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Routing

Aging America's Achilles' Heel
Medicaid Long-Term Care

by Stephen A. Moses

Executive Summary

Seventy-seven million aging baby boomers will sink America's retirement security system if we don't take action soon. A few years ago, the problem went unrecognized by most Americans. Today, the prospect of a fiscal crisis has forced policymakers to focus on solutions.

Social Security has center stage these days with a $10 trillion unfunded liability. Medicare is an even greater problem, with $60 trillion in unaccounted-for obligations. The good news is that these massive "social insurance" programs have finally begun to attract the attention of analysts, policymakers, and legislators.

Another social program bears scrutiny but receives much less attention. Medicaid is the poor relative among government programs. It is means-tested public assistance—in a word, welfare. While Social Security and Medicare have spurious "trust funds," Medicaid draws its financing from general tax revenue without even the pretense of a trust fund. Medicaid is the principal payor for long-term care (LTC), especially nursing home care. LTC is an 800-pound gorilla of social problems that lurks just around the bend. If we wait to deal with Medicaid and LTC until after we handle Social Security and Medicare, it will be too late.

At last, we have a window of opportunity to address the challenges of Medicaid and LTC financing. Congress has committed to find $10 billion in Medicaid savings over the next five years. Despite the handwringing this has caused, such savings and much more can be achieved while actually improving the program. This paper will explain how that can be done.

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Introduction

Medicaid expenditures today exceed the cost of Medicare and continue to skyrocket. Medicaid is the biggest item in state budgets, having topped elementary and secondary education combined for the first time in 2004.[1] Long-term care (LTC) accounts for one-third to one-half of total Medicaid expenditures in most states, 35 percent on average.[2] For 2003, total Medicaid expenditures were $267 billion. Of this, Medicaid-financed nursing home care accounted for approximately $51 billion and home care $9.9 billion.[3]

Medicaid LTC recipients consume a disproportionate share of total program expenditures. Consider, for example, people who are eligible for both Medicaid and Medicare. Such "dual eligibles" account for 42 percent of Medicaid spending, although they make up only 16 percent of Medicaid recipients.[4] Dual eligibles are heavy users of LTC and Medicaid-financed acute care services that are not covered by Medicare. On top of this, Medicaid pays for Medicare premiums and cost sharing for dual eligibles.

Aged, blind, and disabled (ABD) individuals—also heavy users of LTC—make up one-fourth of Medicaid recipients but account for two-thirds of program costs, whereas poor women and children make up three-quarters of the recipients but account for only one-third of Medicaid expenditures.[5] Clearly, there is an imbalance between the types of people who use Medicaid and the resources spent on them.

Key Points and Queries

LTC is Medicaid's most expensive benefit. The heaviest users of LTC—those who are eligible for both Medicaid and Medicare and those who are aged, blind, or disabled—consume a disproportionate share of Medicaid's total resources.[6] Therefore, every actual or potential dual eligible, ABD, or other LTC recipient who is kept from becoming dependent on Medicaid will result in disproportionate savings to the program. In other words, if policymakers can prevent Medicaid dependence for even a small number of these heavy LTC users, the savings would be extraordinarily high.

But aren't dual eligibles, the aged, blind, and disabled, and heavy LTC users the poorest of the poor? Isn't Medicaid their only safety net after a catastrophic spend-down has devastated their life's savings and driven them into financial destitution? Actually, the truth is not that simple. By confronting the true complexity of Medicaid eligibility, we can find the savings, fix the program, and improve LTC for everyone.

Examine Your Premises

Are people on Medicaid necessarily poor? Only if they're young and need acute or preventive medical care. But not if their eligibility is based on their being aged, blind, or disabled and in need of LTC. Medicaid's financial eligibility rules are relatively tight for poor women and children. For people over the age of 65 who have a medical need for nursing-home-level care, however, Medicaid's eligibility rules —contrary to conventional wisdom—are very loose.

Income Eligibility

Even substantial income is rarely an obstacle to Medicaid eligibility for the elderly who require LTC. If they have too little income to pay all their medical expenses, including nursing home care, they're eligible.[7] Medicaid "income eligibility" is determined in one of two ways. According to the Social Security Administration, 35 states and the District of Columbia have "medically needy" income eligibility systems.[8] Those states deduct each Medicaid applicant's medical expenses—including private nursing home costs, insurance premiums, medical expenses not covered by Medicare, and so forth—from the applicant's income.[9] If the applicant has too little income to pay for all of these expenses, he or

she is eligible for Medicaid—not just for LTC but for the full array of Medicaid's optional services, which often stretch far beyond what Medicare covers.

The remaining states have "income cap" Medicaid eligibility systems.[10] In those states, anyone with income of $1,737 or less per month (300 percent of the SSI monthly benefit of $579) is eligible for LTC benefits.[11] But any additional income makes the applicant ineligible for Medicaid, even though that amount is not enough to pay privately for nursing home care. Thus, Congress approved "Miller income diversion trusts" in the Omnibus Budget Reconciliation Act of 1993 (OBRA '93). These special financial instruments allow people to siphon excess income into a trust to become eligible for Medicaid. The trust proceeds must then be used to offset the Medicaid recipient's cost of care, and any balance in the trust at death is supposed to revert to Medicaid. Nevertheless, Miller income trusts allow people with incomes substantially over the ostensible limit to qualify for Medicaid, take advantage of the program's low reimbursement rates, and receive an extensive range of additional medical services.

No one has to be poor to qualify for Medicaid. There is no set limit on how much income you can have and still qualify as long as your private medical expenses are high enough or, if you live in an "income cap" state, you have a Miller income diversion trust. All anyone needs to qualify for Medicaid is a cash-flow problem—that is, too little income after all medical expenses are deducted.

Asset Eligibility

One might ask, "So what?" Everyone knows that people must spend down their assets before becoming eligible for Medicaid.[12] Here again the truth belies the conventional wisdom. Medicaid beneficiaries can easily retain unlimited assets while qualifying for Medicaid LTC benefits, as long as those assets are held in an exempt form. For example, Medicaid exempts one home and all contiguous property regardless of value. A simple "intent to return" to the home keeps it exempt, whether or not anyone resides in the home or the Medicaid applicant has any objective medical possibility of ever returning.[13] How is this rule used to protect assets? Here are some examples:[14]

> Another sheltering strategy is to convert available, countable assets into noncountable, exempt assets. For example, money in checking or savings accounts may be used, without creating a period of ineligibility, to purchase or improve a home, pay off a mortgage . . . pre-pay residence-related taxes and insurance, or even pay outstanding bills, including legal fees.[15]

> Once Medicaid eligibility is established, the community spouse may acquire unlimited assets in her own name. Such assets might be received by gift, inheritance, or by selling the home and, thereby, converting an exempt asset into a non-exempt asset (cash) with impunity.[16]

> A transfer of the home with reserved special powers of appointment can provide the best of all possible worlds. It can completely protect the home from the reach of Medicaid after the applicable waiting period while allowing the powerholder to retain control of the property and preserve all desirable tax benefits with no exposure to estate recovery.[17]

Medicaid also allows an exemption for one business, including the capital and cash flow of unlimited value.[18] How is this rule used to protect assets? Here are some examples:

