THE NEW YORK LONG-TERM CARE DAPACT PROPOSAL: UPDATE, ANALYSIS

Table of Contents

Preface	1
Introduction	1
National Background]
New York Background	2
The New York Long-Term Care Compact Proposal: Who, What, When, Why	4
Who Favors the LTC Compact and Why?	8
Who Opposes the LTC Compact and Why?	9
The LTC Compact: Savings or Cost?	10
Analysis	11
Conclusions and Recommendations	15
Postscript: The Kansas Connection	17
List of Interviewees	21
Appendix A: Comments on the report from the NY State Bar Ass'n Elder Law Section Compact Working Group with author's replies	23
Appendix B: Excerpts from an article on Post-DRA Medicaid planning.	29
Appendix C: Comments on the report from a long-term care insurance producer (agent)	31
Bibliography	.34
Endnotes	36

The New York Long-Term Care Compact Proposal: Update, Analysis and Recommendations by Stephen A. Moses, President Center for Long-Term Care Reform

Preface

The following report is based on a study of the New York Long-Term Care Compact proposal conduced by the Center for Long-Term Care Reform (www.centerltc.com). The Center is a private institute dedicated to ensuring quality long-term care.

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Introduction

Long-term care service delivery and financing in the United States are serious problems. New York, which spends more money to care for the elderly and disabled than any other state, is a case in point. Over the past few years, a group of New Yorkers devised a plan to address the current and future challenge of providing and funding long-term care. This report examines their "Long-Term Care Compact" proposal, including its history and current status, concluding with analysis and recommendations.

National Background

Long-term care (LTC) is medical or custodial assistance provided to aged or disabled people who are unable to care fully for themselves. Families and friends, especially wives and daughters, provide most LTC for free. But formal LTC, provided in nursing homes or home and community-based settings, is commonplace, growing rapidly and very expensive. The U.S. spent \$169.4 billion on nursing home and home health care in 2005. Most of this spending comes directly or indirectly, and increasingly, from government sources.

For example, the percentage of nursing home costs (\$121.9 billion in 2005) paid by Medicaid and Medicare has gone up over the past 35 years (from 26.8% in 1970 to 59.6% in 2005, up 32.8 % of the total) while out-of-pocket costs have declined (from 52.0% in 1970 to 26.5% in 2005, down 25.5% of the total). Likewise, of the \$47.5 billion spent on home health care in 2005, Medicare (37.7%) and Medicaid (32.6%) paid 70.3% and private insurance paid 12.2%. Only 10.7% of home health care costs were paid out of pocket in 2005.

In spite of this large expenditure of public funds for long-term care, America's LTC service delivery and financing system has serious problems. Financing is inadequate at all care levels. Access and quality are frequently doubtful. Institutional (nursing home) bias prevails and HCBS infrastructure is underdeveloped despite the public's preference for home care. Caregiver shortages and high turnover are the rule. Tort liability and liability insurance rates are high. LTC insurance sales are low and flat. While the public appears to be in denial about the risk and cost of long-term care, the ability of public programs to continue carrying most of the financial burden is dubious.

New York Background

New York state faces all these challenges and more. People 85 years of age and older--those most likely to need expensive LTC--were 1.9% of the state's population in 2005, compared to 1.7% nationally. These "old-old" people will constitute 2.6% of New York's population in 2020, compared to 2.2% nationally, an increase of 38% only 13 years from now. A disproportionate share of older New Yorkers are minorities (24.5% vs. 18.5% for the U.S.) or living at or below the poverty level (12.7% vs. 9.9% for the U.S.), groups most likely to need public assistance in funding their long-term care. Already, New Yorkers use a high level of long-term care services. The state ranks number one in total nursing facility residents with 113,278 and 19th in residents per 100 people age 65 plus. New York is also number one in home health aides per 1,000 age 65 plus--46 compared to a national average of 18.

Whether formal LTC services are provided in a nursing home or in the community, government programs pay most of the cost. Medicaid is the primary payor for 73% of nursing facility residents in New York compared to the U.S. average of 65%. Medicare pays for 13%. Only 14% of nursing facility residents in New York have "other" funding sources, including "out of pocket" expenditures, the VA and others. Medicaid is also the dominant funder of home care in New York, ranking the state number one nationally in HCBS funding, \$370 per person in the state compared to only \$119 per person nationally. New York ranks fourth among states in HCBS expenditures as a percentage of total Medicaid LTC expenditures for people 65 plus, 31% as compared to the national average of 17%. 4

The burden of funding most long-term care through Medicaid weighs heavily on New York's budget and upon state policy makers. After education, Medicaid is the largest component of the general fund budget, comprising 18 to 20 percent. Medicaid costs are increasing 10% per year in New York, far more than inflation. Long-term care is half of the cost now and threatens to consume ever more as the coming demographic age wave crests. Of the 4.2 million New Yorkers currently on Medicaid, only 11% are elderly, but they consume 26% of the program's resources, mostly for long-term care. Between now and 2030, New York will gain 500,000 in total population, but increase by 1.4 million elderly, because younger people are moving away and marriages and child births are down. That means there are and will be fewer free caregivers and a need for more paid LTC services. Bottom line, "We'll have more bills and fewer bill payers," said Robert Herz, Legislative Director/Committee Director in the office of State Senator

Martin J. Golden, who chairs the Senate Aging Committee, and is a leading sponsor of the LTC Compact legislation.

New York's heavy dependency on Medicaid for funding long-term care also creates a severe strain on LTC providers. Carl Young, President and CEO of the New York Association of Homes and Services for the Aging, whose members include nursing homes, adult care facilities, assisted living providers, continuing care retirement communities, senior housing facilities, home care agencies, and adult day care providers, said "68 percent of the not-for-profits are losing money on operations. They're digging into endowments and turning to their religious sponsors to make up the difference. They can't take budget cuts every year." For-profit providers may have it even worse. Richard Herrick, President and CEO of the New York State Health Facilities Association, said Medicaid pays nursing homes \$22 to \$24 per day less than allowable costs, the worst shortfall anywhere in the country. Nursing facility stays are shorter; occupancy is lower (down from 97% to 92%); and private payers (who pay over half again as much as Medicaid have dwindled to under 10%. Both the non-profit and for-profit associations have experienced closures among their members. It's a "perfect storm," said Herrick.

Nor is there much hope for private financing of long-term care to come to the rescue of the Medicaid budget and LTC providers in New York. According to NYSHFA, of the 41 million days of nursing facility care provided annually in New York, 77.4% are Medicaid days, 8.6% are Private Days and only 2.1% are Private Insurance Days. New York has one of the lowest private long-term care insurance market penetration rates in the United States, only 1% to 5%. While home equity is a potential source of private LTC financing, New York state ranks 50th in home ownership by people age 65 plus. Only 64% of elderly New Yorkers own their homes compared to 79% nationwide. There is no hard evidence that New Yorkers use home equity, through reverse mortgages or otherwise, to fund long-term care. Besides, New York Medicaid exempts up to \$750,000 worth of home equity for any Medicaid recipient who expresses an intent to return to the home.

For the time being, and unless or until long-term care financing policies change, state and federal taxpayers will pay for the vast majority of all professional long-term care services in the state of New York. But given the demographic and fiscal realities discussed above, something has to change before the baby boom generation reaches senescence. As a wag once said: "Trends that can't continue, won't." So, a group of New Yorkers concerned about long-term care has gone back to the drawing board, consulted with many different experts and interest groups, and designed an extraordinarily innovative, ingenious and radical LTC reform plan: The New York Long-Term Care Compact.

The New York Long-Term Care Compact Proposal: Who, What, When, Why

Who? By most accounts, the LTC Compact proposal was the brainchild of a group of elder law attorneys and an expert on public and private long-term care insurance with the aid and encouragement of some state legislators and their staff.

The legislators told the interest groups--who were constantly importuning them for more long-term care funding and fewer constraints on Medicaid-funded care--to recognize the seriousness of the LTC financing problem, stop complaining and propose something positive for a change. (In a letter commenting on a draft of this report, the New York State Bar Association Elder Law Section Compact Working Group denied the Elder Law Section was told by legislators to stop complaining. See Appendix A.)

The lawyers, frustrated first by former-Governor Pataki's efforts to constrain Medicaid LTC eligibility and later by the Deficit Reduction Act of 2005, which federally mandated the same kinds of controls (e.g. longer and stronger asset transfer penalties, a home equity exemption cap, etc.), saw the futility of fighting change and took up the challenge.

Gail Holubinka, who ran the highly regarded New York Long-Term Care Partnership for more than a decade and later became and remains now Vice President for Business Development of the MedAmerica [Long-Term Care] Insurance Company, conferred with the interested parties, designed the LTC Compact with their advice and consent and in February 2005 documented it in "A Proposal for a New York State LTC Compact," a chapter in a New York State Bar Association report on long-term care.

