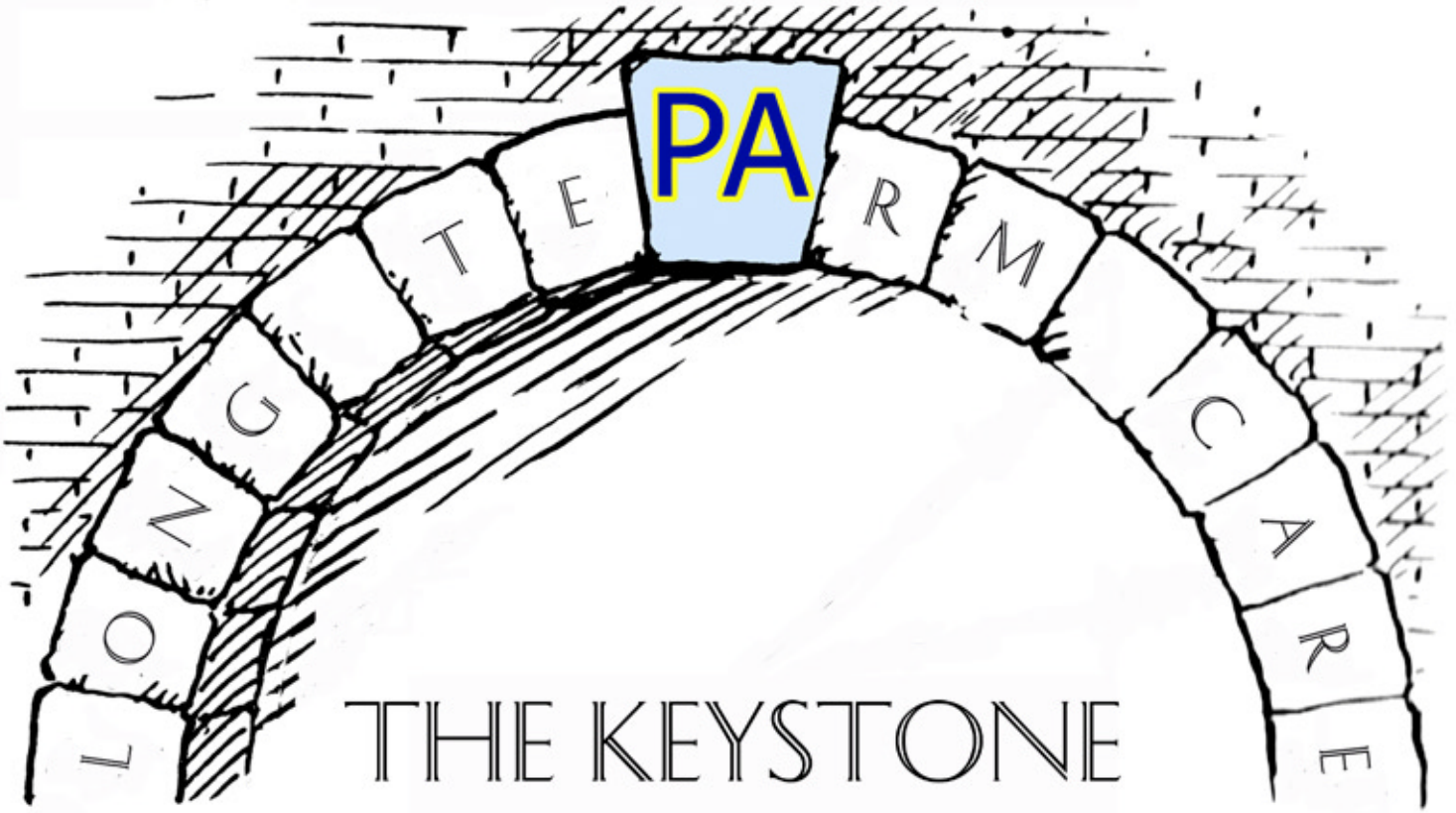

THE KEYSTONE OF LONG-TERM CARE:

MORE ACCESS TO BETTER CARE AT LOWER PUBLIC COST FOR PENNSYLVANIANS

CENTER FOR
LONG-TERM CARE
REFORM

The Keystone of Long-Term Care:
More Access to Better Care at Lower Public Cost for Pennsylvanians

presented by the

CENTER FOR
LONG-TERM CARE
REFORM

"Dedicated to ensuring quality long-term care for all Americans"

in cooperation with the

Commonwealth Foundation
for PUBLIC POLICY ALTERNATIVES

"Limited government, economic freedom, and personal responsibility"

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The Keystone of Long-Term Care:
More Access to Better Care at Lower Public Cost for Pennsylvanians

Executive Summary

Long-term care is very expensive whether provided in a nursing home, an assisted living facility or in someone's home.

Medicaid pays for most professional long-term care in Pennsylvania. The cost is already huge and likely to increase rapidly because of the Commonwealth's aging demographics.

Most people prefer to receive long-term care in their homes instead of going to a nursing home, but Pennsylvania Medicaid pays mostly for nursing home care.

That's all changing as Pennsylvania Medicaid pursues "rebalancing" from nursing-home to home care in a massive effort one official compared to the "Manhattan project."

The goal of rebalancing is to provide more of the home care people prefer at less cost, based on the opinion that, overall, home care is less expensive than nursing home care.

But research does not bear out the view that home care saves money overall. In fact, providing more home care delays but does not replace institutional care and costs more in total.

Furthermore, rebalancing without controlling eligibility discourages free care and private LTC financing alternatives while encouraging Medicaid enrollment and "Medicaid planning."

The only way to rebalance Medicaid to provide more home care at less cost is to reduce the number of Pennsylvanians who become dependent on the program in the future.

Only four alternative sources of LTC financing exist: (1) Asset Spend Down, (2) Estate Recoveries, (3) Home Equity Conversion, and (4) Private Long-Term Care Insurance.

This report explains why these alternative funding sources remain small and how to maximize them to relieve Medicaid and enable the program to rebalance cost-effectively.

Pennsylvania Medicaid would save nearly $120 million per year by preventing only 20% of its "dual eligibles" from ending up dependent on the program in the future.

If Pennsylvania Medicaid recovered from estates at the same rate as Oregon, the Commonwealth could recover an additional $213 million per year.

Pennsylvania may have 135,000 households "at risk for spending down" that could receive an estimated $62,800 each or $8.5 billion in total from reverse mortgages to help pay for their own long-term care, stay off Medicaid or at least delay Medicaid dependency.

In the absence of Medicaid's $500,000 home equity exemption and with other tougher income and asset limits, far more Pennsylvanians would purchase private long-term care insurance, avoid Medicaid dependency altogether, and save the Commonwealth large sums.

Introduction

Medicaid is called "Medical Assistance" in Pennsylvania, but we will employ the more general term "Medicaid" for consistency with other reports and to minimize confusion for readers from other states.

This report is the product of a collaboration between the Center for Long-Term Care Reform of Seattle, Washington (www.centerltc.com) and the Commonwealth Foundation (www.commonwealthfoundation.org) of Harrisburg, Pennsylvania. The Commonwealth Foundation intends to publish an abridged version of this report.

Stephen A. Moses, president of the Center for Long-Term Care Reform, did the research for this project (with the assistance of Joshua D. Hoerner, a Commonwealth Foundation Research Assistant) and wrote the report.

The subject of long-term care service delivery and financing, especially as it involves Medicaid eligibility, is complicated and often esoteric. We have attempted to keep this report as simple and straightforward as possible. But much of what you read herein will contradict widely held beliefs about the subject.

