parent that they are on Medicaid because it would "break their heart to know they are on welfare." Really strange situation. Once we let grandpa and grandma keep their money, though, and encourage them to keep it, we're still helping them out through a public program so they don't get caught in this grinder and have to sell the house, because nursing home care is very very expensive. We have to get them to keep the property while they are on the program. The next step is a lien as a condition of eligibility. All this says is that your principle creditor, in this case the state and federal government in the form of the Medicaid program or the Senior Financial Security Program, gets to know if you try to get rid of a big asset. That's all a lien does. It doesn't say you can't sell a house, it just says your creditors need to be advised that you're doing it so you can work out some sort of equitable arrangement. That helps to keep the property in grandpa and grandma's possession.

Then, when the last surviving exempt dependent relative

dies, you're not going to take the house away from grandma just because grandpa dies in the nursing home on Medicaid. You use the estate to recoup the cost of their care for the public program, so there's something in there for other people as they come along. Maybe you can even provide some Medicaid for poor people, which was the original idea. We estimate that you can recover about 5 percent of the cost of your Medicaid nursing home program from liens and estate recoveries if you do it aggressively. That isn't the big value of the liens and estate recoveries which we recommend though. The real value comes if you take about 10 percent of the amount that's recovered and launch a massive public education campaign. What do you educate the public about? You have a 9 percent probability of spending 5 years or more in a nursing home at $30,000 to $70,000 per year. You had better worry about that because you are not gonna get it for free anymore. You can either pay me now or pay me later, just like the old Fram oil filter commercial. Take $20 and get your oil changed and save your engine, or you can let that engine burn up. But from now on the government isn't going to put a new engine in every time you burn one up. Which is what we've been doing in the past. We're going to expect you to either pay up front or to pay out of the estate.

This sends a very strong message both to seniors and the heirs. To the seniors it says: If I don't want that to happen, if I don't want to end up dying in a nursing home on welfare, and have to pay it back, too, then I better figure out a way to protect myself. How can I do it? If I am young enough and healthy enough to be able to afford long-term care insurance, I might want to look creatively for ways to finance the premiums. Because if I'm older, they're going to be relatively high. That's where they can tap the equity in the home. We have research that shows 57 percent of homeowners could buy long-term care insurance with nothing more than the proceeds of a reverse annuity mortgage. The other party that gets a strong message is the heirs. These are people like you and me, in their 50s and 60s, in their peak earning years. We've got the cash flow, mom and dad have the assets, there's this wonderful intergenerational contract just waiting to happen. In fact, I do it with my own folks. I pay the premiums for their long-term care insurance, and when they die I get the estate. If there's anybody in the United States of America who can get them in a nursing home on Medicaid, and keep them in a good one, it's me, because I know all the tricks. My dad owned his own store for 25 years, however, and there's no way he's going to end up dying in a nursing home on welfare, not if I have anything to say about it.

So, you change the incentives in the system. Instead of using scarce welfare resources to indemnify upper-middle class

heirs, not for taking care of their folks, or helping them supplement their income so they can afford insurance, or helping them pay for a chore aid or home care or assisted living to keep them out of the nursing home, we're literally using public resources to indemnify them for ignoring the problem until it's too late to do anything else, taking away all their money and putting them in a Medicaid nursing home. This explains an awful lot. It explains why we're under-developed in home and community-based services and over-developed in institutional care, why we're taking care of seniors in nursing homes where they don't want to be instead of in their own homes where they would rather be. It explains why we have such a small market in long-term care insurance and why there's very little home equity conversion.

If we changed the incentives, we would change the behavior. We're going to end up with fewer people on Medicaid. We will have fewer people in nursing homes. We will have a strong and profitable home and community-based services infrastructure, which, by the way, will hire a lot people, pay a lot of taxes, and generate revenue for the state. Same for the long-term care insurance industry which will blossom and grow. We'll have more and more people protected. Those who do go to nursing homes will more likely be private payers instead of Medicaid recipients. This will raise all the ships in the nursing home harbor. Seniors will get better access to better care because there will be more financial oxygen breathed into the system at the lower levels as well as at the more acute levels, and the tax-payers will be relieved. And most important of all (this comes back to why I got into government service in the first place): Maybe we can give Medicaid back to the poor people it was originally meant to serve. In this country today, two-thirds of the elderly poor and half of all poor children are not covered by Medicaid, even for acute, emergency or preventive care. Folks who need nursing home care come under a completely different set of eligibility criteria, and the way this system is set up, the wealthier you are, the easier it is to qualify for public assistance; the poorer you are, the harder it is to get welfare.

At this point, the audience was invited to comment and ask questions. Thereafter, they were asked to respond to a lengthy interview schedule designed especially for the stakeholder group they represented.