> A new amendment to the Social Security Act allows an exemption for the family business, farm or ranch from countable assets for Medicaid eligibility. The advocate should take maximum advantage of this exemption to achieve immediate or very rapid eligi-

Medicaid beneficiaries can easily retain unlimited assets while qualifying for Medicaid LTC benefits, as long as those assets are held in an exempt form.

bility for clients in need of Medicaid assistance. A considerable amount of resources can be excluded including the value of land and buildings, equipment, livestock, inventory, vehicles, and liquid resources used in the business. The attorney should also counsel his clients on the best method of transferring the business, farm or ranch to avoid the imposition of liens and recovery from the estate for amounts spent for Medicaid.[19]

> For farm and ranch families, the Medicaid planning strategy may consist of transferring the farm to the children in full with the children then renting the farm back to the parents. The parents would then act as tenants under a lease with the children. . . . The appropriate Medicaid planning strategy for a client who is the holder of closely held stock in a family owned corporation may be to work the potential Medicaid applicant into a minority position by making a series of gifts during life outside of the applicable look-back period until the applicant is in a minority position. Then, the strategist should argue that the applicant is no longer able to sell the stock and therefore should be immediately eligible for Medicaid benefits. This strategy allows the practitioner to preserve the asset in question for the applicant and the applicant's family.[20]

A prepaid burial space is another excluded resource, regardless of value. This includes improvements or additions to such spaces as well as contracts for care.[21] Medicaid eligibility workers often suggest prepaying burial expenses to expedite Medicaid eligibility.

Medicaid exempts one home and all contiguous property regardless of value.

Whole life and other kinds of life insurance that build equity are limited to a cash-surrender value (i.e., the amount that the policy holder can collect by voluntarily terminating the policy) of $1,500. But one can hold unlimited term life insurance with no effect on eligibility.[22] Because the proceeds of a life insurance policy pass to beneficiaries outside a probated estate, not only can a term life policy shelter large assets from Medicaid eligibility limits, it can also be used to avoid estate recovery.

Home furnishings are officially excluded regardless of value. Personal property that is held for "its value or as an investment" is a "countable resource." However, such assets are not usually counted, because Medicaid eligibility workers rarely verify whether such property is held for the purpose of investment or hiding assets.[23] In fact, Medicaid eligibility workers often suggest that applicants purchase new or additional household goods to minimize the amount they have to spend down and expedite Medicaid eligibility.

One car of unlimited value is exempt, assuming it is used to transport the Medicaid recipient or a member of the recipient's household.[24] And because it is exempt, giving it away is not a transfer of assets to qualify for Medicaid, so the applicant can give one car away, buy another, give it away, and so on until he or she reaches the $2,000 eligibility threshold for nonexempt assets. That's called the "two Mercedes" rule.

How are these rules used to protect assets? Here are some examples:

> [A] common misconception among applicants is that excess resources must be spent only on doctors, hospitals, nurses, medication, and nursing homes. Nowhere in the law is this indicated. Quite literally, an applicant could spend all of his or her assets on something "frivolous," such as a 90th birthday celebration . . . and this should not be cause for denial of Medicaid, because the applicant received "value" for his or her money.[25]

> The real goal . . . is to work with your parents on an asset-shifting plan that will allow them to have Medicaid pick up the tab for their long-term care if need be. . . . Planners also suggest shrinking the total assets your parents have to begin with.

> One way to do this is by turning assets that aren't exempt from Medicaid into those that are. Money in the bank or a certificate of deposit could be spent on a prepaid funeral or a more extravagant engagement ring, for example; both are exempt assets.[26]

> Another tactic is to spend the assets on property that won't count for Medicaid purposes . . . [such as] a home . . . a new car . . . household goods . . . funeral expenses . . . and . . . a burial plot . . . A client can also reduce his net worth by spending money on travel, which many elderly people enjoy.[27]

According to one press account, elder law attorney Howard Black, of Westbury, New York, suggested this technique to qualify for Medicaid: "if the individual happens to have about $82 million lying around, he or she could even buy a painting by Renoir to hang on the walls of the house," a strategy he calls "'burying money in the treasure chest of the house.'"[28]

Married couples are given even higher income and asset protections than single people, including up to $2,377.50 of monthly income and up to $95,100 of assets for the community spouse as of 2005.[29] How is this rule used to protect even more income and assets? Here is an example:

> A potential planning technique would be for the community spouse to reallocate his or her assets into forms that pay less income. For example, money market funds could be used to buy zero coupon bonds, gold, or growth stocks, all of which pay no income at all. The community spouse could then legitimately argue that he or she requires a larger allocation of income up to the Monthly Maintenance Needs Allowance.[30]

In spite of these generous special exclusions and exemptions, married couples are frequently advised to consider qualifying for Medicaid by getting a divorce.

> Divorce is one of the more extreme Medicaid planning strategies. A successful divorce, in which both parties are represented by independent counsel, and containing an agreement in which most or all of the couple's assets are given to the community spouse, can result in almost immediate Medicaid eligibility for an institutionalized spouse.[31]

> The divorce option will likely become increasingly attractive to the current generation of wealthy baby-boomers as they near retirement age. They can hardly be expected to willingly give up the standard of living to which they have grown accustomed just because their spouse has suffered a catastrophic injury or illness that requires full-time medical care in a nursing home. It is unlikely that the current generation will feel it is beneath them to preserve their hard-earned assets by taking advantage of poorly drafted Medicaid legislation.[32]

Bottom line, *there is no limit* to how much wealth people can stash in exempt assets or jettison by means of a calculated divorce settlement to become eligible for Medicaid LTC subsidies.

Medicaid Estate Planning

On top of these already generous income and asset limits, professional Medicaid planners—including attorneys, financial planners, accountants, and some insurance agents—use other techniques to protect additional hundreds of thousands of dollars for more affluent clients and their heirs. Such techniques include gifting strategies, annuities, trusts, life-care contracts, and dozens of others delineated in hundreds of books, law journal articles, and the popular media. The proceedings of the annual symposia and institutes of the National Academy of Elder Law Attorneys are a rich repository of the creative and highly profitable methods of Medicaid planning.

Medicaid allows an exemption for one business, including the capital and cash flow of unlimited value.

There simply is no evidence of widespread catastrophic spend-down of personal assets for LTC.

Hundreds of articles, legal treatises, and books spanning the past three decades are readily available in any law library. I have personally published over 100 columns describing the practice and techniques of Medicaid planning.[33] To obtain even more references, one can simply conduct an Internet search for "Medicaid planning" and find more than two million links to sources, methods, and purveyors of artificial self-impoverishment techniques. Similar techniques allow people with substantial income and assets to avoid Medicaid's ostensibly mandatory estate recovery rules, although states rarely enforce these rules effectively.

Here's how a Medicaid planner described the process to the Department of Health and Human Services' Office of Inspector General in 1988:

> For a fee of $950, I guarantee eligibility within 30 days. . . . I change the ownership of all property including life insurance policies, car titles, mobile homes, residences and other real property, bank accounts, certificates of deposit, stocks, government or private bonds, and anything else. Property transfers go from the ill to the well spouse. . . . If a contract or deed of trust is involved, I do an assignment so that the income becomes separate to the well spouse. I help them buy burial plots and other exempt property.[34]

The techniques and practices of Medicaid estate planning have changed little since this account was published 17 years ago. What has changed is the cost in legal fees to qualify someone for Medicaid LTC benefits virtually overnight without "spending down." Today, Medicaid eligibility can be bought for a legal fee equal on average to one month in a private nursing home. That's roughly $5,000 or $6,000—very cheap insurance for LTC, especially when it can be purchased *after* the insurable event occurs.