Therefore, we recommend that you review the report in a special way. First, suspend your disbelief temporarily. Read only the text. It's intended to make the argument as concisely and compellingly as possible. Disregard the footnotes at first reading. Ask yourself, if this is true, do the conclusions and recommendations follow logically?

Next, re-read the report critically. When you see something in the text that contradicts conventional wisdom, read the footnote and decide which to believe--conventional wisdom or the facts as stated and verified.

I want to make one thing crystal clear. Most of the problems discussed in this report spring from perversely counterproductive federal law and regulations. Pennsylvania Medicaid staff have no choice but to implement and enforce those rules as written and interpreted by federal officials.

We were granted only limited access to Pennsylvania Medicaid staff. We had to rely on information garnered from one two-hour face-to-face meeting and the written response to a questionnaire on Medicaid estate recoveries. Because we were unable to get critical questions answered, we will intersperse this report with "queries" in the hope that others will be able to obtain the needed answers. These queries are also listed in a separate section of the report following our recommendations.

We firmly believe there are ways to operate Pennsylvania's Medicaid long-term care program that make more sense, cost less in public funds, and that will provide better results for the Commonwealth's neediest citizens. We hope this report provides insights and suggestions that will facilitate the achievement of those objectives.

The Challenge of Long-Term Care

Long-term care (LTC) is medical or custodial assistance people require when they are unable to care for themselves fully for an extended period of time (usually 90 days or more) because of injury, illness or frailty.

A common goal of everyone involved in long-term care service delivery, financing or policy, is access for all to top quality care at the most appropriate level, *i.e.*, home care, assisted living, or skilled nursing as needed.

But formal long-term care is very expensive,[1] whether it is provided in a nursing home,[2] assisted living facility[3] or in someone's home.[4] Skilled caregivers are in short supply.[5] Major funding sources, such as Medicaid, Medicare, personal resources, and private insurance, are severely limited.

Anyone at any age may require long-term care, but the biggest demand and highest cost for LTC comes from the elderly,[6] especially those 85 and older.[7]

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[1] Several companies publish reports on the cost of formal long-term care. Citations in the following footnotes are from the MetLife Market Survey, but Prudential and Genworth publish similar studies: See "The Genworth Financial 2009 Cost of Care Survey" (http://www.genworth.com/content/etc/medialib/genworth_v2/pdf/ltc_cost_of_care.Par.8024.File.dat/cost_of_care.pdf) and Prudential's "Long-Term Care Cost Study", http://www.prudential.com/media/managed/LTCCostStudy.pdf. (The Prudential report is being revised as of July 28, 2010. Watch for publication of the 2010 update.)

[2] "National average rates for a private [nursing home] room increased by 3.3% from $212 daily or **$77,380** annually in 2008, to $219 daily or **$79,935** annually in 2009 [$248 per day and $90,520 per year in Pennsylvania, p. 18]. National average rates for a semi-private room increased by 3.7% from $191 daily or **$69,715** annually in 2008, to $198 daily or **$72,270** annually in 2009 [$235 per day and $85,575 per year in Pennsylvania, p. 18]." (MetLife Mature Market Institute, "The 2009 MetLife Market Survey of Nursing Home, Assisted Living, Adult Day Services, and Home Care Costs," October 2009, p. 4; http://www.metlife.com/assets/cao/mmi/publications/studies/mmi-market-survey-nursing-home-assisted-living.pdf.) Emphasis in the original.

[3] "National average assisted living base rates increased by 3.3%, from $3,031 monthly or **$36,372** annually in 2008, to $3,131 monthly or **$37,572** annually in 2009 [$2,986 per month or $35,832 per year in Pennsylvania, p. 24]." (*Ibid*.)

[4] "The 2009 national average hourly rate for home health aides increased by 5.0% from $20 in 2008 to $21 in 2009 [$20 in Pennsylvania, p. 30]. The national average hourly rate for homemaker/companions increased by 5.6% from $18 in 2008 to $19 in 2009 [$18 in Pennsylvania, p. 30]." (*Ibid*.)

[5] "The long-term care workforce is facing several critical challenges that affect Medicaid funded programs: there is an impending shortage of workers, turnover rates (which are associated with poor quality of care) are high, and training is inadequate. These problems are faced by all categories of LTC providers. . . . In summary, the implications for Medicaid of continued problems in the direct-care work force are poor quality of care in all settings due to turnover and vacancies. The use of temporary agency staff leads to increased cost. Finally, in HCBS [home and community-based services], limitations in the supply of labor will hinder program expansion. Inadequate training raises quality concerns for all settings." (Howard B. Degenholtz and Judith R. Lave, "Long-Term Care in Balance: The Role of Medicaid Policy in Pennsylvania," Pennsylvania Medicaid Policy Center, Pittsburgh, Pennsylvania, 2007, pps. 6-7, footnote omitted; http://www.pamedicaid.pitt.edu/documents/PA%20long%20term%20care%20rebalancing%20-%20final.pdf.)

[6] "In 2006, there were an estimated 1.9 million state residents age 65 and older, 15.2 percent of the Pennsylvania population. Pennsylvania's share of the population age 65 and older is higher than the national average, and in 2007 was the third highest share in the country [after Florida and West Virginia]. Nora Dowd Eisenhower, former Secretary of the Pennsylvania Department of Aging, noted in recent commentary: 'Pennsylvania is undergoing a demographic change that most other states will not see for another 10 to 15 years.'" (Pennsylvania Senior Care and Services Study Commission, "Initial Review: Current Care, Services, and Resources for Pennsylvanians Age 65 and Older," Harrisburg, Pennsylvania, April 30, 2009, p. 5, footnotes omitted.)

[7] "The large projected increase in the elderly population over the next 40 years, especially among the population aged 85 and older, almost guarantees that the demand for long-term care will rise dramatically in the future." (Joshua M. Wiener and Wayne L. Anderson, "Follow the Money: Financing Home and Community-Based Services," Pennsylvania Medicaid Policy Center, Pittsburgh, Pennsylvania, 2009, p. 22; http://www.pamedicaid.pitt.edu/documents/Homecare_rp_09.pdf.)

As the "Age Wave" crests and crashes over the next two decades, we'll have many more old people requiring much more long-term care at rapidly escalating cost.[8]

But America's long-term care service delivery and financing system is already plagued by serious problems of access, quality,[9] reimbursement,[10] discrimination,[11] institutional bias,[12] loss of independence, and welfare dependency.

Pennsylvania's LTC system is no exception. State policy makers worry that available resources will not suffice to ensure access to quality care in the most appropriate and desirable settings for people in need.[13]

Will Pennsylvania's tax base support public LTC financing at current and rapidly growing levels?[14] Will the federal Medicaid and Medicare programs continue to do their part?[15] Will private LTC financing sources go on supporting public LTC programs through "cost-shifting"?[16]

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[8] "The percentage of the [Pennsylvania] population over 65 was projected to drop from 15.6 percent in 2000 to 15.4 percent in 2005, then increase steadily from 2006 onward, reaching 21.9 percent in 2025. The percentage of the Pennsylvania population over age 85 was projected to increase steadily from 1.9 percent in 2000, to a high of 3 percent in 2025. At the same time, the proportion of people under age 65 is expected to fall from 84.6 percent to 78.1 percent placing greater burden on working age people to finance services for the disabled and the elderly. By contrast, the US population is projected to be slightly younger, with 80 percent under age 65." (Howard B. Degenholtz and Judith R. Lave, "Long-Term Care in Balance: The Role of Medicaid Policy in Pennsylvania," Pennsylvania Medicaid Policy Center, Pittsburgh, Pennsylvania, 2007, p. 5, footnote omitted; http://www.pamedicaid.pitt.edu/documents/PA%20long%20term%20care%20rebalancing%20-%20final.pdf.)