What? The LTC Compact proposes to offer New Yorkers a new option to pay for long-term care. Under the Compact, a person who is chronically ill and needs long-term care could become a Compact participant by pledging to spend for qualified LTC services an amount equal to half his or her non-housing assets (not counting the first \$20,000 for someone with less than \$40,000 in total) or the cost of three years in a nursing home (circa \$300,000 depending on region of residence), whichever is less. Upon spending the pledged amount for approved LTC services as satisfactorily documented and verified, the Compact participant would become a Compact beneficiary, eligible for a Compact subsidy. The Compact subsidy is an amount of payment for future LTC services equal to the Medicaid rate for the same or a similar service. A Compact beneficiary would be entitled to receive lifetime LTC services funded by the Compact program at the Compact subsidy rate, in accordance with an assessment of need and a plan of care, by paying out of pocket an additional 10% of the Compact subsidy rate plus an annual participation fee not to exceed 25% of personal income.

The benefits of participation in the LTC Compact would be substantial as compared to circumstances imposed by Medicaid eligibility. Compact beneficiaries would preserve remaining resources after the Compact pledge amount is satisfied. They would endure no additional resource or income limitations and no lien or estate recovery requirements as are imposed on Medicaid recipients. They would have the right to

purchase qualified services from any willing provider at the Compact rate (i.e. the Compact subsidy plus the beneficiary's 10% co-payment). Compact participants could satisfy their required pledge amounts and/or their service co-pays and annual participation fees by means of private insurance policies, if they had the foresight to buy them while they were still insurable. Such policies would likely cost considerably less than coverage of their full lifetime LTC liability in the absence of the Compact program. Individuals who were refused long-term care insurance at least twice could contribute, or have contributed on their behalf, up to \$10,000 per year into a tax-favored "qualified long term care savings account" for purposes of planning ahead to fund their pledge amount. Special conditions and protections would apply for married Compact beneficiaries.

The foregoing description of the LTC Compact proposal is based on provisions in Senate Bill 00116 as "prefiled" January 3, 2007. That bill specifies that operation of the Compact program would be entirely conditional upon approval and receipt of federal financial participation (i.e. Medicaid money) to help fund it. It authorizes a "program management entity" to administer the Compact and specifies that such entity shall not be a state agency. According to the bill, an advisory committee would be appointed consisting of two elder law attorneys, two senior advocates, two LTC providers, and two LTC insurers. It also provides for an education and outreach campaign in support of the Compact. The current bill contains restrictions on asset transfers done within three years of applying for the Compact, except for participants who pledge and satisfy the "maximum" pledge amount. It contains no cap on protected home equity. Therefore, it does not reflect changes made by the Deficit Reduction Act of 2005 regarding asset transfers (e.g. five year look back) and exempted home equity (capped at no more than \$750,000) under Medicaid.

When? The seed of the LTC Compact idea is said to have come from a 1996 report titled "Securing New York's Future." That report contained this recommendation: "Develop a program to assure access to affordable long-term care for the uninsurable to serve as a transition for current elderly while the long-term care insurance market matures." It recommended a "Defined Private Contribution" with "Medicaid financing available after the private contribution has been met." ²⁰

According to Bob Herz, a principal legislative staffer for the LTC Compact legislation, the Compact idea picked up momentum in 2004 when the Pataki administration was considering measures to restrict Medicaid eligibility and prohibit the use of "spousal refusal" to avoid LTC expenditures. Medicaid costs were exploding and something had to be done. Senator Golden, Herz's boss and a key committee chairman, countered an appeal from the elder law bar opposing Medicaid cut backs by asking them to suggest a positive solution that would avoid cutting Medicaid.

By September 2005, the Compact plan was fully designed and being actively promoted. Two of its principal supporters, Vincent Russo and Howard Krooks, reported: "The Compact proposal reflects the continuing painstaking efforts of the Compact Working Group, whose members include Michael Amoruso, Esq., Howard Angione, Esq., Daniel G. Fish, Esq., Gail Holubinka, Howard S. Krooks, Esq., Louis W. Pierro,

Esq., and Vincent J. Russo, Esq."²² Nevertheless, Howard Krooks and his brother Bernard, were surprised to find around this time that the legislative branch had already taken up the gauntlet and translated the Compact proposal into draft legislation.²³

In last year's legislative session, the LTC Compact bill passed the New York Senate and was the subject of a hearing in the Assembly. So far this year, the legislation has been re-introduced in the Senate. The prognosis based on interviews conducted for this study is that the Compact will probably not become law this year, but that interest continues to run high and the plan will definitely continue to receive close consideration. ²⁴ If and when it passes and is signed into law by Governor Spitzer, the Compact act as currently formulated would take effect on the ninetieth day after enactment.

Why? The purpose of the LTC Compact as described in Senate Bill 00116 "shall be to provide coordinated coverage for the expenses of qualified long term care services to eligible individuals, a purpose hereby declared to be in every respect an appropriate public purpose conducted for the benefit of the people of the state of New York."²⁵ That does not tell us very much. A better insight into the reasons for the LTC Compact proposal can be found in the writings of its designers and promoters:

Elder Law Attorneys Vincent Russo and Howard Krooks:

The cornerstone of the Long Term Care Compact is to create a partnership between seniors and people with disabilities and government wherein seniors and people with disabilities will pay a fair share for Long Term Care services with the government's support. The foundation of the program is the belief that public policy concerning social programs should be a contract between seniors and people with disabilities and the government. Under the contract, the senior or the person with a disability pledges to contribute his/her fair share of the cost burden of Long Term Care services in exchange for retaining a protected amount of personal assets while receiving government assistance. ²⁶

Recommendation by the New York State Bar Association submitted to, but not reviewed or approved by, the American Bar Association House of Delegates:

The Compact serves as an alternative to the Medicaid system of forced impoverishment as a pre-condition to qualifying for government assistance to pay for long-term care.²⁷

Assemblyman Steven Englebright, Chair, Committee on Aging at the Assembly hearing on the LTC Compact proposal:

I would like to read a quote that I believe is very relevant to why we're here today. 'No agency of the government has any right to complain about the fact that middle-class people, confronted with desperate circumstances,

choose voluntarily to inflict poverty upon themselves when the government itself, which has established the rule that poverty is a prerequisite to the receipts of government assistance and the defraying of the cost of ruinously expensive but absolutely essential medical treatment.' That is a quote from the New York State Court of Appeals in the year 2000. . . . It is important to explore different approaches to finance long-term care that will enable individuals and families to access and receive the quality care they deserve, remain as independent as possible for as long as possible and in control of their care and to not be forced to impoverish themselves in order to receive care and not be incentivized to transfer their assets in order to receive care.²⁸

Gail Holubinka for the MedAmerica Insurance Company:

Incentives under the Compact are similar to those under the [New York] partnerships. That is, in exchange for asset protection, the participant agrees to cover a set amount of their LTC expenses. The differences between the original NYPLTC [New York Partnership for Long-Term Care] and the Compact are that

a) the Compact includes the less wealthy and less healthy. These two groups constitute not only the majority of the population but most of the divesters as well. Lacking access to insurance, the less healthy face a choice between impoverishment and divestiture. The Compact offers a third option and an incentive so the outcome is likely to be far more advantageous to the state.

"The less wealthy face the same choices. Again the state gains, but so does the LTCi [long-term care insurance] industry. Lifetime comprehensive coverage based on 1/2 one's personal assets means less benefits and much lower premiums. The market for LTCi immediately expands from 10% of the population to 50% or more.

- b) the Compact allows participants to keep more income. A drawback of standard PLTCs [LTC partnership policies] is that participants must adhere to Medicaid income rules. In New York, a very generous state, that means the participant in home care is allowed only \$692/mo if single or \$900/mo if married. These limits lead many to avoid the partnership.
- c) the Compact amplifies personal responsibility. In addition to the up front Pledge, Compact participants are expected to cover a 10% copayment on their subsidized LTC services and pay for all their other health needs on their own. Unlike the PLTCs, Compact coverage is for only LTC. Paying for other Medicaid covered services such a physician care, Medicare co-payments and deductibles, and drugs [are] up to the participant.

d) the Compact saves state dollars. Legislative scoring done by Milliman, Inc. indicates that the Compact shows savings potential for one year's entry population of up to \$500M [\$500 million]. It's easy to understand why legislators from both parties and both houses find the idea intriguing.²⁹

(It should be noted that MedAmerica has since adopted a neutral stance toward the LTC Compact and no longer actively supports the proposal.)

Who Favors the LTC Compact and Why?

Elder lawyers say: The Compact would . . . be more equitable and rational because it discourages divestment and "forced impoverishment" . . . amplify personal responsibility for LTC costs . . . lack institutional bias and encourage HCBS . . . benefit workers and the middle class . . . define and reduce LTC risk . . . attract new LTC financing sources . . . encourage LTC insurance by making it less expensive, fairer, and more like Medicare supplemental (Medi-Gap) insurance . . . reduce Medicaid costs up to \$500 million per year . . . avoid LTC financial disaster for New York and the U.S . . . reverse eligibility restrictions in the DRA . . . have bipartisan appeal: "The concept of privatization and decreased government spending should appeal to Republicans. The extension of government benefits the proposal will spawn should appeal to Democrats." 30

LTC providers say: The Compact might . . . reduce dependency on low Medicaid reimbursements by encouraging private financing alternatives such as private insurance, reverse mortgages and the LTC Savings Account . . . increase reimbursements 10% over the Medicaid rate for services provided to subsidy beneficiaries . . . encourage more HCBS . . . reverse some problematical eligibility restrictions in the DRA. Bottom line, LTC providers favor the Compact to the extent it would help reduce their revenue shortfalls from Medicaid.