Medicaid Spend-Down

If Medicaid eligibility rules are so generous, why do so many Americans spend down into impoverishment before they become eligible for benefits? The answer is, they don't. Dozens of so-called "Medicaid spend-down" studies were conducted in the late 1980s and early 1990s that showed that spend-down was much less common than previously believed.[35] Before those studies, academics assumed that one-half to three-quarters of all people in nursing homes had been admitted as private-pay patients and spent down until their life savings were consumed. Since the spend-down studies, however, we have known that the actual figure is less than one-quarter of nursing home residents who begin as private-pay patients and later convert to Medicaid. And, because none of those spend-down studies distinguished between people who spent down the conventional-wisdom way (writing big checks to a nursing home every month) and people who spent down the Medicaid planning way (writing one check to an elder law attorney), we have every reason to believe that genuine catastrophic spend down of real personal assets is even less than those studies indicated.

Out-of-Pocket Spending

If there is no reason to spend down assets, then why is such a large proportion of LTC spending composed of out-of-pocket expenditures? Again, the answer is, it isn't. Because Medicaid patients have to contribute their Social Security income toward their cost of care, the percentage of nursing home costs paid out of pocket is really much less significant than it appears. The Centers for Medicare and Medicaid Services (CMS) reports that out-of-pocket spending accounted for 27.9 percent of nursing home care spending in 2003 (down from 38.5 percent 15 years earlier).[36] Nearly half of those out-of-pocket expenditures are actually the recipients' Social Security income, which the recipients are required to contribute to the cost of their care under Medicaid.[37] That is to say, what is usually assumed to be spend-down of life savings is largely just money transferred from one government program (Social Security) to another government program (Medicaid).[38] Back out the other major sources

of nursing home financing as well (Medicaid at 46.1 percent in 2003, Medicare at 12.4 percent, private health insurance at 7.6 percent, and other public and private funds and State Children's Health Insurance Program at 6 percent), and one is left with only one dollar out of seven (14 percent) spent for nursing home care that could even possibly be coming from people's life savings.[39] Fully 86 percent of all nursing home expenditures come from direct government funding (Medicaid and Medicare) plus indirect government funding (spend-through of Social Security income by people already on Medicaid) plus private health insurance, and much of the remainder comes from personal income other than Social Security (i.e., not from assets). There simply is no evidence of widespread catastrophic spend-down of personal assets for LTC.

Bottom Line

Medicaid is not primarily an LTC safety net for people who have spent down into impoverishment. Rather, it is the principal payor of LTC for nearly everyone regardless of economic status. Medicaid provides fewer than half the dollars expended for nursing home care but covers two-thirds of nursing home residents. And because Medicaid residents have the longest stays, the program touches more than 80 percent of all nursing home patient days.[40] Home care is no different. Only 17 percent of home health care costs were paid out of pocket in 2003.[41] The remainder comes from Medicaid, Medicare, and private health insurance.

The fundamental problem with LTC financing is that government pays for so much of it that the public has been anesthetized to the risk and expense of high-cost extended care. People can ignore the risk, avoid the premiums for private insurance, wait to see if they will need LTC, and transfer the cost to taxpayers. Is it any wonder that so few Americans buy private insurance or use reverse mortgages (see below) to finance LTC? Is it any wonder that most Americans who need LTC end up dependent on Medicaid?

Building on the Facts

How can we use these facts to save Medicaid as an LTC safety net, restrain its rising tax burden, and improve the program in the process? One thing is certain: as long as Medicaid exempts unlimited assets, most people will not spend their own money on LTC or buy private insurance. A good first step would be to ask: what is the single biggest asset that Medicaid protects from LTC costs? As discussed above, Medicaid exempts the home and all contiguous property, regardless of value, for both nursing home and home care recipients.

How is that fact significant? According to the National Council on the Aging, 81 percent of America's 13.2 million households aged 62 and over own their own homes. Seventy-four percent of those senior homeowners own their homes free and clear. Altogether, seniors own nearly $2 trillion worth of home equity.[42] That wealth is illiquid, is largely untapped for LTC costs, is totally exempted from Medicaid eligibility limits, and is usually protected against Medicaid estate recovery.

What would happen if home equity, or at least part of it, were at risk for financing LTC? There are ways to liquefy this wealth and put it to use financing quality LTC for frail and chronically ill seniors, without compelling people to leave or sell their homes. Reverse mortgages, for example, allow people to convert illiquid home equity into usable income or assets. Essentially, the homeowner borrows against his home equity, and the lender makes payments to the homeowner based on the homeowner's age and the value of the home. The payments continue as long as the borrower occupies the property. After that, the loan becomes due.

Reverse mortgages allow seniors to spend their home equity any way they see fit and still remain in their homes as long as they are physically able to do so.[43] Forty-eight percent of households aged 62 and older could get $72,128 on average from reverse mortgages. "In total, an estimated $953 billion could be available from reverse mortgages for immediate

Altogether, seniors own nearly $2 trillion worth of home equity.

Placing home equity at risk before granting access to Medicaid LTC benefits would relieve the fiscal pressure on Medicaid.

long-term care needs and to promote aging in place."[44]

Yet reverse mortgages are rarely used to finance LTC today, because Medicaid obviates the need to tap home equity for that purpose. Placing at least some home equity at risk before granting access to Medicaid LTC benefits would substantially relieve the fiscal pressure on Medicaid, create a stronger incentive for people to purchase private LTC insurance, and add significantly to the number of market-rate private payers that LTC providers so desperately need.

Home equity is the single largest asset protected from LTC spend-down by Medicaid, but there are many others that could also be tapped to relieve the financial burden on Medicaid and enhance private financing sources. As discussed above, those assets include one business, burial spaces for the whole family, household furnishings, a car, and term life insurance.

Do those assets amount to much? Take just one category for example. In a study the Center for Long-Term Care Financing conducted on behalf of the Nebraska State Legislature in 2003, state eligibility workers estimated that more than 80 percent of the state's 9,800 Medicaid LTC recipients had exempted a total of $51 million for prepaid burials, for an average of $6,505 per recipient.[45] If this were true for the country as a whole, it would mean nearly $7 billion is diverted from LTC funding at any given time to prefund burials.

Is it good public policy to use scarce Medicaid resources to indemnify heirs of recipients against the cost of burying their parents? How much could be saved if Medicaid only exempted $1,000? What if Medicaid placed reasonable limits on all the assets the program currently exempts without limit? Is Medicaid's proper role to protect inheritances or to provide access to quality LTC for the genuinely needy?

Those and many other difficult technical, ethical, and political questions need to be answered. But to date, the questions have almost never even been asked.