[9] "Medicaid is a notoriously low-quality provider of health care. Studies show that those with private health insurance, as well as those without health insurance, have better health outcomes than those on Medicaid. Poor quality care is caused by the limited selection of doctors as Medicaid pays doctors and hospitals less for the same procedures than private insurance companies. The poor quality of Medicaid affects all Pennsylvanians by driving up the cost of private coverage." (Elizabeth Stelle, "Welfare Fraud and Abuse," testimony by Elizabeth Stelle, Research Associate, Commonwealth Foundation, Harrisburg, Pennsylvania, June 2, 2010, http://www.commonwealthfoundation.org/research/detail/welfare-fraud-and-abuse.)

[10] According to Stuart H. Shapiro, president of the Pennsylvania Health Care Association (www.phca.org), a major LTC provider trade association: "Simply put, we have no means of paying for the long-term-care needs of the nation's 77 million baby boomers . . .. We expect somebody to pay it, and believe vaguely that it will be paid -- but, in fact, we have not planned for it, individually or as a community. It is thus our nations greatest unfunded mandate." (Stuart H. Shapiro, "Funding Crisis in Elder Care," *Philadelphia Inquirer*, May 27, 2007.)

[11] Accusations of discrimination against Medicaid recipients because of Medicaid's low reimbursement rates are common, current and they go back decades: "A report prepared by the Senate Special Committee on Aging estimates that 'up to 80 percent of what are called federally certified [nursing] homes (that is, those that voluntarily participate in the Medicare and/or Medicaid programs) are reported to actively discriminate against Medicaid beneficiaries in their admission practices.'" (Toby Edelman, "Discrimination by Nursing Homes Against Medicaid Recipients: Improving Access to Institutional Long-Term Care for Poor People," *Clearinghouse Review*, Special Issue, Summer 1986, p. 339.)

[12] "Despite the preference by older people for care in the community rather than in institutions, most long-term care expenditures are for nursing home care. For example, in 2007, only 31 percent of Medicaid long-term care expenditures for older people and younger persons with physical disabilities were for home and community-based services." (Joshua M. Wiener and Wayne L. Anderson, "Follow the Money: Financing Home and Community-Based Services," Pennsylvania Medicaid Policy Center, Pittsburgh, Pennsylvania, 2009, p.1; http://www.pamedicaid.pitt.edu/documents/Homecare_rp_09.pdf.)

[13] "Over the last 25 years, Pennsylvania's Medical Assistance spending increased approximately 8% annually, and has doubled as a share of state spending. At the current rate of growth, Medicaid will consume 94% of the state budget by 2075. At the same time, Medicaid is a low-quality provider of health care. The program delivers episodic treatment, provides poor preventive care, and offers low-quality services to many beneficiaries. Furthermore, recent reviews by the Auditor General found upward of $1 billion of ineligible Medicaid payments." (Nathan Benefield, "Cost-Saving Ideas for Pennsylvania State Budget," testimony of Nathan A. Benefield, Director of Policy Research, Commonwealth Foundation to the Pennsylvania Senate Government Management and Cost Study Commission, April 12, 2010, http://www.commonwealthfoundation.org/research/detail/cost-saving-ideas-for-pennsylvania-state-budget.)

[14] Among states, Pennsylvania ranks 46th in "economic performance" and 43rd in "economic outlook" according to the 2010 ALEC-Laffer State Economic Competitiveness Index. (Arthur B. Laffer, Stephen Moore, Jonathan Williams,

The answer to all these questions is "highly doubtful."[17] Nevertheless, the goal of financing quality long-term care for all Americans is not a "bridge too far."

Closing the gap between needed LTC services and sufficient LTC financing, however, will require a new approach, a conceptual "keystone,"[18] to connect the span. Where better to look for the answers than Pennsylvania, the "keystone state?"[19]

Is Rebalancing the "Keystone" of Long-Term Care?

The federal government, most states[20] and Pennsylvania[21] for sure[22] are pursuing "rebalancing"[23] or "deinstitutionalization" as their "keystone of long-term care."[24]

The goal of LTC rebalancing is to give more people the care they prefer (home and community-based services and supports) at a cost measurably lower than providing services in a setting most people would rather avoid (nursing home care).[25]

Rich States, Poor States: ALEC-Laffer State Economic Competitiveness Index, American Legislative Exchange Council, Washington, DC, 2010, p. 109, http://www.alec.org/AM/PDF/tax/10RSPS/RSPS2010-Final.pdf.)

[15] Pennsylvania's newly passed budget "relies on $850 million in additional funds from the federal government [supplemental federal Medicaid matching funds] which has yet to pass Congress. According to Senate Majority Leader Dominic Pileggi, 'No one, including the governor, thinks we'll receive $850 million.'" (Commonwealth Foundation, "2010 Budget Deal Fails to Plan for Future," press release, June 30, 2010, http://www.commonwealthfoundation.org/research/detail/2010-budget-deal-fails-to-plan-for-future.)

[16] "Cost shifting" occurs when private payers are charged more to make up for shortfalls in the level of reimbursement from public LTC programs such as Medicaid.

[17] According to Ray Prushnok, Deputy Secretary for Aging, the Rendell Administration and the state legislature recognize the importance of long-term care and have maintained financial support for institutional and non-institutional Medicaid LTC services in spite of financial challenges in recent years. Nevertheless, financial pressures are growing and long-term care took a $34,000,000 cut in the newly passed 2010-11 state budget. (Meeting, July 13, 2010 with state Medicaid personnel.)

[18] Wikipedia defines keystone as the architectural piece at the crown of a vault or arch which marks its apex, locking the other pieces into position.

[19] "State Nicknames" at http://www.50states.com/bio/nickname4.htm.

[20] "Balancing the long-term care delivery system by expanding home and community-based services enjoys remarkable political consensus across the political spectrum-liberals view these initiatives as a way of empowering an underclass and conservatives view them as a way of promoting market solutions." (Joshua M. Wiener and Wayne L. Anderson, "Follow the Money: Financing Home and Community-Based Services," Pennsylvania Medicaid Policy Center, Pittsburgh, Pennsylvania, 2009, p.2; http://www.pamedicaid.pitt.edu/documents/Homecare_rp_09.pdf.)

[21] "In Pennsylvania, as in other states, there are major ongoing efforts to shift LTC spending away from nursing homes and toward home and community-based alternatives. The overall goal of such rebalancing policies is to provide people who need LTC and prefer to live in their own homes or with a relative with appropriate financing and services under Medicaid." (Howard B. Degenholtz and Judith R. Lave, "Long-Term Care in Balance: The Role of Medicaid Policy in Pennsylvania," Pennsylvania Medicaid Policy Center, Pittsburgh, Pennsylvania, 2007, p. 1; http://www.pamedicaid.pitt.edu/documents/PA%20long%20term%20care%20rebalancing%20-%20final.pdf.)

[22] Office of Long-Term Living (OLTL) officials told us they are engaged in a "Manhattan project for LTC" to reduce nursing home bed days, "possibly the largest nursing home transition program anywhere in the country." They've already gone "from 8% for HCBS to 20%" and have "transitioned 1000 people this year from nursing homes to the community." (July 13, 2010 meeting with OLTL management staff.)