Legislators say: The Compact should . . . reduce catastrophic spend down . . . build on the LTC partnership program by helping people who don't qualify or can't afford LTC insurance . . . protect participants' income whereas the partnership doesn't . . . supplement other state efforts to encourage LTC planning such as the 20% LTC insurance tax credit and LTC education campaign which have had only minimal success so far . . . encourage LTC insurance innovation by inviting new front-end and back-end products.

LTC Insurer says: The Compact would . . . reduce impoverishment . . . avoid frantic asset giveaways . . . encourage LTC sales by defining risk and making the product more affordable . . . reach the less wealthy people with insurance and less healthy people with protection . . . privatize more LTC expenses which are currently 80% Medicaid . . . build on LTC partnership base . . . avoid estate recovery . . . let participants keep more income than Medicaid allows . . . increase personal responsibility because of the initial pledge, 25% income participation fee, and 10% co-pay . . . change Medicaid from a 'first resort' for LTC to a true 'safety net' . . . save the state money without harming the truly needy.

(A single LTC insurer, MedAmerica, originally favored the Compact but is now officially neutral.)

Who Opposes the LTC Compact and Why?

LTC insurers say: The Compact would . . . reduce the public's sense of urgency and responsibility about long-term care because people will be able to wait until they need LTC, save half their estate, and get a better deal than Medicaid . . . hurt the LTC insurance market including the LTC partnerships which are a superior way to preserve Medicaid for the needy . . . lack portability unlike LTC insurance . . . institutionalize the "half-a-loaf" strategy outlawed by the Deficit Reduction Act . . . reverse other progress made in the DRA (asset transfer and home equity changes) toward encouraging early planning for LTC . . . replace "Medicaid planning" with "Compact planning" gimmicks to the benefit of elder lawyers . . . increase government costs by shifting the expensive "back end" of long-term care expenditures, i.e. long institutional stays, to Medicaid . . . use public funds to pay for the LTC of rich people who meet the relatively small "maximum pledge" . . . create a huge bureaucracy to determine the value of a participant's assets, track patients and their LTC expenditures, administer funds and fight fraud . . . never be granted a federal waiver to allow the use of federal matching funds for non-Medicaid services. (At last year's Assembly hearing on the LTC Compact, a witness from AARP encapsulated the insurance industry's objection to the Compact by saying: "And I'm not buying long-term care insurance until the Compact is ready, so get going guvs.")³¹

LTC Providers say: The Compact . . . is hard to understand and explain . . . is unclear about how rates will be set for non-Medicaid services, how the transition from pledge period to subsidy will be managed and who will collect the 10% co-pay . . . raises questions about the use of unlicensed providers and staffing agencies giving publicly funded care free of the rules that govern licensed providers . . . lacks a mechanism to determine the appropriateness of the care plan or the services that are provided . . . includes no time frame related to the payment for services . . . does not clearly address instances where the participant reaches a subsidy limit or for some reason is unable or unwilling to make required payments during the subsidy period . . . ignores evidence of asset shelters and divestment, when the impact of Medicaid planning should be thoroughly studied before other action is taken . . . creates a large workload for stakeholders to evaluate a program that depends on a federal waiver unlikely to be granted . . . has a nine-member panel with only two provider representatives.

NY Department of Health says: The Compact . . . discourages early LTC planning by inviting people to postpone decisions . . . does not impose asset transfer penalties in the same way as Medicaid . . . puts "half-a-loaf" back in play . . . could create a "woodwork" effect attracting people, including non-New Yorkers, to rely on public financing who otherwise would not . . . has no limit on purchasing unduly expensive services to spend down the pledge amount . . . protects all assets including possible future windfalls with only a little insurance . . . would create a two-tier LTC program: the Compact for rich New Yorkers, Medicaid for the poor . . . implementation and operation

would be susceptible to administrative complications . . . raises the issue of whether or not private LTC insurers will evolve the new kinds of products to coordinate with Compact requirements and benefits . . . shields private insurers from their biggest liabilities and from criticism that they are not designing policies to protect lower income people . . . requires a non-state entity to administer.

Legislators say: The Compact . . . would encourage denial of risk and Medicaid-style planning by reducing spend-down liability to half instead of all assets . . . discourage private LTC insurance . . . leave LTC providers vulnerable for collection of fees . . . attract new dependents from the woodwork . . . create a new bureaucracy . . . put the asset floor to low for people to live . . . leave incentives to hide or divest assets in place.

Senior advocates say: The Compact . . . is too complex and hard to understand . . . discourages advance planning for LTC . . . invites fraud and abuse . . . privatizes LTC, thus contradicting the state's commitment to provide care . . . discourages free caregiving by creating an incentive to spend down the pledge amount . . . is fraught with many potential problems and does not ensure that all consumers are protected and guaranteed equal access to care. ³²

An elder law attorney who asked to remain anonymous says: The Compact would. . . subsidize people with wealth at the expense of people with little or nothing . . . make large property owners relatively riskless compared to property nonowners . . . "leave me paying the bills for rich home owners when I rent an apartment." This lawyer points out that the National Academy of Elder Law Attorneys has not endorsed the New York LTC Compact. He says that NAELA's leadership does not believe the Compact would be a good model for the rest of the country.

The LTC Compact: Savings or Cost?

Leaving aside for now the arguments in favor or against the LTC Compact, would this new approach to long-term care save money or cost more and how much? Advocates for the LTC Compact retained Milliman, the international actuarial and consulting firm, to "score" the proposal, i.e. estimate its cost or savings compared to the existing Medicaid-based system. Milliman provided its score for the LTC Compact in a letter report dated March 24, 2006, 33 which explained:

Assumptions regarding the frequency and continuance of the use of long term care services . . . were provided by Milliman and are based on LTC insurance industry data. Assumptions regarding the distribution of New York residents by age, income, and assets, regarding the monthly cost of LTC in New York, and regarding the number of months of private vs. public pay under various Medicaid scenarios were provided by the NY Compact sponsors.

Some of the assumptions on which the Milliman score was based include the percent of people who are expected to (1) meet the asset requirements for the

program, (2) become disabled in a given year, (3) use home care vs. nursing home care, (4) be on claim within in various time periods, (5) own homes and have income and assets of various values, etc. Two key assumptions are that 75% of people eligible to pledge under the Compact would do so, approximately 25,000 individuals per year, and that "the Medicaid eligibility rules will be significantly tightened in the State, so that 'loopholes' are closed and divestiture is difficult."³⁴

Based on these assumptions, Milliman arrayed the anticipated lifetime costs for an annual cohort of long-term care recipients across five possible Medicaid scenarios and compared these to the expected cost under the Compact. In other words, to find the comparable costs or savings, you pick the Medicaid scenario you consider most likely, consult the array, and find the comparable cost under the LTC Compact versus under the specific Medicaid scenario selected. The Medicaid scenarios range from near total "divestiture" (recipient divests everything after six months of paying for care) to total spend down (recipient spends all personal wealth including home equity) before going on Medicaid.³⁵

Milliman scores the lifetime cost of an annual cohort under the Compact at \$1.6 billion compared to a cost under the Medicaid scenarios ranging from \$412 million to \$2.4 billion. Bottom line, based on the foregoing assumptions and Milliman's analysis, the LTC Compact is estimated to save \$800 million compared to a Medicaid program that allowed recipients to divest all of their assets after paying six months for care. On the other hand, the Compact would cost \$1.2 billion more than a stricter Medicaid program that required all recipients to spend all their wealth, including their home equity, for long-term care before becoming eligible for Medicaid benefits. According to interviewees for this study, most people choose an estimate somewhere between Scenario 4 (25% divest) resulting in savings under the Compact of \$52 million and Scenario 5 (50% divest) resulting in savings of \$562 million. For example, legislative analyst Bob Herz's best guess is that the LTC Compact would save \$175 million to \$225 million in lifetime costs for a new annual cohort of LTC users compared to a continuation of current Medicaid policies.

Analysis

On the positive side . . . the LTC Compact is an imaginative, politically attractive proposal to reform a hopelessly flawed long-term care service delivery and financing system. For example:

Is Medicaid overwhelmed by LTC costs? Then, bring in more private financing by encouraging the public to pay their "fair share."

Is the system biased toward nursing home care? Then, get more people spending their own "pledged" funds so they won't go to nursing homes until they need to medically.

Are people so overwhelmed by the huge risk and cost of long-term care that they're in denial and fail to act? Give them a more manageable risk and cost so they'll respond more rationally.

Do most people fail to buy private long-term care insurance? Then, define the LTC risk, reduce it by half, and make private insurance more affordable.

Does the New York LTC Partnership give people lifetime LTC protection while preserving assets, but most people can't afford and don't buy it? Then, give them a way to preserve substantial wealth for a fraction of the Partnership's premiums.

Does Medicaid "force" people to spend down into poverty or divest their assets? Then, give them a more dignified option to pledge half their assets and they'll respond more responsibly.