The Solution

When the problem of Medicaid and LTC financing is properly understood, its solution is obvious. Most people will not pay for something the government is giving away. This is true unless and until the product government gives away is so undesirable that people will spend their own money to obtain a better service. That is already beginning to happen as consumers gravitate toward privately financed home care and assisted living to avoid or postpone Medicaid-financed nursing home care.

Medicaid has a dismal reputation for problems of access, quality, reimbursement, discrimination, and institutional bias. This is well-established in the literature, which is replete with comments like the following:

> Nursing homes whose patients are mostly private generally provide higher-quality care than facilities dependent on Medicaid patients.[46]

> It is usually easier to enter a nursing home of your choice if you are a private pay patient than if you are on Medicaid. Because the Medicaid approved rate of payment is lower than what the nursing home charges private pay patients, many nursing homes are reluctant to accept Medicaid patients. After you are in a nursing home, you may later qualify for Medicaid and remain at the facility. Once you are on Medicaid, the reluctance of some nursing homes to accept Medicaid patients may make it difficult for you to transfer to another facility, even though discrimination is illegal. . . . Nursing homes are not supposed to discriminate against patients who go on Medicaid. However, some states do allow Medicaid patients to be assigned to a separate wing of the nursing home, or to be discharged to another nursing home if no Medicaid bed is available. If you have to receive acute care in a hos-

pital, the nursing home will keep your Medicaid bed for you for a limited time. If this period expires, the nursing home may not readmit you.[47]

If we do nothing, the quality of Medicaid-financed LTC will continue to deteriorate. If we allow the current financing system to collapse entirely, there will be no way left for people to obtain access to quality LTC at any level except to pay privately. When that time comes—certainly within 20 or 30 years and probably sooner—there will be no place for aging boomers to go for the private resources to purchase their LTC except their home equity.

If that is where we will end up by sustaining or expanding the status quo, why not spare the American public that pain by implementing policies that place home equity at risk for LTC now? This would not force people to use their home equity, but it would provide the necessary incentive for Americans to protect against this financial risk as they do against other financial risks: by purchasing private insurance.

Achieving that objective does not require forcing anyone to do anything. This is America. We should not compel people to buy insurance or take out a reverse mortgage. But neither should we use a public welfare program to indemnify heirs against the cost of providing their parents with quality LTC. With their inheritances at risk for LTC, adult children will pull together to help their parents obtain quality care or to purchase insurance instead of fighting over the Medicaid planning spoils, as the current system encourages.

Recommendations

To fix the current dysfunctional LTC financing system, the following steps should be taken:

1. Pass a congressional resolution stating that Medicaid should be a safety net for the poor—and only the poor. This would signal that it is Congress's intent to restore Medicaid to its original mission, and it would help blunt the Medicaid planners' argument that if Congress didn't want the wealthy on welfare, it wouldn't have put the loopholes in the law. Here's an example of that argument from two prominent Medicaid planning attorneys: "The mere fact that Congress and the states have enacted statutes and regulations expressly permitting and endorsing Medicaid planning is clearly an expression of the public policy to allow such planning."[48]

2. Eliminate all or most of Medicaid's open-ended home equity exemption for LTC recipients. Denying public assistance until home equity is consumed for LTC will not force anyone to leave or sell their homes. Families may choose to (1) support their elders and keep the home in the family, (2) rent the house (in lieu of consuming the equity) to pay for the elders' LTC, (3) sell the house and spend down to purchase top-quality care, or (4) get a reverse mortgage to liquefy home equity for that purpose. Paying privately, seniors will have better access to a wider range of higher-quality services.

3. Place reasonable limits on the amounts of other assets that people can shelter while qualifying for Medicaid LTC benefits. It is inappropriate and unethical to shelter assets for the purpose of qualifying for public assistance intended for the poor. The current unlimited exemptions for assets such as a business, a car, home furnishings and improvements, prepaid burials for the whole family, and term life insurance should be limited. Reasonable limits on these exemptions would give adults more incentive to plan responsibly for their parents' and their own LTC needs. And while the courts have held that lawyers cannot be held criminally liable for advising nonpoor clients to take advantage of Medicaid, state bar associations can hold their members to a higher standard by declaring such practices unethical and grounds for disbarment.

4. Extend the look-back period for asset transfers to 10 years for most property and 20 years for real property. States are required to determine if Medicaid applicants made asset transfers for less than fair market value for the purpose of becoming eligible. The "look-back" period

If we do nothing, the quality of Medicaid-financed LTC will continue to deteriorate.

refers to how many years prior to an individual's Medicaid application the state examines such transfers. The look-back period is currently three years for most assets, and five years for transfers to trusts. If a state finds that assets were transferred for less than fair market value during those periods, the state is supposed to delay the applicant's Medicaid eligibility date by one month for each month the applicant could have paid privately for nursing home care. Yet many applicants get around the look-back period by planning their asset transfers over three years (or five years in the case of trusts) in advance of applying for Medicaid when they know LTC is imminent. (The average period of time from onset to death in Alzheimer's disease, for example, is eight years.) However, few would want or be able to game the system 10 or 20 years in advance. Transfers of real property would be much more easily tracked than transfers of personal property because the former are publicly recorded. If individuals need to prepare for LTC long enough in advance, they will be much more likely to plan responsibly by purchasing insurance when they are younger, still medically insurable, and financially able to do so.

5. Appoint a commission of legal experts to study the practice of Medicaid estate planning, and recommend further reforms. The commission should review the extensive legal literature on the subject, monitor the conferences and publications of the National Academy of Elder Law Attorneys (the Medicaid planners' trade association), and prepare recommendations on how to curtail the most egregious Medicaid planning techniques, such as trusts, annuities, life care contracts, life estates, "spousal refusal," and so forth, that are routinely used to impoverish affluent seniors artificially.

There is no need to reinvent the wheel, however. Ten years ago, Medicaid LTC scholars Brian Burwell and William Crown suggested many specific measures for Congress to consider, all of which still deserve serious consideration.[49] These options include numerous modifications to complicated provisions of OBRA '93, which implemented the most recent set of far-reaching changes to Medicaid LTC eligibility requirements made by Congress.[50] For example, Congress should do the following:

- Reconsider the special new trusts created by OBRA '93, particularly a provision that allows transfers from the community spouse to a third party "for the sole benefit of the community spouse," also known as "sole-benefit trusts."[51]
- Eliminate the "half-a-loaf" strategy, which allows people to transfer half their assets, spend down the other half during the resulting eligibility penalty period, and become eligible for Medicaid in half the time originally intended by Congress.[52]
- Apply transfer-of-assets penalties to *all* transfers done for the purpose of establishing eligibility for Medicaid or avoiding estate recovery, including transfers that shift wealth from nonexempt assets to exempt assets.[53]
- Prohibit the "spousal refusal" or "just-say-no" gambit. "Another asset preservation strategy is for a community spouse to 'just say no' to paying for the other spouse's nursing home care. Say Mrs. Jones holds more money than the state allows for her husband to qualify for Medicaid coverage. If it can be shown that she simply refuses to spend her money on her husband's care, Medicaid coverage will be allowed for Mr. Jones if other easily met requirements are satisfied. This approach has been particularly successful in New York."[54]
- Explicitly empower state Medicaid estate recovery programs to recover from the estates of surviving spouses of deceased Medicaid recipients. OBRA '93 required states to implement Medicaid estate recovery programs. States are not allowed, however, to recover from a recipient's estate until after the death of a surviving spouse. Some courts have interpreted this to mean that the recipient's cost of care can be recovered from the estate of a surviving spouse. Other courts have held otherwise. Congress

Congress should eliminate all or most of Medicaid's open-ended home equity exemption for LTC recipients.

should clarify this point.