[23] "Creating a more balanced delivery system by expanding home and community-based services and reducing reliance on institutional care where possible is a major goal for virtually all states and the Centers for Medicare & Medicaid Services." (Joshua M. Wiener and Wayne L. Anderson, "Follow the Money: Financing Home and Community-Based Services," Pennsylvania Medicaid Policy Center, Pittsburgh, Pennsylvania, 2009, p.1; http://www.pamedicaid.pitt.edu/documents/Homecare_rp_09.pdf.)

[24] From 2002 to 2007, Pennsylvania was among the four states with the largest percentage increase in Medicaid home and community expenditures. (Ari Houser, Wendy Fox-Grage, Mary Jo Gibson, "Across the States: Profiles of Long-Term Care and Independent Living," eighth edition, 2009, AARP, Washington, DC, p. 15, http://assets.aarp.org/rgcenter/il/d19105_2008_ats.pdf.)

On the face of it, achieving this goal--better care at lower cost--seems too good to be true. Will it work?

Will rebalancing give people more of the kind of care they want?

Yes, there is no question that most people prefer home care or assisted living to nursing home care whenever the lower levels of care are medically appropriate. The only challenge is how to pay for it.[26]

So, will rebalancing save money?

It seems logical it will because, on a per capita, point-in-time basis, home and community-based care is dramatically less expensive than the dominant venue of service, the nursing home.[27]

Unfortunately, there is little evidence that providing long-term care in the home and community is less expensive than nursing home care[28] across individual life spans and across the society as a whole.[29]

Rather, most studies show that home care delays but does not replace nursing home care and increases rather than decreases total LTC costs.[30]

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[25] "In addition to meeting the preferences of people with disabilities to remain in the community if at all possible, consumer advocates and state and some federal officials support expansion of home and community-based services because they believe that people with disabilities can be served at lower cost in the community and that expanding services will result in less costly systems of care. In particular, they hope to substitute home and community-based services for nursing home care." (Joshua M. Wiener and Wayne L. Anderson, "Follow the Money: Financing Home and Community-Based Services," Pennsylvania Medicaid Policy Center, Pittsburgh, Pennsylvania, 2009, p. 1; http://www.pamedicaid.pitt.edu/documents/Homecare_rp_09.pdf.)

[26] "Generally, these new care models were associated with increased costs, but greater client and caregiver welfare." (Joshua M. Wiener and Wayne L. Anderson, "Follow the Money: Financing Home and Community-Based Services," Pennsylvania Medicaid Policy Center, Pittsburgh, Pennsylvania, 2009, p. 10, footnote omitted; http://www.pamedicaid.pitt.edu/documents/Homecare_rp_09.pdf.)

[27] "The primary argument for the cost savings potential of home care rests on a comparison of the average per person Medicaid expenditures for people in the community and in nursing homes. The average annual Medicaid expenditures for home care for older people and adults with physical disabilities ($8,355 in 2004) per person are dramatically less than average annual Medicaid expenditures ($27,650 in 2004) per person for nursing home care. This comparison, however, is incomplete because it does not address differences in disability levels, use of acute care services, and the exclusion of housing and room and board costs from home care expenditures. Thus, it is not strictly an 'apples to apples' comparison." (Joshua M. Wiener and Wayne L. Anderson, "Follow the Money: Financing Home and Community-Based Services," Pennsylvania Medicaid Policy Center, Pittsburgh, Pennsylvania, 2009, p. 10, footnote omitted; http://www.pamedicaid.pitt.edu/documents/Homecare_rp_09.pdf.)

[28] "As desirable as this model of care is, it is inherently inefficient in that it requires a worker to travel from one residence to another, rarely seeing more than one consumer at a time. Recognizing that there are certain economies of scale in group residential settings that are lacking in traditional home care, many states and older people are exploring the potential role of residential care, including adult foster care, board and care homes, and assisted living facilities, in part as alternatives to nursing home care." (Joshua M. Wiener and Wayne L. Anderson, "Follow the Money: Financing Home and Community-Based Services," Pennsylvania Medicaid Policy Center, Pittsburgh, Pennsylvania, 2009, p.20, footnote omitted; http://www.pamedicaid.pitt.edu/documents/Homecare_rp_09.pdf.)

[29] We interviewed Robert J. McNamara, Director, Policy and Strategic Planning, Departments of Public Welfare/Aging on July 13, 2010 and asked if there were any studies that show rebalancing from institutional long-term care to home and community-based services saves money. He mentioned only the "channeling studies" from the early 1980s. According to AcademyHealth, however: "The Channeling demonstration . . . found that, while community-care models were often welcome by recipients and their caregivers, they led to overall increases in public spending for long-term care." (Francis Caro, "Long-Term Care: Informed by Research," AcademyHealth, Washington, D.C., 2003, p. 2; http://www.academyhealth.org/files/publications/ltcresearch.pdf.)

Nevertheless, many academics and public officials believe in the idea that rebalancing will lead to Medicaid LTC savings almost as a matter of faith.[31]

Query: How do Pennsylvania Medicaid officials justify their confidence that rebalancing program services from dominantly institutional care (with its economy of scale) to mostly home and community-based care (dispersed and labor-intensive) will save money in spite of the evidence adduced here to the contrary?

Impact of Rebalancing on LTC Providers

There are other problems with reliance on rebalancing Medicaid LTC services as the keystone of long-term care. Medicaid pays all LTC providers much less than market rates for private payers.[32]

For example, nursing home respondents told us that Medicaid pays a daily rate of $155, which is only 75% of the $208 private pay rate.[33] Research shows Pennsylvania Medicaid reimbursed

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[30] "When compared to an elderly population for whom traditionally available care is offered, recipients of expanded community-based services do not use significantly fewer days of nursing home care." (General Accounting Office, "The Elderly Should Benefit From Expanded Home Health Care But Increasing Those Services Will Not Insure Cost Reductions" (Dec. 7, 1982) p. 43, http://archive.gao.gov/f0102/120074.pdf.)

"An increasingly large number of studies, including the results of a national channeling demonstration program, have shown that noninstitutional services typically do not substitute for nursing home care, but, rather, represent additional services most often to new populations." (John F. Holahan and Joel W. Cohen, *Medicaid: The Trade off Between Cost Containment and Access to Care*, The Urban Institute Press, Washington, D.C., 1986, p. 106.)

"Although community-based LTC programs proved beneficial to both clients and informal caregivers in the LTC demonstrations, they did not prove budget neutral or cost effective." (Kenneth G. Manton, "The Dynamics of Population Aging: Demography and Policy Analysis," *The Milbank Quarterly*, Vol. 69, No. 2, 1991, p. 322.)

Some recent research makes the case that perhaps someday funding more home and community-based care through Medicaid will save money: "Medicaid spending on home and community-based services (HCBS) has grown dramatically in recent years, but little is known about what effect these alternatives to institutional services have on overall long-term care costs. An analysis of state spending data from 1995 to 2005 shows that for two distinct population groups receiving long-term care services, spending growth was greater for states offering limited noninstitutional services than for states with large, well-established noninstitutional programs. Expansion of HCBS appears to entail a short-term increase in spending, followed by a reduction in institutional spending and long-term cost savings." (H. Stephen Kaye, Mitchell P. LaPlante, and Charlene Harrington, "Do Noninstitutional Long-Term Care Services Reduce Medicaid Spending?," *Health Affairs*, Vol. 28, No. 1 (2009), p. 262, http://content.healthaffairs.org/cgi/reprint/28/1/262, gated).

So, while offering home and community-based services in lieu of nursing home care under Medicaid arguably may reduce the rate of growth in LTC expenditures, there is no evidence whatsoever that rebalancing or deinstitutionalization can reduce total Medicaid long-term care expenditures over the long run. The demographic imperative to shift long-term care costs from Medicaid to private financing sources remains.