Does Medicaid require most income to be contributed toward cost of care? Then, let people who pledge and spend half their assets keep 75% of their income.

Does Medicaid pay for a lot of non-LTC expenses that some recipients could afford to pay on their own? Then, help those people with their biggest expense, long-term care, but let them pay for their other medical expenses not covered by Medicare.

Do LTC providers complain that Medicaid pays them too little? Then bump up the reimbursement level 10% for services provided under the Compact subsidy.

Does Medicaid tie recipients into using only Medicaid-certified providers? Then, free consumers to use "any willing provider" with their pledged funds and Compact subsidy.

Does Medicaid impose liens on real property and recover the cost of their care from deceased recipients' estates? Then, remove that onerous obligation for anyone willing to pledge half their assets up front and pay the Compact's co-insurance and participation fees.

Are most ways to cut Medicaid costs politically unpopular? Then, offer a solution that provides something attractive for everyone at an arguably reduced cost.

But, on the other hand . . . if all this seems too good to be true, here's a plausible reason why. The LTC Compact proposal addresses the symptoms, but not the causes of New York's long-term care service delivery and financing problems. Nowhere in the voluminous documentary materials we reviewed nor in the interviews we conducted for this study was there any explanation of why the LTC system is as dysfunctional as it is or how it came to be that way. There is a huge risk of unintended, negative consequences when policy makers interfere with a marketplace without first understanding why it is the way it is. For example:

In the Assembly hearings on the LTC Compact proposal, Aging Committee Chairman Steven Englebright said:

"Our current long-term care financing structure is primarily private pay and of course, Medicaid, with a small percentage covered by long-term care insurance. Someone in need of long-term care can expect to quickly exhaust their entire life savings and resources, a very scary proposition to that individual and their spouse." ³⁶

Is that true? No. There is zero evidence that large numbers of New Yorkers spend down their life's savings for LTC. Medicaid rules do not require such spending and only a small portion of LTC providers' receipts come from patients' out-of-pocket costs. Most of these minimal out-of-pocket costs come from income, not assets. The average New Yorker over the age of 65 who needs long-term care faces little or no obstacle to Medicaid nursing home eligibility based on income or assets. That's the main reason for Medicaid's institutional bias. For an explanation of Medicaid LTC eligibility rules, see "Aging America's Achilles' Heel: Medicaid Long-Term Care." For a discussion of Medicaid LTC eligibility specific to New York state, see "The Realist's Guide to Medicaid and Long-Term Care." The fact that a relatively small number of affluent New Yorkers divest or shelter assets in excess of Medicaid's already generous eligibility rules--often with the help of professional advisers--only exacerbates the fundamental problem that long-term care is very nearly a free good to which most people feel entitled and for which they qualify easily in New York without spending down significant assets for their own care first.

The LTC Compact proposal is based on a false premise that Medicaid forces people to spend down into impoverishment for long-term care before receiving public benefits. If that were true, the public would not be complacent about the risk and cost of long-term care. Families would pull together, plan early, save, invest and insure for LTC instead of ignoring the problem until a crisis occurs and turning to Medicaid and Medicaid planners. The reason that long-term care service delivery and financing is so problematical in New York is that, more than any other state in the country, New York has transferred the risk and cost of LTC from consumers to the government. That's why the public is in denial, doesn't buy private LTC insurance, ends up on Medicaid, and strains the state budget. Well-intentioned but counterproductive public policy has created a self-fulfilling prophecy that the burden of financing long-term care will fall predominantly on Medicaid.

Can government continue to fund the lion's share of long-term care either through Medicaid or through a program like the LTC Compact?

No. If Medicaid struggles already to carry most of the burden of long-term care financing, it has no hope whatsoever of doing so in the future. The LTC financing problem goes far beyond the widely recognized fact that aging demographics will deliver more and more elderly people into the long-term care system. Two federal programs that support Medicaid LTC today are unlikely to do so in the future. First, generous Medicare

reimbursements to LTC providers currently compensate partially for the financial shortfall from grossly inadequate Medicaid reimbursements. But that won't continue indefinitely, because Medicare has a \$75 trillion unfunded liability that will force the program to cut back. It will be much easier politically for Medicare to reduce reimbursements to LTC providers than to raise payroll taxes or reduce benefits. When that happens, Medicare will no longer pick up the LTC funding slack left by Medicaid.

Likewise, Social Security relieves the fiscal pressure on Medicaid, because all LTC recipients have to contribute most of their income toward their cost of care under Medicaid. Their Social Security income directly reduces Medicaid's expenditures. That's why Medicaid can cover two-thirds of all nursing home residents nationally while paying less than half the total cost. But Social Security's unfunded liability is \$16 trillion. The Social Security Administration warns beneficiaries every year that they will receive only 75% of what they've been promised unless that shortfall is fixed somehow.³⁹ Social Security benefit cutbacks won't directly affect Medicaid LTC recipients whose contribution to cost of care will merely be reduced. But such cutbacks will mainline financial disaster to Medicaid.⁴⁰

To assume that federal financial support from Medicaid, Medicare and Social Security will continue to supplement state funding for long-term care in the future at levels comparable to those in the past is perilously unrealistic. Even if the Centers for Medicare and Medicaid Services were to approve a waiver allowing federal money to flow into the LTC Compact to fund its subsidies, which is highly unlikely, such approval would come with no guarantee and little likelihood of continuation indefinitely. At some point, the state would end up on the horns of a dilemma: fund the LTC Compact without federal support or renege.

Is it wise to shift more of the enormous back-end cost of long-term care onto government as the LTC Compact does?

No. Leave aside the question of whether or not it is appropriate for tax payers to fund the remaining long-term care costs for wealthy people who pay the first three years of their care. For reasons just explained, government is not equipped to meet the high cost of long-term care in the future. But, that's exactly what private insurance IS designed to do. The purpose of insurance is to replace the small risk of a catastrophic loss with the certainty of an affordable premium. By changing the role of private insurance to cover comparatively small front-end risks and Medi-Gap-like co-pays and fees, the LTC Compact would prevent private insurance from ever helping with the larger back-end costs of catastrophic long-term care that will sink the publicly financed programs in the future.

Critical to solving the LTC financing problem is to recognize that easy access to Medicaid has crowded out any significant role for private long-term care insurance. As Brown and Finkelstein concluded in a paper for the National Bureau of Economic Research:

We . . . estimate that Medicaid can explain the lack of private [LTC] insurance purchases for at least two-thirds and as much as 90 percent of the wealth distribution . . . Medicaid's large crowd out effect stems from the very large implicit tax (on the order of 60 to 75 percent for a median wealth individual) that Medicaid imposes on the benefits paid from private insurance policies. ⁴¹

Why then do most studies find that people fail to buy insurance for long-term care because of denial of the risk and cost? Because no study has ever asked the more important question: "If long-term care is such a huge risk and expense, how can people be in denial about it and why are they unwilling to pay a fair premium to protect against it?" The answer is that since 1965, Medicaid has made it possible to ignore the risk of long-term care, avoid the premiums for private insurance, wait to see if expensive LTC services are ever needed, and if so, shift the cost to government. That's the real reason most people don't plan or insure for long-term care. It's not that they're planning to go on Medicaid, but rather that they don't think about long-term care until it's too late for insurance. Medicaid's generous and elastic LTC eligibility rules, as stretched by Medicaid planning specialists, enable consumers' denial which would otherwise be irrational and self-destructive.

Would the LTC Compact help providers improve their financial viability by increasing reimbursement rates above Medicaid's penurious levels?

Not really and not for long. For reasons already explained, financial pressures on Medicaid will continue to grow. Historically, the easiest way for policy makers to constrict Medicaid expenditures during serious economic downturns--when welfare rolls increase and tax receipts decline substantially--has been to cut provider reimbursements. There is no reason to think that anything different will happen when future recessions occur. So, even if the LTC Compact brings LTC providers a few more patients paying the Medicaid rate plus 10%, providers will still be locked into the Medicaid base rate which is unlikely ever to keep pace with their costs or inflation. The only way to ensure that a larger proportion of LTC patients will pay an economically sustainable rate for services is to increase the number of private payers, reduce dependency on Medicaid-based rates, and let the market determine prices. An added benefit of this approach is that when people are spending their own money (or their insurance benefits) for long-term care, they will seek the lowest cost, least institutional, and best value thus enhancing HCBS and reducing institutional bias in the LTC system.

Conclusions and Recommendations

The New York LTC Compact proposal is a highly creative and politically seductive approach to long-term care financing reform. Unfortunately, it is based on false premises and would aggravate rather than ameliorate New York's LTC service delivery and financing challenges.

Before continuing with consideration of the LTC Compact proposal, responsible officials in New York should undertake to learn precisely why most citizens in the state ignore the risk of long-term care until the only financing alternative available to them is Medicaid.

Find out how many people dependent on Medicaid for long-term care today could have and would have prepared to pay for their own long-term care privately if Medicaid had not been available for the past forty years to pick up most of the cost after the insurable event has occurred.

Begin by performing this thought experiment: if no public funding were available for long-term care, if people had to spend all their income and savings for LTC, and then depend on private charity when their money ran out, would they still ignore the risk and cost? Would they fail to save, invest or insure?