- Eliminate the "resources-first" option for raising the Community Spouse Resource Allowance. Federal law allows states to use either an "income-first" or a resources-first method of determining the community spouse's resource allowance and monthly maintenance needs allowance. Under the income-first approach, the institutionalized Medicaid recipient's income is transferred to the community spouse in amounts sufficient to bring the community spouse up to the amount the state determines that spouse needs (i.e., his or her "maintenance needs allowance"). Under the "resources first" approach, the Medicaid recipient is allowed to transfer assets above the limits otherwise prescribed for the Community Spouse Resource Allowance. The resources-first approach invites abuse because it allows the Medicaid recipient to transfer substantial excess resources to the community spouse, thus becoming eligible more quickly and spending down less. It allows the community spouse to seek the lowest possible return on invested capital for the purpose of maximizing the assets transferred without exceeding the maintenance needs allowance, a perverse result as compared to sensible financial planning. In some cases, such methods have been used to shelter more than $200,000 in assets above the limit of $95,100 that would otherwise apply.[55]
- Require liens on exempt real property as a condition of receiving Medicaid LTC benefits. The Medicare Catastrophic Coverage Act of 1988 made transfer-of-asset penalties mandatory under federal law. OBRA '93 made estate recoveries mandatory. Liens on real property ensure that the property remains in the estate so that it can be recovered. State use of such liens is still voluntary under the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA '82). The absence of TEFRA liens in many states means that real property, including exempt homes, often disappears during a recipient's time on Medicaid and is therefore not available for estate recovery. Mandating liens on real property would help to keep home equity in the recipient and spouse's estate for recovery.
- Change the "intent-to-return" rule so that homes remain exempt assets only so long as the recipient can reasonably be expected to return home based on his or her medical condition. Medicaid rules currently allow a home to remain exempt indefinitely as long as the recipient or a personal representative claims the intent to return. The intent is entirely subjective; the home remains exempt even if it is vacant and it is medically impossible for the recipient to return.

These measures would postpone or eliminate Medicaid dependence for many Americans. How much could these public policies save? Medicaid spent $91 billion on 7.2 million dual eligibles in 2002, or $12,646 per dually eligible recipient.[56] To save $20 billion per year, Medicaid would only need to reduce the number of dual eligibles by approximately 1.6 million, or 22 percent. Rodney Whitlock of the Senate Finance Committee staff believes the potential savings to Medicaid are even greater. In a speech to the National Conference of State Legislatures, he said that based on Congressional Budget Office numbers, Medicaid could save $160 billion between 2011 and 2015 (the second five-year portion of the current 10-year budget window) by diverting only one-third of the people who would otherwise have ended up on Medicaid in nursing homes to private-pay status instead.[57]

Are such large potential savings in Medicaid's long-term care budget feasible? They are if, as NCOA reports, half of households headed by people over 62 could get over $70,000 each from a reverse mortgage. When added to other income and assets people would retain, those funds could delay or prevent Medicaid dependence for millions of Americans.

Understand, of course, that savings of this magnitude would not come from eliminating

These measures would postpone or eliminate Medicaid dependence for many Americans.

The savings will come over time by preventing people from *becoming* "impoverished" Medicaid dependents.

eligibility for *current* dual eligibles. Most of them are poor and lack home equity. The savings will come over time by preventing people from *becoming* "impoverished" Medicaid dependents. The proposed changes in eligibility rules would eliminate the perverse incentives that discourage responsible LTC planning. They would create strong positive incentives for people to purchase private LTC insurance while they are still able to qualify medically and financially.

Whether or not one accepts much larger estimates of potential savings, changes to Medicaid like those recommended above would easily save the $10 billion that Congress is trying to save over five years. In fact, it is reasonable to conclude that such changes, if implemented, would save enough to fund the cost of an above-the-line tax deduction for private LTC insurance and/or the cost of funding a national LTC Partnership program. That program, originally sponsored by the Robert Wood Johnson Foundation, allows individuals to exempt assets above the usual $2,000 limit if they have purchased LTC insurance. The program exists in only four states and has languished since OBRA '93 denied its participants exemption from estate recovery. Legislation has been proposed that would eliminate that restriction and lead to rapid expansion of the LTC Partnership program.

These measures would pay dividends over time as more and more people buy insurance, pay privately for LTC, and avoid Medicaid dependence. It is also worth mentioning that healthy markets for LTC insurance and reverse mortgages would mean more jobs, more tax revenue, and hence more resources to operate Medicaid as a safety net for the genuinely needy.

Objections

If this is such a big problem, why is there so little empirical evidence of "asset transfers" or Medicaid planning? First of all, Medicaid planning is a dirty little secret. Adult children, who take early inheritances and put their parents in nursing homes on welfare, often won't talk. Seniors whose assets are taken are often cognitively impaired and/or intimidated by their heirs. They don't talk. Medicaid planners easily hide from scrutiny through attorney/client privilege. They refuse to talk. Nursing home staff are silenced by confidentiality. They can't talk. State Medicaid staff are also silenced by confidentiality. They can't talk either.

The second reason we don't have more solid empirical evidence of the extent of Medicaid planning is a widespread preference among academics, foundations, and some think tanks for public financing of LTC over private financing alternatives. Those who might be expected to support private LTC financing—such as conservative and libertarian think tanks—have mostly ignored Medicaid and LTC to focus on Social Security and Medicare. Whatever one's political preferences, however, all should be able to support targeting Medicaid to the needy as a fairness issue. Why use scarce public welfare resources to indemnify affluent heirs of well-to-do seniors?

Elderly Americans are not very rich. Just how costly can Medicaid planning possibly be? Overzealous Medicaid planning is just the tip of the iceberg. Only a small percentage of seniors have the average wealth of Medicaid planning clients, (i.e., a home worth $250,000 to $400,000 plus additional assets in the range of $150,000 to $250,000).[58] But, to use a different metaphor, these people are the straw that breaks the camel's back. The load that makes the camel vulnerable comes from the open-ended home exemption and all the other routine exclusions and allowances that permit people with substantial assets and income to qualify. As a result, the average senior easily qualifies for Medicaid LTC benefits without spending down significantly.

If using home equity to pay for LTC is such a great idea, why don't people already use reverse mortgages for these expenses? Why would they, when Medicaid exempts the home and all contiguous property regardless of value and estate recovery is easy to avoid? Put home equity at risk and consumers will take LTC seriously, plan for it, and save, invest, or insure against the risk.

How would requiring people to use their home equity and other wealth improve Medicaid? With

fewer people to serve, Medicaid would have more resources to help those who are genuinely in need. Medicaid would require fewer eligibility workers and estate recovery staff, thus reducing administrative costs. Part of the Medicaid savings could be applied to increasing reimbursement rates and expanding the continuum of services provided, thus improving access to and quality of care. Finally, the jobs created in the financial services industry (reverse mortgage lenders) and the insurance industry (LTC insurance agents) would generate new tax revenues to help states and the federal government support Medicaid.