[31] "The research evidence that changing the delivery system will produce substantial Medicaid savings is not strong, but it is a premise strongly held by many state officials and consumer advocates." (Joshua M. Wiener and Wayne L. Anderson, "Follow the Money: Financing Home and Community-Based Services," Pennsylvania Medicaid Policy Center, Pittsburgh, Pennsylvania, 2009, p.22, http://www.pamedicaid.pitt.edu/documents/Homecare_rp_09.pdf.)

[32] "Medicaid payment rates are lower than the payments received from other sources. For example, the average reimbursement rate in the state of Pennsylvania [for nursing home care] in 2004 from Medicare was $303.75 per day, compared to $160.70 per day from Medicaid. People who pay for nursing home care themselves or with private LTC insurance pay a rate that is slightly less than the Medicare rate." (Howard B. Degenholtz and Judith R. Lave, "Long-Term Care in Balance: The Role of Medicaid Policy in Pennsylvania," Pennsylvania Medicaid Policy Center, Pittsburgh, Pennsylvania, 2007, p. 4, footnote omitted; http://www.pamedicaid.pitt.edu/documents/PA%20long%20term%20care%20rebalancing%20-%20final.pdf.)

nursing homes an estimated $254 million less than allowable costs in 2009 or $13.88 per bed day below the cost of providing the care.[34]

Home health respondents told us that Medicaid pays only $88 for a one-hour skilled care visit by a nurse, but the actual cost in Northeast Pennsylvania is $120 to $125.[35] The most successful home health provider we interviewed said she accepts no Medicaid because of "hoops to jump through," low reimbursements, and payment delays.[36]

Pennsylvania Medicaid does not fund assisted living and although it has authorized 300 ALF slots, a leading assisted living provider told us his company will not participate, nor will other high-quality providers because of the likely inadequacy of Medicaid reimbursements under the waiver.[37]

Query: How can Medicaid sustain access to and quality of long-term care as the baby-boomer generation ages without paying adequate reimbursement levels to long-term care providers at all levels of care?

The "Woodwork Factor"

Even more basic than the problem of inadequate Medicaid reimbursements for all levels of long-term care is the effect on non-Medicaid LTC financing sources of making ever-more-desirable services available through the public program without constricting eligibility and utilization.

Will families now providing long-term care for free in the community[38] come out of the "woodwork"[39] to take advantage of home and community-based services provided for free or highly subsidized by Medicaid?

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[33] They said "We won't get costs met. It is a hidden tax; a stealth tax on the elderly. Medicaid wants us to provide services at 85% of the cost; we have to make it up by raising the rate for the few still paying privately." (Interview with representatives of the Pennsylvania Association of Non-Profit Homes for the Aging on July 13, 2010.)

[34] According to research sponsored by the American Health Care Association, Medicaid reimburses Pennsylvania's nursing homes $13.88 per bed day less than allowable costs for an estimated total of 18,300,220 "Medicaid days" and a total loss of $254,007,058 in 2009. (ELJAY, LLC, "A Report on Shortfalls in Medicaid Funding for Nursing Home Care," for the American Health Care Association, November 2009, pps. 7, 30; http://www.ahcancal.org/research_data/funding/Documents/2009%20Medicaid%20Shortfall%20Report.pdf.)

[35] Meeting with home health provider representatives and senior advocates on July 13, 2010 at the office of the Pennsylvania Homecare Association..

[36] Opinion of Susan Heinle, Owner/President, Visiting Angels Living Assistance Services expressed at July 13, 2010 meeting with home health providers.

[37] Comment by Ted Janeczek, Executive Vice President and Chief Financial Officer, Country Meadows Retirement Communities, the largest assisted living provider in Pennsylvania and the 25th largest in the United States, representing the Pennsylvania Assisted Living Association in an interview on July 15, 2010. Mr. Janeczek expressed the opinion that only "lower end facilities" will participate in Medicaid. "Rebalancing is a good idea," he said, "but the people promoting it have unrealistic expectations. I don't understand how rebalancing will decrease Medicaid expenditures. It's just going to increase the number of recipients."

[38] "Unpaid assistance with ADLs [activities of daily living, such as dressing or toileting] and IADLs [instrumental activities of daily living, such as using a telephone or balancing a checkbook] is typically performed by close relatives of the person with disabilities, such as a spouse, adult child, or parent. Many also receive assistance from volunteers, neighbors, and friends. The level of assistance can vary considerably, from just a few hours per week to full-time support. A recent study by the AARP estimated that the economic value of family caregiving in the state of Pennsylvania was $14.5 billion dollars per year, which is the sixth highest of all 50 states. By way of comparison, total expenditures (all payers) for nursing home care in Pennsylvania were $7.6 billion in 2004." (Howard B. Degenholtz and Judith R. Lave, "Long-Term Care in Balance: The Role of Medicaid Policy in Pennsylvania," Pennsylvania Medicaid Policy Center, Pittsburgh, Pennsylvania, 2007, p. 3, footnotes omitted; http://www.pamedicaid.pitt.edu/documents/PA%20long%20term%20care%20rebalancing%20-%20final.pdf.)

Will people be less likely to plan responsibly for long-term care by saving, investing or insuring if Medicaid pays not only for the nursing home care they'd rather avoid but also for the home and community based services they prefer?

Will people otherwise financially ineligible for Medicaid be more likely to seek legal assistance to become artificially impoverished if it gets them home care services instead of only nursing home institutionalization?[40]

In other words, will making Medicaid long-term care more attractive to more people increase rather than decrease overall costs and, at the same time, crowd out alternative private sources of LTC financing even more than it already has?[41]

The answer to the last question is "yes" based on the evidence adduced in the preceding footnotes and by simple logic.

Query: As Pennsylvania Medicaid rebalances from nursing home care citizens would rather avoid to home and community-based care they'd much prefer, how can the program avoid "reverse cost-shifting" away from free care currently provided by families and private LTC financing toward Medicaid?

Saving Medicaid LTC for Those in Need

If it is true that Medicaid will be unable to fund quality care adequately in the most appropriate and desirable settings for a rapidly growing base of frail or infirm elderly . . .

How can Pennsylvania simultaneously reduce Medicaid LTC costs and provide the most desirable and medically appropriate services to all recipients?

There is only one answer: Pennsylvania must have fewer of its citizens dependent on Medicaid for their long-term care. More Pennsylvanians must be able to pay privately in the future for the long-term care services they prefer.[42]

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[39] This is the problem often called the "woodwork factor": "Because a high proportion of people with disabilities do not use paid home and community-based services and because some of the services are inherently desirable (e.g., homemaker services), making these services more widely available can dramatically increase the number of people who use them, enrolling people who would not otherwise be institutionalized." (Joshua M. Wiener and Wayne L. Anderson, "Follow the Money: Financing Home and Community-Based Services," Pennsylvania Medicaid Policy Center, Pittsburgh, Pennsylvania, 2009, p.10, footnote omitted; http://www.pamedicaid.pitt.edu/documents/Homecare_rp_09.pdf.)

[40] We discuss the practice of "Medicaid planning" below and provide examples of its practices and practitioners in Appendix B.

[41] For example, according to peer-reviewed, published research, Medicaid alone--not counting Medicare, the Veterans Administration and all the other public sources of long-term care financing--crowds out 2/3 to 90% of the market for private long-term care insurance: "We examine the interaction of the public Medicaid program with the private market for long-term care insurance and estimate that Medicaid can explain the lack of private insurance purchases for *at least two-thirds and as much as 90 percent of the wealth distribution*, even if comprehensive, actuarially fair private policies were available." (Jeffrey R. Brown and Amy Finkelstein, "The Interaction of Public and Private Insurance: Medicaid and the Long-Term Care Insurance Market," National Bureau of Economic Research, December 2004, cited from the paper's "Abstract," http://www.nber.org/~afinkels/papers/Brown_Finkelstein_Medicaid_Dec_04.pdf), emphasis added.