The Milliman "score" for a Medicaid scenario requiring a full spend down of all assets including home equity was only \$412 million compared to a lifetime cost for an annual LTC cohort under the LTC Compact of \$1.6 billion. That's solid evidence that Medicaid could save huge amounts of money by returning to its original intent, that is, to be a high-quality long-term care safety net for otherwise truly destitute people.

No one wants to cut Medicaid back that far and it would be politically infeasible to do so. Now. But in the future, as the fiscal vise of declining revenues and increasing expenditures closes on Medicaid, Medicare and Social Security, it will become economically infeasible not to cut back dramatically on all public benefits programs.

Thus, the challenge for public officials is to find a middle way by which to remove Medicaid as a disincentive to responsible long-term care planning without hurting innocent citizens who, heretofore, have had every reason to believe--based on decades of experience--that government would cover their long-term care risk and cost. One analytical model described in detail in "The Realist's Guide to Medicaid and Long-Term Care" suggests that any state with very easy Medicaid LTC eligibility rules, generous and attractive Medicaid-financed HCBS, and little estate recovery should expect its Medicaid nursing home census to be very high, home equity conversion for financing LTC to be very low and long-term care insurance market penetration to be minimal. All three independent and dependent variables apply in New York as the cited report explains.

So, before experimenting with the LTC Compact approach, New York should conduct a thorough study of a valid random sample of Medicaid long-term care cases. Subject them to the kind of thorough review eligibility workers rarely have time to conduct. For example, check with county assessors for property ownership, with county recorders for transfers, with banks and other financial institutions for unreported assets; interview recipients and their families about the eligibility process, e.g. did they consult an attorney?, could they have paid privately for long-term care and for how long? Then,

project the findings to the current caseload and use the result to estimate the likely future Medicaid LTC liability.

Find out why New York's estate recoveries are so much lower than other states', .2% of LTC expenditures compared to a national average of .61%. How could New York increase this amount and thereby encourage more people to plan early for long-term care expenses?

Finally, and most importantly, ask the question: what was the financial condition of current Medicaid recipients 10 or 12 years ago when they could have, should have and might have saved or insured for LTC if it were not for the perverse incentives in the Medicaid system that discourage early planning and insurance?

Until New York knows the answers to these questions, experimenting with a new way to extend ever more public benefits to ever more affluent people is to tempt fate and invite future financial disaster.

Instead of requesting a federal waiver to expand publicly financed long-term care, the state should consider requesting a waiver that would re-target Medicaid to people truly in need. Then use the savings to incentivize responsible LTC planning through private insurance and reverse mortgages. In the long run, that's a much kinder and more responsible approach than making promises about long-term care that cannot be kept.

Postscript: The Kansas Connection

What does Kansas have to do with the New York Long-Term Care Compact proposal?

The Center for Long-Term Care Reform has done a good deal of work on long-term care financing policy in Kansas with the Flint Hills Center for Public Policy, located in Wichita (www.flinthills.org.) Together, we've presented state legislative testimony on several occasions, addressed community forums around the state and published a report titled "Plain(s) Talk on Medicaid Long Term Care in Kansas: A Case Study of Medicaid and LTC Financing in Kansas"

(http://www.centerltc.com/pubs/plains_talk_on_medicaid_ltc_in_kansas.pdf).

Besides its work with the Center for Long-Term Care Reform, Flint Hills has conducted many other studies and published numerous reports on all aspects of the Medicaid program in Kansas. Examples include its "Medicaid Handbook," numerous policy papers, editorials, and testimonies, all viewable at www.flinthills.org.

So, when it became evident that the LTC Compact program in New York could impact the cost and effectiveness of Medicaid in Kansas, we decided to pursue and examine the connection. This is the story.

One very interesting factor about Medicaid is that the program is funded partly with state money and partly with federal funds. States pay what they are able and choose to pay for Medicaid. The federal government matches that amount based on the state's FMAP or Federal Medical Assistance Percentage.

FMAPs vary inversely with the economic prosperity of each state. The original idea was to help poorer states afford comparable programs to wealthier states by giving them an advantage in their access to federal funding. Thus, FMAPs range widely from a minimum of 50% in New York and several other very prosperous states to more than 75% in Mississippi.

Put simply, a rich state like New York gets one dollar from the federal government for every dollar it commits to fund Medicaid. A poor state like Mississippi gets approximately three dollars for every dollar it puts into Medicaid. To bring the discussion back to Kansas, that state's FMAP is roughly 60%, which means Kansas receives about \$1.50 from the federal government for every dollar it invests in Medicaid.

One would expect, therefore, that relatively poor states would receive proportionately more money from the federal coffers for their Medicaid programs than relatively wealthy states. But that is not the case. Some fascinating research by the American Enterprise Institute's Robert B. Helms shows that exactly the opposite holds true. Following are excerpts from Helms' paper (footnotes omitted). The paper includes sources and references for the underlying data.

Poorer states today are falling behind as wealthier states are collecting a disproportionate share of federal Medicaid dollars. (p. 1)

[D]ata for all states reveal that there is a negative relationship between the per-capita amount of federal funds flowing to the states and the amount of poverty in the states-that is, as a general tendency, the poorer the state, the less federal money that state receives. (p. 2)

Not only can the wealthier states afford to spend more on Medicaid, the open-ended process of obligating the federal government to match what the state chooses to spend creates an incentive for states to increase Medicaid spending relative to all other priorities. (p. 3)

Clearly, the FMAP procedure is not successfully achieving the original objective of Medicaid: targeting federal assistance toward the states with the greatest share of poverty. Poorer states today are falling behind as wealthier states are collecting a disproportionate share of federal Medicaid dollars. (p. 4)

Numerous analysts have pointed out that we have created a situation in which each governor and state Congressional delegation has a strong incentive to increase federal funding under the FMAP procedures rather

than consider reforms that would be in the best interest of those Medicaid is intended to serve. (p. 4)

Meanwhile, Congress tries to control costs by passing new controls on payment rates to providers and suppliers. This dissonance between state incentives to expand eligibility and federal attempts to control expenditures can only be expected to intensify in future years as the population ages and the cost of caring for the disabled puts more pressure on federal and state budgets. As in any system that relies primarily on price controls and government rationing, Medicaid beneficiaries will have access to fewer providers and will experience decreases in the quality of care. (p. 5)

With limited resources, how does the government target resources to the neediest? The present Medicaid program seems designed to do just the opposite, shifting resources toward citizens who live in wealthier states. (p. 5)

During the research for our New York LTC Compact project, we asked Dr. Helms to compare how the FMAP system affects Kansas and New York. He replied that "NY gets over twice as much per poor person . . . as does the state of Kansas. . . . This is the result even though Kansas has a higher FMAP (61% in 2005) than does NY (50%)." He went on to explain: "This illustrates once again that it is not the FMAP that is pumping more and more of the federal Medicaid dollars toward the Northeast, but the open-ended payment policy that allows the wealthier states to keep expanding their programs relative to what the poorer states can do."

Hopefully by now "The Kansas Connection" is clear. Federal taxpayers in Kansas have no choice but to subsidize New York state's extremely generous Medicaid program, but poor Kansans get less than half the return per capita from federal Medicaid funds than do their counterparts in the Empire State.

What's more, because of New York's relatively easy Medicaid LTC eligibility rules, generous "spousal refusal" policy, truly munificent benefits including home and community-based care without asset transfer penalties, and ineffective estate recovery efforts, Kansans are compelled to pay the benefits of people in New York who would be far too affluent to qualify for Medicaid in the Sunflower state or would at least have to repay the cost of their care from their estates.

That's the reality today. But what if the New York Long-Term Care Compact became operational? Then, any New Yorkers who pledged and spent half their non-housing assets for LTC could subsequently draw with no total limit whatsoever on the FMAP provided by federal taxpayers around the country . . . including Kansans. The perverse incentive that already exists, encouraging rich

states to throw more and more money toward Medicaid at the expense of poorer states which lack the economic wherewithal to compete, would be increased immeasurably.

The Helms paper contains recommendations to fix these problems, but they've persisted since Medicaid's inception in 1965. One doubts change is coming soon. Suffice it here to say that as long as the FMAP system works the way it does now, the New York Long-Term Care Compact program would exacerbate the already egregious inequity. More money would flow away from poor people in economically challenged states to more affluent people in economically prosperous states.