Wouldn't reverse mortgages impoverish spouses of Medicaid recipients and leave them dependent on public assistance? No, just the opposite. Reverse mortgages provide extra income indefinitely. They are fully insured by the federal government so that families retain the income and the use of the home until they move, sell, or die, even if the home equity is entirely consumed.

Wouldn't this take away a sacred right people have to pass on their homes to heirs? No, Congress made it clear over 20 years ago that "all of the resources available to an institutionalized individual, including equity in a home, which are not needed for the support of a spouse or dependent children will be used to defray the cost of supporting the individual in the institution."[59] That was the justification for estate recovery, which has not worked well because it is punitive, after-the-fact, and politically sensitive. Reverse mortgages as a precondition of eligibility would achieve the same objective far more efficiently and before Medicaid has to obtain and expend the funds.

Wouldn't LTC providers, including nursing homes, assisted living facilities, and home care agencies, lose Medicaid patients? Yes, and they would be thrilled to replace Medicaid recipients, whose reimbursement is often less than the cost of providing their care, with private patients who pay a market rate. Furthermore, the influx of new revenue would improve access and quality for all LTC patients, both private-pay and Medicaid.

Wouldn't baby boomers, who are counting on inheritances protected by Medicaid, object vehemently? Probably, but why should Medicaid, which was intended as a safety net for the poor, be inheritance insurance for middle-class boomers? Boomers are exactly the generation we need to awaken to LTC risk and to their need to insure against it. For nearly 40 years, Medicaid has done exactly the opposite. It has anesthetized boomers to the risk by paying for their parents' LTC. We must worry about the unfunded liabilities of Medicaid just as we do those of Social Security and Medicare. Medicaid is a deadweight drag on state and federal general funds. Medicaid will have nowhere to turn when the demographic tsunami hits.

How would we prevent people from gaming this rule the same way they use Medicaid planning to circumvent the current system? Most people who transfer assets to qualify for Medicaid do it after they have an LTC crisis or when they (or usually their heirs) anticipate such a crisis coming soon. By that time, they don't qualify medically or cannot afford private LTC insurance, so they turn to Medicaid. Confront them with the risk of a real Medicaid spend-down liability while they are still young, healthy, and affluent enough to insure privately, and most people would do so. Unlike transfers of liquid assets or negotiable securities, real property transfers are publicly recorded and easily discovered. It would be simple to hold people accountable who give away large amounts of home equity any time before applying for Medicaid, even a decade or more.

This is a political nonstarter because Medicaid is a "third rail" like Social Security and Medicare. Nonsense. We are quickly approaching the time when the political risk of failure to confront exploding Medicaid costs will exceed the political risk involved with confronting them honestly. How will politicians justify cutting dental benefits for poor children or slashing education or letting roads go unrepaired just so prosperous seniors can pass their wealth to affluent heirs at the expense of ever-skyrocketing Medicaid LTC costs?

Why should Medicaid, which was intended as a safety net for the poor, be inheritance insurance for middle-class boomers?

If people's home equity were at risk to pay for LTC, most would plan early to save, invest, and insure against that risk.

Do enough people who are currently receiving Medicaid LTC benefits own their homes to achieve such big savings immediately? No. Probably no more than 15 to 20 percent of people already receiving Medicaid still own their homes. Besides, policymakers would likely want to grandfather in current recipients under the status quo. The major savings will come over a period of three years as the Medicaid LTC population turns over and fewer new recipients qualify until after they spend down their home equity, either with a reverse mortgage or by other means.[60]

The big question here is: what happens to the homes owned by most seniors? As noted earlier, 81 percent of households over age 62 own their homes. Despite the facts that illnesses like Alzheimer's disease strike irrespective of whether seniors own or rent and that the vast majority of LTC patients are Medicaid patients, a 1989 study by the General Accounting Office found that only about 14 percent of Medicaid nursing home residents own their homes.[61] Why is it that by the time they qualify for Medicaid, most seniors no longer own their homes? How can this be the case, if fewer than one-quarter of nursing home residents spend down their assets before becoming Medicaid eligible? Are the homes being transferred to heirs? Are they being sold and the money used somehow? How? Evidently not for LTC, as the above data indicate. Research is needed to answer these questions.

Conclusion

Medicaid is supposed to be America's LTC safety net for the poor. Instead, it is the principal LTC payor for nearly everyone. Medicaid's LTC benefit has become "inheritance insurance" for baby boomers, lulling them into a false sense of security regarding their own future LTC needs. Medicaid's loose eligibility rules for LTC create perverse incentives that invite abuse and discourage responsible LTC planning. The conventional wisdom that most people must spend down their life savings before they qualify for Medicaid LTC benefits is a myth.

If people's biggest asset, their home equity, were at risk to pay for LTC, most people would plan early to save, invest, and insure against that risk. Reverse mortgages permit people to withdraw supplemental income or assets from their otherwise illiquid home equity without risking use of the home. This extra cash can purchase services to help them remain at home and delay Medicaid dependence—or avoid it altogether. The single most effective step Congress and the president can take to fix Medicaid, reduce its cost, and improve the quality of LTC would be to replace Medicaid's wide-open home equity exemption with a more limited exemption of home equity or none at all.

With that one change in effect, families would pull together to fund quality LTC for their elders, rather than fighting over the spoils of Medicaid-planning abuse as they do now. That simple measure combined with other, lesser modifications would pump desperately needed oxygen into LTC markets, ease the tax burden of Medicaid, enable Medicaid to provide better access to higher-quality care for the genuinely needy, and supercharge the market for LTC insurance and home equity conversion products. Everyone will be better off, with the exception of legal experts who currently profiteer on Medicaid's extravagantly loose eligibility rules.

Notes

1. National Association of State Budget Officers, "Table 3: Comparison of Shares of State Spending with Fund Sources, Fiscal 1994 to 2004," *2003 State Expenditure Report*, p. 8, http://www.nasbo.org/Publications/PDFs/2003ExpendReport.pdf.

2. Steven R. Gregory and Mary Jo Gibson, *Across the States, 2002 Profiles of Long-Term Care*, 5th ed. (Washington: AARP Public Policy Institute, 2002), p. xi, http://assets.aarp.org/rgcenter/health/d17794_2002_ats.pdf.

3. These two areas of care make up the lion's share of Medicaid LTC expenditures. Centers for Medicare and Medicaid Services, "Table 10: Expenditures for Health Services and Supplies

under Public Programs, by Type of Expenditure and Program: Calendar Year 2003," http://www.cms.hhs.gov/statistics/nhe/historical/t10.asp.

4. Judy Kasper, Risa Elias, and Barbara Lyons, "Dual Eligibles: Medicaid's Role in Filling Medicare's Gaps," Kaiser Commission on Medicaid and the Uninsured, March 2004, p. 1, http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=33892.

5. Diane Rowland, "Medicaid: Addressing the Future," Testimony before the U.S. Senate Special Committee on Aging, June 28, 2005, Figure 1, Kaiser Commission on Medicaid and the Uninsured, p. 12, http://www.kff.org/medicaid/upload/53725_1.pdf .