[42] According to Stuart H. Shapiro, president of the Pennsylvania Health Care Association [www.phca.org]: "[N]ow is the time for the federal government to gradually shift from acting as the major payer for long-term care to helping individuals save and invest for their own long-term care, using a variety of market-based mechanisms that enable compounding interest and time to work for us, not against us. In effect, expanding reliance on private-sector markets would constitute a fourth pillar -- supplementary to Social Security, Medicare and Medicaid -- to stabilize a wobbling,

To increase private financing of long-term care at market reimbursement rates and reduce dependency on Medicaid's currently less desirable and underfunded services is the true "keystone of long-term care."

Private financing is the crown at the apex of the arch that closes the connection between needed LTC services and today's inadequate funding.

What are the alternative private sources of LTC financing? Why are they inadequate today? Why is Medicaid, a means-tested public assistance program, the dominant payor of long-term care in the USA and Pennsylvania?[43] These are the puzzles we must resolve before we can identify specific recommendations to implement the keystone of LTC.

The Keystone of Long-Term Care

There are only four potential sources of private long-term care funds that could relieve the financial burden on Medicaid and free up more of the program's severely limited resources to improve care for the most needy.[44]

Those four sources are (1) more "spend down" of personal assets, (2) more non-tax revenue from liens and estate recoveries, (3) home equity conversion, and (4) private long-term care insurance.

We will examine them one by one. How limited are they now? Why are they so limited? How can Pennsylvania tap each of them more to relieve the burden on Medicaid of financing long-term care?

Source #1: **More spend down**. Most people assume Medicaid eligibility rules impose draconian income and asset limits which require applicants to spend down catastrophically into impoverishment.[45] If this were true, it would mean asset spend down is already tapped out. But it is not true.

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crumbling retirement-program foundation." (Stuart H. Shapiro, "Aging U.S. lacks a plan for long-term care," *Philadelphia Inquirer*, September 12, 2008.)

[43] "The Medicaid program is the single largest payer for LTC provided in nursing homes [in Pennsylvania], covering 63.4 percent of all residents and accounting for 49 percent of all nursing home expenditures. (Howard B. Degenholtz and Judith R. Lave, "Long-Term Care in Balance: The Role of Medicaid Policy in Pennsylvania," Pennsylvania Medicaid Policy Center, Pittsburgh, Pennsylvania, 2007, p. 1; http://www.pamedicaid.pitt.edu/documents/PA%20long%20term%20care%20rebalancing%20-%20final.pdf.)

[44] Arguably, there is a new, fifth source of potential private long-term care funds: the Community Living Assistance Services and Supports or CLASS Act program signed into law by President Obama on March 23, 2010 as part of the Patient Protection and Affordable Care Act of 2010, also known as "health reform." See Appendix A for a description of the CLASS program and an explanation of why it is unlikely to become a significant source of private LTC financing.

[45] Even scholars who accurately describe Medicaid long-term care financial eligibility rules usually do not document how widespread and costly various eligibility exemptions are, especially when supercharged by "Medicaid planning" experts. For overviews of Medicaid nursing home eligibility rules governing single and married applicants respectively, see Jennifer Rose, Monica Costlow, and Judith Lave, "Medical Assistance Eligibility Requirements for Seniors Needing Skilled Nursing Home Care," Pennsylvania Medicaid Policy Center, Pittsburgh, Pennsylvania, December 21, 2007, http://www.pamedicaid.pitt.edu/documents/nursinghomefs.pdf and Jennifer Rose, Monica Costlow, and Judith Lave, "Medical Assistance Eligibility Requirements for Seniors Needing Skilled Nursing Home Care When Their Spouse Lives in the Community," Pennsylvania Medicaid Policy Center, Pittsburgh, Pennsylvania, December 21, 2007, http://www.pamedicaid.pitt.edu/documents/spousefs2.pdf.

Truth #1: Medicaid long-term care eligibility rules are far more generous and elastic than commonly believed. Anyone with income below the cost of a nursing home ($7,514.74 per month in 2010[46] on average in Pennsylvania) qualifies based on income. The "medically needy" qualify with even higher incomes.[47] Assets held in exempt form, such as a home (up to $500,000 in equity),[48] one business "regardless of value or rate of return,"[49] one automobile of unlimited value,[50] burial insurance or prepaid burial plans "regardless of value,"[51] and term life insurance in any face value amount,[52] are virtually unlimited. People who are so affluent they do not qualify under the basic rules may hire "Medicaid planners" to impoverish them artificially.[53] See Appendix B for examples of Pennsylvania Medicaid planners, their advertising claims, and the techniques they use. Fraudulent misrepresentation of applicants' income and assets is also a large problem, possibly involving hundreds of millions of dollars.[54] Bottom line, neither income nor assets are significant obstacles to obtain Medicaid-financed LTC in Pennsylvania.

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[46] Cited from the website home page of elder law attorney Robert C. Gerhard, III at http://www.paelderlaw.net/home/ as of July 26, 2010.

[47] "Medically Needy" Medicaid recipients have additional medical expenses deducted from their income before income eligibility limits are applied.

[48] Federal Medicaid LTC eligibility rules exempted unlimited home equity, including the value of all property contiguous to the home, until the Deficit Reduction Act of 2005, signed into law by President Bush on February 8, 2006, capped the home equity exemption at $500,000 or $750,000 depending on state legislative option. Pennsylvania opted for the lower, half million dollar, cap. New York, California, Massachusetts and Idaho opted for the higher cap.

[49] "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.

[50] "One automobile per household is excluded regardless of the value if it is used for transportation of the eligible individual/couple or a member of the eligible individual's/couple's household. ASSUMPTION: Assume the automobile is used for transportation, absent evidence to the contrary. Social Security Administration, *Program Operations Manual System (POMS)*, "SI 01130.200: Automobiles and Other Vehicles Used for Transportation," http://policy.ssa.gov/poms.nsf/lnx/0501130200. Emphasis in original.

[51] "A burial space or agreement which represents the purchase of a burial space held for the burial of the individual, his or her spouse, or any other member of his or her immediate family is an excluded resource, regardless of value." Social Security Administration, *Program Operations Manual System (POMS)*, "SI 01130.400: Burial Spaces," http://policy.ssa.gov/poms.nsf/lnx/0501130400.

Medicaid eligibility workers in other states estimate that between 65% and 80% of all Medicaid LTC recipients have prepaid for burial costs at least for themselves and/or family members. Such burial costs vary from $5,000 to $15,000 with $10,000 a reasonable average. "Direct cremation" (no visitation or services at all) is available as low as $695. (Source: Personal email communication on 6/28/10 from Harry C. Neel of the Pennsylvania Cemetery Cremation and Funeral Association's Consumer Service Council.)

[52] "[T]he FV [face value] of the following are not taken into account: burial insurance policies; and term insurance policies that do not generate a CSV [cash surrender value]." (Social Security Administration, *Program Operations Manual System (POMS)*, "SI 01130.300: Life Insurance," http://policy.ssa.gov/poms.nsf/lnx/0501130300.) Why would a 90-year-old buy a million dollar term life policy when the premium would almost equal the benefit? Instantaneous self-impoverishment and the term insurance benefit passes to the beneficiary at death thus avoiding Medicaid's "mandatory" estate recovery requirement.