List of Interviewees

Leonard Berns, Senior LTC Consultant, Associates of Clifton Park, NY

Larry Feldman, Principal, CFK LIFE Plans Inc., Latham, NY

Allan S. Filler, Executive Director, Council on Health Care Financing, New York State Senate, Albany, NY

Kim Fine, Deputy Director, New York State Division of the Budget, Albany, NY

Paul Francis, Director of the Budget and Senior Advisor to the Governor, New York State Division of the Budget, Albany, NY

Phillip Gallant, Executive Vice President, New York Long-term Care Brokers, Ltd., Clifton Park, NY

Dawn Helwig, Consulting Actuary, Milliman, Inc., Chicago, IL

Bob Hennigan, Assistant Chief Budget Examiner, New York State Division of the Budget, Albany, NY

Richard Herrick, President and CEO, New York State Health Facilities Association, Albany, NY

Robert Herz, Legislative Director/Committee Director, Senator Martin J. Golden, New York State Senate, Albany, NY

Gail Holubinka, Vice President, Business Development, MedAmerica Insurance Company, Rochester, NY

Kevin J. Johnson, President, New York Long-Term Care Brokers, Ltd., Clifton Park, NY

Mark L. Kissinger, Deputy Commissioner for Long-Term Care, State of New York, Department of Health, Albany, NY

Bernard A. Krooks, Founding Partner of Littman Krooks, President of NY Chapter of NAELA, New York, NY

Howard S. Krooks, Elder Law Associates, PA, Boca Raton, FL

Mark Meiners, Professor and Director Center for Health Policy, Research & Ethics, George Mason University, Fairfax, VA

Robert Murphy, Executive Vice President for Government Affairs, New York State Health Facilities Association, Albany, NY

Dennis Norton, Chief Budget Examiner, New York State Division of the Budget, Albany, NY

Lou Pierro, Founder and Principal, Pierro and Associates, Albany, NY

Arthur Rudnick, The Rudnick Agency, White Plains, NY

Adrianna Takada, Director of the Partnership for Long-Term Care, State of New York, Department of Health, Albany, NY

Morris Tenenbaum, Chief Executive Officer, Kings Harbor Multicare Center, Bronx, NY

William H. "Bill" Thomas, MD, Distinguished Fellow at the University of Maryland's Erickson School, Sherburne, NY

Bob Vandy, Director of Business Development, New York Long-Term Care Brokers, Ltd., Clifton Park, NY

Gaurav Vasisht, Assistant Counsel to the Governor [for insurance], Executive Chamber, State Capitol, Albany, NY

Carla Williams, Deputy Director, Office of Long-Term Care, State of New York, Department of Health, Albany, NY

Kevin S. Wrege, Esq., President, PULSE Issues & Advocacy LLC, Washington, DC

Carl Young, President and CEO, New York Association of Homes and Services for the Aging, Albany, NY

Appendix A: Comments on the report from the New York State Bar Association Elder Law Section Compact Working Group with author's replies

[Received by S. Moses on July 24, 2007. The sections titled "Postscript: The Kansas Connection" and "Appendix C" were added to this report after draft reviewed below so are not reflected in the Elder Law Section's comments.]

Stephen Moses, President The Center for Long Term Car Reform, Inc. 2212 Queen Anne Avenue North - #110 Seattle, WA 98109

[Steve Moses's replies follow in red and/or underline:]

Re: Compact for Long Term Care

Dear Mr. Moses:

I am writing on behalf of the New York State Bar Association Elder Law Section Compact Working Group. We have reviewed the draft of your report on the New York State Compact for Long Term Care and wish to provide you with additional information regarding how the Compact idea was conceived and developed. When the New York State Bar Association Elder Law Section met with legislators to discuss public policy issues affecting seniors and people with disabilities, it became clear to the leadership of the Section that legislators were grappling with many of the issues that our clients confronted on a daily basis – how to pay for long term care. Upon learning of the Compact, the legislature charged the Elder Law Section to further develop this alternative approach to long term care financing since the existing proposals were not viable.

While long term care insurance remains a viable option, it still requires medical underwriting, excluding those with pre-existing conditions, and is prohibitively expensive, even by insurance industry guidelines, for many others. The question, and the challenge we all face, is whether we are going to simply maintain the status quo and continue to "fix" a Medicaid system that is broken, or adopt a new way of thinking about how to finance long term care. The Compact is the New York State Bar Association Elder Law Section's proposal that represents an entirely new way of thinking about long term care.

We offer the following comments on the report and trust that you will take these comments into account in preparing your final report:

[Moses: On May 31, 2007, I provided a draft copy of our LTC Compact report to all who participated in the study. I requested comments and explained the final report would be published in "late July." I will answer these comments here and include them in the final report.]

1. The report begins with the statement that New York has one of the lowest long term care insurance penetration rates in the nation. This is not true. Studies from the Long Term Care Strategy Group and LifePlans, Inc show that New York is among the 18 states that exceed the national average of 5.9% with a penetration rate of 8%. [Moses: My source, a publication of America's Health Insurance Plans (AHIP), is cited in the report at Endnote #12. It shows New York's LTCi market penetration rate among people 50 plus years of age to be between 1% and 5%, the lowest of four categories cited. Your source may use different definitions, but in any case an 8% market penetration is extremely low.]

2. The report states that:

There is no hard evidence that New Yorkers use home equity, through reverse mortgages or otherwise, to fund long-term care. Besides, New York Medicaid exempts up to \$750,000 worth of home equity for any Medicaid recipient who expresses an intent to return to the home. Page 4.

Working Group Comment – This implies that New Yorkers do not use the equity value of their homes to pay for long term care costs. This statement is misleading because many individuals on Medicaid lose the value of their homes due to Medicaid's estate recovery rights against the home once the individual dies. Furthermore, individuals requiring long term care services in their home often use the equity in their home to pay for these costs through reverse mortgages or lines of credit. Even individuals who are on Medicaid require the equity in their homes to cover monthly expenses since Medicaid only allows the individual to keep income of about \$700 per month.

[Moses: NY is a "medically needy" state. Medical expenses including the cost of nursing home care are deducted from income before the income standard you cite is applied. Thus people can have many thousands of dollars of income and qualify for Medicaid. They need a "cash flow" problem to qualify, but not low income.

If you have hard evidence that New Yorkers use reverse mortgages in significant numbers to fund LTC, you should provide it. Otherwise, I stand by the report's conclusion that there is none.

As to recovery of home equity from recipients' estates, New York's rate of estate recovery is less than one-third the national average according to an AARP study at

http://www.aarp.org/research/assistance/medicaid/2007 07 medicaid.html.

Medicaid planners frequently advertise their services and to help clients avoid estate recovery.]

3. The report states that:

The legislators told the interest groups--who were constantly importuning them for more long-term care funding and fewer constraints on Medicaid-funded care--to recognize the seriousness of the LTC financing problem, stop complaining and propose something positive for a change. Page 5.

<u>Working Group Comment</u> – the Elder Law Section was never advised by the legislators to "stop complaining". Rather, we determined on our own that we wished to become more proactive in the legislative and public policy arena pertaining to long term care issues. The result of that effort was the Compact proposal. We continue to work with legislators to find alternative ways to finance long term care costs in New York.

[Moses: The report reflects what I was told by a legislative interviewee. I'll include your denial parenthetically in the report.]

4. The report states that:

The lawyers, frustrated first by former-Governor Pataki's efforts to constrain Medicaid LTC eligibility and later by the Deficit Reduction Act of 2005, which federally mandated the same kinds of controls (e.g. longer and stronger asset transfer penalties, a home equity exemption cap, etc.), saw the futility of fighting change and took up the challenge. Page 5.

Working Group Comment – we reiterate that it was our own desire to become involved in the legislative process to formulate alternative solutions to financing long term care costs in New York. Furthermore, our efforts were begun in the middle of 2004, long before the DRA was passed. Therefore, this statement is misleading in that it implies that the reason we decided to make a proposal such as the Compact was that we "saw the futility of fighting change."

[Moses: The report reflects my understanding of the circumstances as communicated by interviewees.]

5. The report states that:

Senator Golden, Herz's boss and a key committee chairman, countered an appeal from the elder law bar opposing Medicaid cut backs by asking them to suggest a positive solution that would avoid cutting Medicaid. Pages 6-7.

Working Group Comment – this statement is inaccurate. The NYSBA Elder Law Section decided on its own to create an innovative solution to long term care financing. In January 2005, the Section wrote and adopted a Long Term Care Report (in collaboration with Gail Holubinka) which included the Compact Proposal as a chapter within that report (Chapter 6). The Section was not initially requested by Bob Herz or anyone else to make a proposal or to stop complaining, nor was this endeavor prompted by frustration. The idea for the proposal came out of the Section's own desire to become part of the solution and not because we were prompted by a third party or out of any sense of frustration. Your report already supports this conclusion where it states that "[n]evertheless, ... [the elder law attorneys], were surprised to find around this time that the legislative branch had already taken up the gauntlet and translated the Compact proposal into draft legislation." The reason we were surprised to learn of the legislation is that we were not at that point responding to anything anyone had said to us; rather, we were acting on our own initiative to become part of the solution. Once it was discovered that the legislature had an interest in creating legislation based on the Compact, we began to work with the legislature in doing so. This work is reflected in revised Compact legislation that has been submitted to the New York legislature since March 2005.

[Moses: Again, the report reflects my understanding based on interviews with key players.]

6. The report states that "Elder Lawyers Say:" (page 9). This should read "Elder Law Attorneys Say."

[Moses: "Elder lawyers" is a term of art used by many as a synonym for "Elder Law Attorneys."]