6. "Per capita spending for dual eligibles in nursing facilities averages $44,600, or about four times the spending for dual eligibles in the community ($10,900) or for other Medicare beneficiaries ($8,400). Because Medicare does not cover long-term care, the higher costs for those who are institutionalized fall heavily on the Medicaid program and account for nearly 4 out of 5 dollars that Medicaid spends on dual eligibles." Kasper, Elias, and Lyons, p. 10.

7. This is true in "medically needy" states. In "income cap" states, a Miller income diversion trust achieves the same purpose.

8. See Social Security Administration, "SI 01715.020 List of State Medicaid Programs for the Aged, Blind and Disabled," http://policy.ssa.gov/poms.nsf/lnx/0501715020. Some "medically needy" states have become "income cap" states and vice versa since Social Security last updated this list.

9. Medical expenses not covered by Medicare can be substantial. They include eye care, dental care, foot care, and (at least until January 2006) pharmaceuticals.

10. See SI 01715.020. Some "medically needy" states have become "income cap" states and vice versa since Social Security last updated this list.

11. SSI stands for Supplemental Security Income, the federal welfare program for aged, blind, and disabled individuals. SSI's monthly benefit increases with inflation every year. The dollar amounts cited here are in effect for 2005.

12. Only $2,000 for an individual ($3,000 for a couple) is exempt from the spend-down requirement in most states.

13. Social Security Administration, *Program Operations Manual System (POMS)*, http://policy.ssa.gov/poms.nsf/lnx/0501130100. A small number of "209b" states can require sale of the home if no exempt relative resides in it and the Medicaid spouse is medically unable to return.

14. The reader will note that many of the sources cited in the following pages are as old as 10 or 20 years. The main reason for this is that Medicaid planning lawyers have become more circumspect about the practice of artificially impoverishing clients to qualify for Medicaid. Years of bad publicity, followed by the legal uncertainty created by a provision in the Balanced Budget Act of 1997 (which made it a crime to recommend certain Medicaid planning practices in exchange for a fee), caused most Medicaid planners to rein in their rhetoric. When citing an older source, I will attempt to point out if anything in it has become invalid in the meantime.

15. Hal Fliegelman and Debora C. Fliegelman, "Giving Guardians the Power to Do Medicaid Planning," *Wake Forest Law Review* 32, no. 2 (Summer 1997): 341–96.

16. Michael Gilfix, "Elder Law in the 90's: No Shortage of Issues," *Trusts and Estates* 129, no. 4 (April 1990): 45. "Community spouse" refers to the healthy spouse of the institutionalized Medicaid recipient. Since the Omnibus Budget Reconciliation Act of 1993, the community spouse can no longer sell the house with impunity. The proceeds of such a sale would not be exempt. The rest of the quote remains true.

17. Alexander A. Bove Jr., "Protecting the Home through Special Powers of Appointment," *The ElderLaw Report* 7, no. 7 (February 1996): 3. "Estate recovery" refers to the practice of state Medicaid programs recovering the cost of care from the recipients' probated estates. Estate recovery was voluntary after the Tax Equity and Fiscal Responsibility Act of 1982 and has been mandatory since the Omnibus Budget Reconciliation Act of 1993.

18. "Property essential to self-support used in a trade or business is excluded from resources regardless of value or rate of return effective May 1, 1990." Social Security Administration, *Program Operations Manual System (POMS)*, http://policy.ssa.gov/poms.nsf/lnx/0501130501.

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

20. Roger A. McEowen, "Estate Planning for Farm and Ranch Families Facing Long-Term Health Care," *Nebraska Law Review* 73, no. 1 (1994): 104–41; See also "Company Makes Landlords of Elderly to Shelter Assets," Associated Press, September 30, 2002.

21. *POMS*, "SI 01130.400: Burial Spaces," http://policy.ssa.gov/poms.nsf/lnx/0501130400.

22. *POMS*, "SI 01130.300: Life Insurance," http://policy.ssa.gov/poms.nsf/lnx/0501130300.

23. *POMS*, "SI 01130.430: Household Goods, Personal Effects and Other Personal Property," http://policy.ssa.gov/poms.nsf/lnx/0501130430.

24. "Assume the automobile is used for transportation, absent evidence to the contrary." Social Security Administration, *POMS*, "SI 01130.200: Automobiles and Other Vehicles Used for Transportation," http://policy.ssa.gov/poms.nsf/lnx/0501130200. Emphasis in original.

25. Ira S. Schneider and Ezra Huber, *Financial Planning for Long-Term Care* (New York: Human Sciences Press, 1989), p. 142.

26. Jean Sherman Chatzky, "Parental Guidance: Changing Places," *Smart Money* 6, no. 10 (October 1, 1997): 134–36.

27. Jim Dam, "Drastic Changes in Medicaid Planning Made by Congress," *Lawyers Weekly* 93, no. 13 (September 27, 1993): 1, 12.

28. Quoted in Mary Schroeder, "Elder Law Expert Outlines Features of Asset Transfer, Power of Attorney," *Financial Services Week* 3, no. 20 (July 9, 1990): 19. Although it is unlikely that someone would actually shelter such an enormous dollar amount in "household furnishings," and more recent SSI rules have clarified that personal belongings actually held for purposes of investment and appreciation are not exempt, the truth is that Medicaid eligibility workers rarely verify the value and kind of Medicaid applicants' personal belongings and applicants can easily protect substantial assets in this way.

29. "Spousal impoverishment" protections began at $1,500 per month of income and $60,000 in assets with passage of the Medicare Catastrophic Coverage Act in 1988. Protection amounts increase with inflation annually.

30. Gregory Wilcox, "Another Strategy to Increase the CSRA," *ElderLaw Report* 2, no. 8 (March 1991): 12.

31. Fliegelman and Fliegelman, pp. 341–96.

32. Michael Farley, "When 'I Do' Becomes 'I Don't': Eliminating the Divorce Loophole to Medicaid Eligibility," *Elder Law Journal* 9, no. 1 (2001): 28. See Dam, pp. 1, 12; and James H. Young, "Medicaid Eligibility," *Maine Bar Journal* 5, no. 4 (July 1990): 227.

33. Many of these are available from the Center for Long-Term Care Reform, http://www.centerltc.com/bullets/subject.htm#medicaid_plan.

34. U.S. Department of Health and Human Services, Office of Inspector General, Office of Analysis and Inspections, *Medicaid Estate Recoveries*, OAI-09-86-00078, June 1988, p. 7.

35. See, for example, Kathleen Adams, Mark Meiners, and Brian Burwell, "Medicaid Spend-Down in Nursing Homes: A Synthesis of Recent Research," draft study conducted under contract for the Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, HHS-100-88-0041, 1990; Denise A. Spence and Joshua M. Wiener, "Estimating the Extent of Medicaid Spend-Down in Nursing Homes," *Journal of Health Politics, Policy and Law* 15, no. 3 (June 1990): 607–26; and Korbin Liu, Pamela Doty, and Kenneth Manton, "Medicaid Spend-Down in Nursing Homes," *Gerontologist* 30 (1990): 715.