[53] Medicaid planning is the practice of legally divesting, diverting or sheltering assets that would otherwise be countable in determining Medicaid long-term care eligibility to make them exempt or non-countable. An internet search for the term "Medicaid planning in Pennsylvania" reveals many practitioners and numerous examples of their claims and techniques.

[54] "In the case of Medicaid, the Auditor General's office found that DPW failed to make proper eligibility determinations on more than 1,600 randomly selected applications between January 2005 and March 2008-resulting in $3.3 million in payments to a fraction of ineligible recipients. Many of the improper disbursements were due to DPW's failure to verify the recipients' age, disability, and family relationship requirements, and to promptly review recipients' financial and other eligibility information. The total cost of this fraud across the Medical Assistance program would likely be hundreds of millions of dollars." (Elizabeth Stelle, "Welfare Fraud and Abuse," testimony by Elizabeth Stelle, Research Associate, Commonwealth Foundation, Harrisburg, Pennsylvania, June 2, 2010, http://www.commonwealthfoundation.org/research/detail/welfare-fraud-and-abuse.)

Potential Savings #1: The potential savings from preventing Medicaid long-term care dependency are staggering. The key is to reach aging Pennsylvanians while they are still young, healthy, and affluent enough and persuade them to plan responsibly for long-term care so they never become "dual eligibles." Dual eligibles receive both Medicare and Medicaid benefits. Medicaid often pays their Medicare co-payments as well as their Medicaid benefits. In 2005, 400,000 duals were 21% of Medicaid eligibles in Pennsylvania, but accounted for 52% of program spending: $14,972 per dual enrollee as compared to $5,979 for non-duals.[55] "The average dual eligible is more costly than the average Medicaid beneficiary because he or she is older, sicker (a significant proportion are enrolled in Medicaid because they are disabled), poorer and they use more expensive services, such as long-term care."[56] Pennsylvania Medicaid would save nearly $120 million per year by preventing only 20% of its duals from ending up dependent on the program in the future.[57]

Query: Given that eligibility for Medicaid-financed long-term care is easy to obtain without significant personal spend down after expensive, extended care is needed, wouldn't it follow that the public may be desensitized to the risk and cost of long-term care? Could that explain why most people fail to plan, save, invest or insure for LTC?

Source #2: **Liens and estate recoveries**.[58] This source of non-tax revenue often evokes inaccurate and unfair criticism as "picking the bones of the poor"[59] or imposing a "Medicaid death tax."[60] The reality is that as long as Medicaid LTC allows recipients to retain large amounts of exempt assets, any failure to collect the cost of their care from their estates means Medicaid operates as "free inheritance insurance" for their baby-boomer heirs. But boomers are precisely the generation that will overwhelm Medicaid if they become dependent on it for their own long-term care.

Truth #2: Despite conventional wisdom that liens and estate recoveries are only a small potential revenue source, the truth is very different. In Fiscal Year 2004, the state of Oregon recovered 5.8 percent of the cost of its Medicaid nursing home program from the estates of deceased recipients. In the same year, the U.S. Department of Health and Human Services reports that Pennsylvania recovered only .1% of nursing home expenditures and was one of only 12 states that collected less that year than in 2002: 74.7 percent less![61] Pennsylvania Medicaid reported estate recoveries

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[55] Judith R. Lave and Caleb B. Wallace, "The Intersection of Medicare and Medicaid: The Dual Eligibles in Pennsylvania," Pennsylvania Medicaid Policy Center, Pittsburgh, Pennsylvania, undated, p. 5; http://www.pamedicaid.pitt.edu/documents/Duals_fs_09.pdf.

[56] *Ibid.*.

[57] For a detailed account of why and how savings of this magnitude are feasible not only in Pennsylvania but nationally as well, see Stephen A. Moses, "How to Save Medicaid $20 Billion Per Year AND Improve the Program in the Process," Center for Long-Term Care Financing, Seattle, Washington, 2005; http://www.centerltc.com/pubs/howtosavemedicaid.pdf.

[58] For detailed descriptions of Pennsylvania's estate recovery program, see Pennsylvania Department of Public Welfare website, "Medicaid Estate Recovery," http://www.dpw.state.pa.us/servicesprograms/other/003670689.htm, cited as of July 22, 2010; Pennsylvania Department of Public Welfare, "Medical Assistance Estate Recovery Program and Related Topics: Questions and Answers," Publication 332, August 2008; http://www.dpw.state.pa.us/ucmprd/groups/webcontent/documents/form/s_002661.pdf, cited December 21, 2010 and Robert C. Gerhard, III, CELA, "Pennsylvania Medicaid, Estate Recovery Program," *Pennsylvania Bar Association Quarterly*, January 15, 2006, http://www.paelderlaw.net/library/PAMedicalAssistance.asp.

[59] For example, see Roger A. Schwartz, J.D. and C.P. Sabatino (November 1994). *Medicaid Estate Recovery Under OBRA '93: Picking the Bones of the Poor?*" American Bar Association, Commission of Legal Problems of the Elderly.

[60] Jeffrey A. Marshall, CELA, "The Medicaid Death Tax: Medical Assistance Estate Recovery in Pennsylvania," undated, http://www.paelderlaw.com/medicaiddeathtax.html, cited July 22, 2010.

[61] 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 Estate Recovery Collections," Policy Brief No. 6, September 2005, p. 8, http://aspe.hhs.gov/daltcp/Reports/estreccol.pdf.

to us of approximately $24 million for 2004. Even at the higher amount, total estate recoveries would be only .6% of nursing home expenditures.

Potential Savings #2: If Pennsylvania Medicaid recovered from liens and/or estates at the same rate as Oregon (5.8%) instead of .6%, the Commonwealth could recover an additional $213 million per year.[62] See the "Recommendations" section of this report for measures Pennsylvania Medicaid could take to achieve this goal.

Query: How do Pennsylvania Medicaid officials justify or rationalize leaving potential estate recoveries uncollected from deceased recipients when "It is their children, after all, who stand to inherit whatever property remains after the costs of long-term care are paid and who currently reap the windfall of Medicaid subsidies."[63]

Source #3: **Home equity conversion**. Most Pennsylvanians own their homes--71.3%, compared to the national average of only 66.2%.[64] Nationally, over 80% of seniors own their homes and over 70% of these own their homes free and clear of mortgage debt.[65] People age 62 and older can access their home equity easily, and without incurring monthly payments, by means of "reverse mortgages."[66] But very few people use reverse mortgages to fund home and community-based services that would enable them to remain in their homes longer and even fewer tap their home equity to be able to afford private LTC insurance premiums.[67] Why?

Truth #3: Under federal law, Medicaid exempts one home and all contiguous property up to $500,000 (Pennsylvania) or $750,000 (New York, California, Idaho) in equity. The median home price in Pennsylvania was about $152,000 in 2009, down from $180,000 in 2006.[68] With the vast majority of Pennsylvania homes valued below the Medicaid home equity exemption amount, aging homeowners have no financial incentive to spend down their home equity for LTC services rather than turn to Medicaid. But home values are a substantial potential resource[69] for LTC financing.[70]

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[62] *Ibid*. Derivation: By collecting 5.2% more of its 2004 nursing home expenditures ($4.1 billion) to equal in total the 5.8% collections achieved by Oregon, Pennsylvania would collect an additional $213 million.

[63] Stephen A. Moses, "Medicaid Estate Recoveries: National Program Inspection," OAI-09-86-00078, Office of Inspector General, Seattle, Washington, June 1988, pps. 47-48; http://oig.hhs.gov/oei/reports/oai-09-86-00078.pdf.