7. Who Opposes (Supports) the LTC Compact and Why? The titles of these sections would seem to indicate that specific individuals have specific reasons for supporting or not supporting the Compact. However, the sections provide a variety of unattributed statements that are sometimes unrelated to the Compact's viability and often contain misstatements and inaccuracies. There is value in noting public opinion, but not in this case. The stated purpose of the report was to provide facts, insight, and the information needed to evaluate. Given this criteria, we believe readers should be able to expect attributed input by individuals with expertise and program knowledge. As

such, their statements would represent genuine differences of informed opinion rather than offhand comments without merit or applicability that serve to confuse, not clarify, the issues.

[Moses: The intent of the report was to convey a fair sampling of the comments pros and con about the LTC Compact grouped by stakeholder or interest group. All interviewees are listed at the end of the report.]

Some examples of statements that invite misunderstanding are:

a) An anonymous provider is quoted as saying a federal waiver is unlikely to be granted (page 11). Who made this statement? What is it based upon? And, since the legislation already states the program will not proceed without a waiver, how does this unsubstantiated comment address the merits or viability of the Compact proposal?

[Moses: I granted anonymity to respondents who requested it. Otherwise comments would have been inhibited. Readers can use their own judgment whether the comments are credible. The purpose of this report was to get all the arguments on the table grouped by general source and type. The point about the federal waiver is relevant because many people and organizations are being asked to invest large amounts of time and resources in evaluating the LTC Compact and forming official positions when this commenter believes it has no chance to gain federal approval regardless of its merits.]

b) Elsewhere in the report (page 11) it states that "[t]his lawyer points out that the National Academy of Elder Law Attorneys has not endorsed the New York LTC Compact. He says that NAELA's leadership does not believe the Compact would be a good model for the rest of the country." The unidentified lawyer is wrong. In fact, the Board of Directors recently adopted a public policy resolution at a meeting held on June 29, 2007 formally approving programs, such as the Compact, that seek alternative means of financing long term care. That resolution was supported by the Board of Directors, including members of the Executive Committee of NAELA, all of whom comprise current NAELA leadership.

[Moses: The cited individual expressly requested to remain anonymous. He or she is entitled to his or her opinion. I tried to cite proponents from the Compact from among groups that generally oppose it. In this case, I was trying for balance to cite an opponent of the Compact from a group that would generally favor it.]

c) Yet another example appears under the heading "NY Department of Health Says:" (page 11). Again the report quotes an unnamed source who "raises the issue of whether or not private LTC insurers will evolve the new kinds of products to coordinate with Compact requirements and benefits". Such a statement would seem to imply familiarity with long term care insurance and the long term care industry. However, the next statement is that the insurance industry is supporting the Compact because they want to avoid the risk of selling large policies and don't want to sell lower priced policies. First, the insurance industry isn't supporting the Compact and the second part of statement, if true, would mean long term care insurers want to put themselves out of business.

[Moses: The comment was cited accurately. In fact a representative of the insurance industry was intimately involved in design of the Compact and in the earlier stages, an important LTC insurance company supported the Compact.]

Aside from the fact they have nothing to do with the Compact as a public financing program, the comments make it clear that the speaker's grasp of the subject may make their comments less than useful.

In closing, we wish to express our gratitude for your undertaking the time to create this report. However, we are disappointed that the value of the study is undermined due to the substitution of unattributed and unsubstantiated opinions for empirical data.

[Moses: Readers can form their own opinions. I'll include your comments and my replies in the final report. It is worth noting that your comments do not take issue with the report's conclusions or recommendations.]

Please feel free to contact me if you would like to discuss any of these points in greater detail prior to publishing your report.

Sincerely,

NEW YORK STATE BAR ASSOCIATION ELDER LAW SECTION COMPACT WORKING GROUP

Howard S. Krooks, Co-Chair

Compact Working Group Members

Howard S. Krooks, Co-Chair Vincent J. Russo, Co-Chair Michael J. Amoruso Howard Angione Marc Leavitt Ellen Makofsky Louis W. Pierro

Appendix B: Excerpts from an article on Post-DRA Medicaid planning

The following excerpts from an article, co-authored by a signatory of the preceding letter and a Compact project interviewee, provide insights into the methods and rationale of "Medicaid planning," a practice referenced in the report:

Excerpts are from: Louis W. Pierro, Jane-Marie Schaeffer and Ryan Coutlee, "The DRA One Year Later-Pitfalls and Opportunities--Under the New Regime," *NYSBA Elder Law Attorney*, Summer 2007, Vol. 17, No. 3,

http://www.nysba.org/template.cfm?Section=Home&Template=/ContentManagement/ContentDisplay.cfm&ContentID=92330, footnotes omitted:

"On August 1, 2006, the Medicaid eligibility changes mandated by the Deficit Reduction Act of 20051 ('DRA') went into effect in New York State. . . . A number of strategies that existed pre-DRA have gained new significance, including caregiver agreements, exempt transfers and use of the irrevocable income only trust. Other strategies that have been developed to ameliorate the harsh results brought about by changes in the implementation date of the asset-transfer penalty, while conforming to the new rules, involve the use of annuities, promissory notes and grantor retained annuity trusts. . . .

"This article will examine the old and new tools available to clients to navigate the rough seas of Medicaid eligibility.

"Exempt Transfers

"One thing the DRA did not change was the use of exceptions built into the law to allow exempt transfers. Specifically, the following transfers of the home are still considered exempt transfers: transfer of the home to the applicant's spouse; to a child under the age of 21 or a child who is certified blind or disabled; to a sibling with an equity interest in the home who resided there for one year prior to the date the applicant became institutionalized; and to a 'caretaker child.' The following transfers of assets other than the home are still exempt: transfers to the spouse; to the individual's child who is certified blind or disabled, or to a trust for such a child; and to a trust established solely for the benefit of an individual under age 65 who is disabled. . . .

"Caregiver Agreements

"Caregiver agreements continue to be a viable Medicaid planning tool not impacted by the implementation of the DRA. The payments made to caregivers under these contracts are not considered uncompensated transfers that would result in a transfer penalty . . .

" A properly implemented caregiver agreement can avoid the new five-year look-back and penalty period commencement. . . .

"Irrevocable Income Only Trust

"Planning five years in advance of the need for care is necessary regardless of the method of transfer, and the new law did not change the protection afforded by the irrevocable income only trust. Assets that have been placed into a properly drafted trust are considered unavailable assets for Medicaid purposes, and if they are transferred to the trust outside the five-year look-back period, there will be no penalty period imposed for the transfer. . . .

"Annuities

"Perhaps one of the areas that changed the most under the DRA is the law surrounding annuities. . . . However, an annuity used in conjunction with a reverse rule of halves transfer can offer a planning opportunity for many individuals. We have successfully used this technique with both a promissory note and a Grantor Retained Annuity Trust.

. . .

"Promissory Notes

"Generally, a promissory note can be utilized to convert resources of an individual into a stream of income to bring the individual below the applicable Medicaid resource levels without incurring a transfer penalty much in the same way as an annuity. The formation of a promissory note does not incur a transfer penalty. The monthly payments provide a means to pay for long-term care during a penalty period for any uncompensated transfers that were made during the applicable look-back period. . . .

"Ultimately, the effectiveness of promissory notes as tools for Medicaid planning remains county specific at this point. . . .

"Grantor Retained Annuity Trust (GRAT)

"One novel Medicaid planning technique involves an estate planning concept known as the Grantor Retained Annuity Trust ('GRAT'). Long used as an estate planning tool to transfer assets to one's heirs at a discounted value, these trusts can now be used for Medicaid planning. The technique used is similar to the promissory note transfer described above, but instead uses a GRAT that has a corporate trustee. This technique is useful for an individual who does not have any close family members to hold a note or for an individual who is not able to purchase a commercial short-term fixed annuity. . . .

"Conclusion

"Despite the harsh measures imposed by the DRA upon the frail and the elderly, there still remain several opportunities to help individuals plan to preserve assets, while providing for their long-term care cost needs."

Appendix C: Comments on the report from a long-term care insurance producer (agent)

June 4, 2007

Steve,

As you requested, I have reviewed your New York State Compact Report and would like to offer some comments.

First of all, I would like to congratulate you on your extremely in-depth analysis of the Compact. It's obvious that your hard work and your ability to meet with and interview so many key players, has resulted in a report that I believe will carry much influence in deciding the outcome of the Compact proposal.

Other than your own personal views, (including the Compact background and your own analysis and recommendations), I don't believe your report sheds any new light on the issues that both sides promote. Those who have previously endorsed the Compact continue to confirm their reasons behind it, as do those who are those against it.