36. Centers for Medicare and Medicaid Services, "Table 7: Nursing Home Care Expenditures Aggregate and per Capita Amounts and Percent Distribution, by Source of Funds: Selected Calendar Years 1980–2003," http://www.cms.hhs.gov/statistics/nhe/historical/t7.asp. The latest version of this table has dropped the 1988 data; it now shows data for only 1980 and 1993 forward. Data cited here for 1988 are taken from the version of this table posted in January 2004.

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

38. For more information, see Stephen Moses, "LTC Bullet: So What If the Government Pays for Most

LTC, 2003 Data Update," Center for Long-Term Care Financing, January 19, 2005, http:// www.centerltc.com/bullets/archives2005/534.htm.

39. Centers for Medicare and Medicaid Services, "Table 7: Nursing Home Care Expenditures Aggregate and per Capita Amounts and Percent Distribution, by Source of Funds: Selected Calendar Years 1980–2003," http://www.cms.hhs. gov/statistics/nhe/historical/t7.asp, and author's calculations. The latest version of this table has dropped the 1988 data; it only shows 1980 and 1993 forward. Data cited here for 1988 are taken from the version of this table posted in January 2004.

40. S. Feinleib, P. Cunningham, and P. Short, "Use of Nursing and Personal Care Homes by the Civilian Population, 1987" (AHCPR Pub. no. 94-0096), Agency for Health Care Policy and Research, August 1994, p. 4.

41. Centers for Medicare and Medicaid Services, "Table 9: Personal Health Care Expenditures, by Type of Expenditure and Source of Funds: Calendar Years 1996–2003," http://www.cms.hhs.gov/statistics/nhe/historical/t9.asp.

42. National Council on the Aging, "Use Your Home to Stay at Home(tm) Program Study Shows That Reverse Mortgages Can Help Many with Long-Term Care Expenses," press release, April 15, 2004, http://206.112.84.147/content.cfm?sectionID=61&detail=576. NCOA has not previously been a strong advocate of private long-term care financing alternatives. The organization's support and encouragement of reverse mortgages as a new funding source for long-term care displays growing doubt among senior advocates that traditional public funding sources like Medicaid and Medicare will be adequate to finance long-term care in the future.

43. The National Reverse Mortgage Lenders Association is a good source of information on home equity conversion, http://www.reversemortgage.org/default.aspx. See also AARP, http://www.aarp.org/revmort/; and the National Center for Home Equity Conversion, http://www.reverse.org/.

44. National Council on the Aging.

45. Stephen A. Moses, "The Heartland Model for Long-Term Care Reform: A Case Study in Nebraska," Center for Long-Term Care Financing, 2003, http://www.centerltc.com/pubs/Nebraska. pdf, p. 19.

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

47. *Long-Term Care Planning: A Dollar and Sense Guide* (Washington: United Seniors Health Cooperative, March 1997), p. 53.

48. Fliegelman and Fliegelman, p. 373.

49. Brian Burwell and William H. Crown, "Medicaid Estate Planning in the Aftermath of OBRA '93," The MEDSTAT Group, Cambridge, MA, 1995, pp. 44–47.

50. Detailed descriptions and explanations of these provisions and recommended changes are beyond the scope of this paper. Full details are given in ibid. and in numerous legal journal articles on the arcane rules of Medicaid long-term care eligibility.

51. For example: "Your wife can transfer her assets into a trust for your sole benefit [under provisions of OBRA '93]. This transfer would not subject her to a Medicaid period of ineligibility." National Academy of Elder Law Attorneys, 1996 conference proceedings, Session 9, pp. 34–38, 46.

52. "The most common means of transferring assets—the 'half-a-loaf' method—is designed to exploit this principle [maximum asset transfers] without breaking any rules, explains Boston attorney Harry Margolis." Chatzky, pp. 134–36. Margolis is publisher of *ElderLaw Report*, a widely read newsletter with a focus on Medicaid planning techniques. The most common method proposed for eliminating the half-a-loaf strategy is to begin the period of ineligibility when the individual enters a nursing home or applies for Medicaid, whichever happens first. If this strategy is implemented, however, a way must be found to hold long-term care providers harmless against the possibility they will end up with residents deemed retroactively ineligible for Medicaid but unable to pay for their own care.

53. See Baird Brown and Robert Fleming, "Planning Options That OBRA '93 Does Not Affect," 1993 *Elder Law Institute Proceedings*, section #12 (1993): 14, 16, 29.

54. Michael Gilfix, "Elders and Nursing Home Expenses: Preserving Client Assets," *Trial* 29, no. 6 (June 1993): 38. For more on Medicaid planners' advocacy of "spousal refusal," see Stephen Moses, "LTC Bullet: They're Baaack, Part IV: 'Abandon Your Spouse . . . Get Medicaid,'" Center for Long-Term Care Financing, October 29, 2001, http://centerltc.com/bullets/archives2001/310.htm.

55. See Dam, pp. 1, 12.

56. "Total Dual Eligibles, 2002," *Statehealthfacts.org*, http://www.statehealthfacts.kff.org/cgi-bin/healthfacts.cgi?action=profile&area=United+States&category=Medicaid+%26+SCHIP&link_cate

gory=Medicare&link_subcategory=Dual+Eligibles&link_topic=Total+Dual+Eligibles; and "Medicaid Spending for Dual Eligibles by Service in Millions, 2002," http://www.statehealthfacts.kff.org/cgi-bin/healthfacts.cgi?action=profile&area=United+States&category=Medicaid+%26+SCHIP&link_category=Medicare&link_subcategory=Dual+Eligibles&link_topic=Medicaid+Spending+by+Service, Kaiser Family Foundation.

57. Rodney Whitlock, Address to the National Conference of State Legislatures, June 17, 2005, pp. 6–7, http://www.kaisernetwork.org/health_cast/uploaded_files/061705_ncsi_briefing_transcript. pdf.

58. Stephen A. Moses, "What We Don't Know about Medicaid and Long-Term Care Is Hurting Washington State," Center for Long-Term Care Financing, Seattle, Washington, December 2004, p. 7, http://www.centerltc.com/pubs/washington.pdf.

59. *United States Code, Congressional and Administrative News, 97th Congress—Second Session—1982, Legislative History (Public Laws 97-146 to 97-248)*, vol. 2 (St. Paul, MN:, West Publishing), p. 814, cited in U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, Office of Disability, Aging and Long-Term Care Policy, "Medicaid Treatment of the Home: Determining Eligibility and Repayment for Long-Term Care," Policy Brief no. 2, April 2005, p. 10, http://aspe.hhs.gov/daltcp/reports/hometreat.pdf.

60. Nursing home occupancy turns over at least 100 percent every three years. Frederic H. Decker, "Nursing Homes, 1977–99: What Has Changed, What Has Not? Facts from the National Nursing Home Surveys," National Center for Health Statistics, p. 3, http://www.cdc.gov/nchs/data/nnhsd/NursingHomes1977_99.pdf. Although savings from current residents based on the proposed rule changes would be minimal, the objective is to encourage policies that delay or prevent Medicaid nursing home institutionalization by encouraging private financing alternatives, especially for home- and community-based care.

61. General Accounting Office, "Recoveries from Nursing Home Residents' Estates Could Offset Program Costs," GAO/HRD-89-56, March 7, 1989, p. 4, http://archive.gao.gov/d15t6/138099. pdf.

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