Appendix C:

MODEL STATE STATUTE EXPLAINED: LONG-TERM CARE FINANCING UNDER A MEDICAID BLOCK GRANT

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

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

A. Preserve generous eligibility

1. Status Quo

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

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

Even in "income cap" states, the median elderly person (based on income) qualifies for Medicaid nursing home benefits immediately and people with higher incomes can qualify quickly by setting up Miller income trusts.

The well known $2,000 limit on assets is meaningless. Medicaid recipients can also keep exempt assets of unlimited value, such as a home, a business, and a car. Married folks have it even easier than single people. They can shelter an additional $76,740 in assets and $1,919 per month in income.

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

Given Medicaid's generous nursing home eligibility criteria, there is little wonder why most Americans (1) fail to plan ahead for long-term care risk, (2) neglect to purchase private long-term care insurance, (3) hesitate to

spend their own money on home care or assisted living, and (4) end up in nursing homes subsidized by Medicaid.

2. Senior Financial Security Program

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

3. ***Model State Statute***

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

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

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

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

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

assistance or avoid estate recovery.

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

"Other exempt resources and limitations to be delineated."

B. Prohibit divestiture

1. Status Quo

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

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

2. Senior Financial Security Program

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

Of course, by birthright, any American is free to dispose of his assets in any way he wishes and at any time. One must no longer be allowed, however, to give away one's

wealth in order to compel other Americans to provide oneself with expensive long-term care benefits.

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

3. ***Model State Statute***

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

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

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

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

C. Require legal security as a condition of eligibility

1. Status Quo

Exempt assets divested legally or illegally while on Medicaid are lost forever as a source of long-term care

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

2. Senior Financial Security Program

No competent financial institution will extend a loan of hundreds of thousands of dollars to anyone without requiring security. The government can no longer afford to do so either. People who expect to depend on the SFSP while preserving substantial income and assets for the support of their dependents must realize and agree that they lose some measure of control over these resources in the process.

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

3. ***Model State Statute***

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

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

relative (to be defined).

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

D. Require estate recoveries

1. Status Quo

For most of the history of the existing Medicaid program, nursing home recipients could preserve unlimited exempt assets in the form of homes, cars and personal property and pass this wealth to their heirs completely unencumbered. It was not until the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA '82) that Congress gave state Medicaid programs the explicit authority to recover from recipient's estates. It was not until the Omnibus Budget Reconciliation Act of 1993 that Congress required estate recoveries. Consequently, few states have so far implemented strong, cost-effective estate recovery programs.

2. Senior Financial Security Program

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

3. ***Model State Statute***

"Every participant in the Senior Financial Security Program must agree in writing to pay back the entire cost of care from his or her estate or from the proceeds of sale of

real or personal property during program eligibility up to the total value of the estate or sale. If the program participant should predecease a spouse or other legitimate, dependent heir or joint tenant, the participant's share of any jointly owned property or purchasing power shall be recovered from such third party as soon as it is no longer needed for the maintenance of the dependent, and in any case, no later than upon the death of the dependent third party.

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

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

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

1. Status Quo

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

2. Senior Financial Security Program

By prohibiting divestiture of assets to qualify, by requiring liens on all property as a condition of eligibility, and by mandating recovery from estates of every program participant who retains exempt assets, the SFSP

creates an enormous incentive for future generations to plan ahead, buy insurance, pay privately for home care or assisted living, and avoid as long as possible starting the meter running for publicly financed nursing home care. Nevertheless, the SFSP should make this goal explicit in the program's statutory language.

3. **Model State Statute**

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

F. Educate the public

1. Status Quo

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

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

2. Senior Financial Security Program

The big challenge to public policy is to provide a long-term care safety net that protects the frail and

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

3. ***Model State Statute***

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

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

II. Conclusion

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

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

Model State Statute for a Senior Financial Security Program

The following is the model state statute described and explained above, but with the description and explanation omitted. This model statute must be adapted to fit the unique circumstances of each state. Differing aging demographics and long-term care infrastructure throughout the United States require such adaptation. The underlying principle, however_to provide a long-term care safety net, but not a hammock_should apply equally well throughout the country.

I. Eligibility System

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

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

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

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

"Automobile: one car of any value provided it is actually

used for the benefit of the program participant. Transfer of an automobile, even though exempt, will be deemed a transfer of assets subject to penalty. Program participants may not give away exempt assets and replace them with new exempt assets as a means to qualify for assistance or avoid estate recovery.

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

"Other exempt resources and limitations to be delineated."

II. Divestiture Policy

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

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

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

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

III. Lien Security

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

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

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

IV. Estate Recovery

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

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

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

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

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

VI. Public Education

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

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