Here are my comments and concerns:

- 1) Prevalent throughout your report is the statement that the reason people do not purchase long term care insurance is because of their denial; "It will never happen to me." I strongly agree with that statement, as does everyone else who you interviewed. However, the concept that with the Compact denial will no longer be a factor is bogus. If one truly believes that they will never require long term care services, not only will they not purchase a LTC policy if the Compact was not available, they will also not purchase a policy if the Compact were available. If "it will never happen to me," then why should I insure the risk at all, regardless of the cost of an annual premium, whether it's \$10,000 or \$1,000? Therefore, the premise that the Compact will remove the word "denial" from the equation is misguided.
- 2) If the LTC industry believed that the Compact would be a boon to LTC sales, then why hasn't one carrier (other than MedAmerica) come out in favor of it? One would think that considering the state of LTCI sales over these past few years, if the Compact was in fact a way to increase sales, the carriers would jump at the opportunity. Shouldn't we assume that insurance companies have a better idea of what's good for their industry than the politicians who have a personal, political agenda?
- 3) In spite of what proponents claim about the Compact promoting personal responsibility, the fact is, the opposite is true. If purchasing a policy when young & healthy is one alternative (which defines personal responsibility), the Compact allows someone to avoid personal responsibility until one is diagnosed as being

- chronically ill. Personal Responsibility does not belong in the same sentence as the word Compact. I have never seen nor heard of any reasonable explanation why a 50-year old would commit to paying premiums for 30 years when they have the option of doing nothing until they require LTC services in the future.
- 4) Proponents of the Compact suggest that a 50-year old should purchase a policy now, to cover ½ of their future assets. I don't know about you, but personally, I'm not sure what my assets will be 1 year from now, forget about 30 years. The estimated value of one's future assets so far in advance is nothing more than an uneducated guess and therefore useless in determining the amount of benefits a policy should have.
- 5) The stated purpose of the Compact is to "offer New Yorkers a new option to pay for long term care, *once a person becomes chronically ill.*" That one sentence is why the Compact will not only end future LTCI sales, but it will also cause anyone who presently has a policy to cancel it. In essence, what the Compact offers and the proponents do not understand, is that anyone with common sense will do nothing until they are diagnosed as being chronically ill. And that is the main reason why everyone in the LTCI industry opposes the Compact. The Compact is nothing more than offering LTCI to the uninsurable.
- 6) The legislative scoring by Milliman shows that the potential savings to NY state with the Compact will be anywhere from \$21-\$500 million each year. The \$21 million number is based on *all* Compact participants divesting their assets prior to becoming a Compact participant. The \$500 million figure assumes that *no one* will divest prior to becoming a participant. Bob Herz informed me that the expected savings to NY will be somewhere in the \$250 million range. If the sponsor of the Bill admits that even with the Compact, one-half of the people will still divest themselves of their assets, then that contradicts the entire purpose of the Compact proposal, which is to avoid asset divestiture.
- 7) Those that favor the Compact, consistently state that it will "define the risk" of the insurers and therefore lower the premium. I find that statement difficult to understand. Every LTC policy, (with the exception of one with a Lifetime Benefit Period) already has a defined risk. If I sell a \$200/day policy with a 3-year benefit period, the insurer's risk is \$219,000. The trend of the carriers over the past few years is to do away with Lifetime Benefits and due to these policy's high premiums, they are becoming less and less of an option. Although the policy has a defined risk, that's not the case for the state. The compact subsidy can continue for however long the participant remains chronically ill, whether it's for 12 months, or 12 years.
- 8) An important issue, which has not been addressed, is what's to stop people from other states from moving to NY and becoming Compact participants once they become chronically ill?

A number of my comments and concerns have been stated in the past but to date, they have not specifically been addressed. I think everyone on both sides of the table agrees that Medicaid is no longer sustainable in the future as it's presently structured. Is the Compact the solution? I don't believe it is.

In my opinion, there is only one obvious answer to the problem and that is to make long term care insurance viable and affordable to as many people as possible. That would address everyone's concerns.

In your analysis, you ask and answer a number of questions. Here are two more to add to the list:

Is long term care insurance, as it's presently structured, unaffordable for the majority of the public?

- 1) Then get the carriers to come up with basic, bare-bones LTC policies without all of the bells & whistles in order to reduce the premiums.
- 2) Then change the mandated, 5% compound inflation riders on NY state Partnership policies. Allow other inflation options like the ones which are proposed by the DRA. Premiums will be reduced substantially.

Do people not purchase a LTC policy because they are in denial about the risk?

- 1) Then educate the public and inform them that doing nothing is not an option that's in their best interest. Have NY state and the insurance companies get together in a sustained, mass marketing campaign, promoting LTCI and the reasons for it.
- 2) Then have NY state become more aggressive about estate recovery. Once the public understands that Medicaid is not an entitlement, but nothing more than a "temporary loan" they will then take the consequences of not purchasing a policy more seriously.

My above comments of course do not mention the many concerns that I have with the Compact which blatantly contradicts the rules and regulations of the DRA.

Please take the above into consideration when coming up with your final report.

Arthur

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⁴ *Ibid*.

⁵ "The Medicaid program, including administrative costs, is financed jointly by the State, the Federal government, and county governments (including New York City). The Medicaid program in New York is projected to total roughly \$47.8 billion for 2007-08, including the local contribution. The State contribution is \$17.5 billion. The Federal contribution, including the local share that flows through the State's Federal Funds, is \$23.2 billion. The Federal match rate on State Medicaid expenditures is 50 percent, the lowest match rate possible. The local government contribution, which is \$7.1 billion, and certain Medicaid-related costs reimbursable by the Federal government, are not included in the State spending totals. Thus, State spending and Federal reimbursement on Medicaid are included in the All Funds budget total of \$120.9 billion, while the local contribution to Medicaid is not." (Eliot Spitzer, Governor and Paul E. Francis, Director of the Budget and Senior Advisor to the Governor, "New York State 2007-08 Enacted Budget Financial Plan," April 19, 2007,

⁶ Based on interviews with New York Division of the Budget staff, May 10, 2007.

⁷ Interview with Robert Herz, Legislative Director/Committee Director, Senator Martin J. Golden, New York State Senate, May 8, 2007.

⁸ Interview with Carl Young, President and CEO of the New York Association of Homes and Services for the Aging, May 9, 2007.

⁹ Interview with Richard Herrick, President and CEO of the New York State Health Facilities Association, May 8, 2007. His Medicaid reimbursement shortfall estimate is based on BDO Seidman, LLP, "A Report on Shortfalls in Medicaid Funding for Nursing Home Care," prepared for the American Health Care Association, June 2006, http://www.ahca.org/brief/seidmanstudy0606.pdf.

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¹⁴ The late economist Herbert Stein's Law, first pronounced in the 1980s, says "If something cannot go on forever, it will stop." Herbert Stein, "It Seems to Me: Herb Stein's Unfamiliar Quotations On Money, Madness, and Making Mistakes," *Slate*, posted Friday, May 16, 1997, http://www.slate.com/id/2561/.

¹⁵ Gail Holubinka, "Chapter 6: A Proposal for a New York State LTC Compact," Report of the Long-Term Care Reform Committee, New York State Bar Association Elder Law Section, February 2005.

¹⁶ An online copy of the proposed New York Long-Term Care Compact legislation may be found at: http://www.assembly.state.ny.us/leg/?bn=S00116&sh=t.

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¹⁹ *Ibid.*, p. 22.

²⁰ *Ibid*.

²¹ Spousal refusal, also known as "just say no," refers to a Medicaid planning strategy in which responsible spouses are advised to renege on their legal obligation of financial support of a dependent husband or wife and challenge the state Medicaid program to sue for recovery of Medicaid costs.

²² Vincent J. Russo Esq. and Howard S. Krooks Esq., "A Compact to Solve New York's Long Term Care Crisis," *ElderLaw E-News*, September 2005,

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²³ Phone interview with attorneys Bernard and Howard Krooks, May 9, 2007.

²⁴ Update as of July 26, 2007: the LTC Compact legislation did not pass during the Legislature's regular session which ended June 22, 2007.

²⁵ Senate Bill 00116, short title: "New York Compact for Long Term Care," p. 5, http://www.assembly.state.ny.us/leg/?bn=S00116&sh=t.

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³³ We were asked not to distribute the Milliman scoring letter but rather to refer interested parties to the company.

³⁴ Letter dated March 24, 2006 from Dawn E. Helwig, F.S.A., M.A.A.A., Consulting Actuary, Milliman to Gail Holubinka of MedAmerica Insurance Company, "Appendix A: Description of New York Compact Proposal and Scoring Model."

³⁵ "The following describes the five different Medicaid scenarios that were tested: 1) All Medicaid participants divest (i.e., shelter or give away) all of their assets, except for enough to pay for 6 months of long term care. 2) There is no divestiture. All participants fully use all of their assets, including the values of their homes, to pay for LTC services, before going onto Medicaid. 3) Participants fully spend down their assets (excluding their homes) to pay for LTC, up to a maximum of 60 months. (I.e., divestiture is

performed so that the maximum private pay period is 60 months.) 4) Twenty-five percent of participants divest at the onset of disability; all others fully spend down their assets (excluding their homes) before qualifying for Medicaid, subject to a maximum of 60 months private-pay. 5) Fifty percent of participants divest at the onset of disability; all others fully spend down their assets (excluding their homes) before qualifying for Medicaid, subject to a maximum of 60 months private pay." *Ibid.*, p. 4.

³⁶ New York State Assembly Public Hearing, Assembly Standing Committee on Aging, Assembly Standing Committee on Health, Assembly Standing Committee on Insurance, "Long-Term Care Compact" Legislation - A.10634-A, Assembly Hearing Room 250, Broadway, 19th Floor, New York, New York, Monday, December 4, 2006, 10:15 a.m., En-De Reporting Services, 212-962-2961, p. 6.

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