[64] U.S. Census, "State and County QuickFacts," Pennsylvania, http://quickfacts.census.gov/qfd/states/42000.html.

[65] "The vast majority of Americans age 65 and older in 2004 (82 percent) are homeowners (Callis and Cavanaugh 2004). Over half the net worth of seniors is currently illiquid in their homes and other real estate (Orzechowski and Sepielli 2003). [p. 1]

"Based on the Health and Retirement Study, in 2000 there were 27.5 million elder households with at least one resident age 62 or older. A high proportion (21.1 million) of these households (78 percent) were homeowners (Figure 3.2). About 74 percent owned their homes free and clear of any mortgages. In aggregate, elder households have accumulated over $2 trillion in home equity. [p. 26]

(Barbara R. Stucki, "Use Your Home to Stay at Home: Expanding the Use of Reverse Mortgages for Long-Term Care: A Blueprint for Action," The National Council on the Aging, January 2005, http://www.reversemortgagetimes.org/guides/reverselongterm.pdf.)

[66] For extensive information about reverse mortgages, see www.reversemortgage.org, the National Reverse Mortgage Lenders Association's (NRMLA's) website.

[67] Pennsylvania reverse mortgage lenders we interviewed on July 15, 2010 said using such loans to fund long-term care is "very rare" and they "never hear anything about using reverse mortgages to buy LTC insurance."

[68] See http://www.trulia.com/home_prices/ and http://www.homepricetrend.com/pennsylvania.

[69] The median net worth of elderly households in the United States is $130,500 of which $109,550 is home equity. (U.S. Census Bureau, Alfred O. Gottschalck, Current Population Reports, "Net Worth and the Assets of Households: 2002 Household Economic Studies," P70-115, Issued April 2008, Table 4. Median Net Worth and Median Net Worth Excluding Home Equity of Households by Age of Householder and Monthly Household Income Quintile: 2000 and 2002, p. 10, http://www.census.gov/prod/2008pubs/p70-115.pdf, cited July 23, 2010.)

Home ownership for all ages in Pennsylvania is somewhat more common (71.3 percent) than in the country as a whole (66.2 percent) but the median value of homes is lower in the Commonwealth ($97,000) than in the USA ($119,600).

Potential Savings #3: Pennsylvania has no authority under federal law to require Medicaid applicants to spend down their home equity below $500,000. But the Commonwealth could strengthen its lien and estate recovery program and utilize education and/or tax incentives to encourage people to tap their home equity for LTC. Pennsylvania could also seek a waiver from the Centers for Medicare and Medicaid services to reduce the Medicaid home equity exemption experimentally to a level more closely resembling the amount of home equity exempted in England, approximately $36,700.[71]

We cannot precisely estimate the potential savings to Medicaid without first determining what happens to home equity from the time when most aging Pennsylvanians have large amounts of it and later when they are on Medicaid receiving LTC benefits and no longer own their homes.[72] We know, however, that nationwide "3.3 million households at financial risk for 'spending-down' could use a reverse mortgage to help them pay for help at home. On average, these homeowners could receive $62,800 from a reverse mortgage to pay for immediate care needs and for early interventions such as home modifications."[73] Because Pennsylvania has about 4.1% of the U.S. population,[74] one might estimate that compared to national data (3.3 million), the Commonwealth has 135,300 (4.1% x 3.3 million) households "at risk for spending down" that could receive

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(U.S. Census, "State and County QuickFacts," Pennsylvania, http://quickfacts.census.gov/qfd/states/42000.html, cited July 23, 2010.)
According to the American Housing Survey for 2007 (http://www.census.gov/prod/2008pubs/h150-07.pdf), the median value of an elderly-owner-occupied home in the United States was $168,654. According to the Historical Census of Housing Tables Home Values (http://www.census.gov/hhes/www/housing/census/historic/values.html), the median value of a home in Pennsylvania as of 2000 was 81.1 percent of the national average ($97,000 for PA compared to $119,600 for the USA).

[70] According to a report published by the National Council on the Aging: "Reverse mortgages can provide additional funds for a broad range of older homeowners:

- 0.4 million Medicaid beneficiary households could be candidates for using a reverse mortgage to pay for long-tem care at home. On average, these homeowners could receive a Home Equity Conversion Mortgage (HECM) loan potentially worth $51,229. These funds could pay for living expenses, along with services and supports, not covered by Medicaid.
- 1.4 million poor homeowners who do not receive Medicaid would be a candidate to use a reverse mortgage. They could access a lump sum or line of credit worth on average $55,085 from a HECM loan to pay for in-home services and supports.
- 3.3 million households at financial risk for 'spending-down' could use a reverse mortgage to help them pay for help at home. On average, these homeowners could receive $62,800 from a reverse mortgage to pay for immediate care needs and for early interventions such as home modifications.
- About eight million affluent homeowners are candidates for using a reverse mortgage and could potentially receive $80,130 on average from this type of loan. This group might consider using these funds to purchase long-term care insurance." (Barbara R. Stucki, "Use Your Home to Stay at Home: Expanding the Use of Reverse Mortgages for Long-Term Care: A Blueprint for Action," The National Council on the Aging, January 2005, pps. v-vi; http://www.reversemortgagetimes.org/guides/reverselongterm.pdf.)

[71] 23,500 British pounds at the July 28, 2010 exchange rate of $1.5607 per pound gives $36,676. "[T]hose with assets - which in most cases will include the value of their home - of more than £23,500 are given no help at all with care costs." (Source: "Long-term care: get the best deal now, A new commission is to investigate the best way of funding care for our ageing population. But what steps can families take now?," *Telegraph.co.uk*, July 21, 2010; http://www.telegraph.co.uk/finance/personalfinance/7902277/Long-term-care-get-the-best-deal-now.html.)

[72] What happens to home equity before people become eligible for Medicaid? Some possibilities include transfers outside the five-year transfer-of-assets penalty window, sale of the home with re-purchase of an interest in an adult child's home, and life estates with reserved special powers.

[73] (Barbara R. Stucki, "Use Your Home to Stay at Home: Expanding the Use of Reverse Mortgages for Long-Term Care: A Blueprint for Action," The National Council on the Aging, January 2005, pps. v-vi; http://www.reversemortgagetimes.org/guides/reverselongterm.pdf.)

[74] Ari Houser, Wendy Fox-Grage, Mary Jo Gibson, "Across the States: Profiles of Long-Term Care and Independent Living," eighth edition, 2009, AARP, Washington, DC, p. 264; http://assets.aarp.org/rgcenter/il/d19105_2008_ats.pdf.

$62,800 each or $8,478,000,000 in total from reverse mortgages to help them pay for their own long-term care and stay off Medicaid or delay Medicaid dependency.

Query: Is the purpose of Medicaid to ensure access to quality care for people in need or to shelter baby-boomer inheritances from the cost of their parents' long-term care?

Source #4: **Private long-term care insurance**.[75] Market penetration by the kind of insurance that will pay for both custodial and skilled long-term care at home, in assisted living or a nursing home is commonly reported to be less than ten percent.[76] It is only half of that in Pennsylvania.[77] Conventional wisdom is that most people fail to save, invest or insure for long-term care because they are in "denial" about the risk and/or because the private insurance is unaffordable.

Truth #4: Published, peer-reviewed research confirms that between two-thirds and 90 percent of the private long-term care insurance market is crowded out by the availability of Medicaid financed long-term care.[78] People don't fail to purchase private long-term care exclusively because of denial or cost. Rather, they don't buy it because they don't think they need it and they don't think they need it because Medicaid has paid for most expensive long-term care since 1965. In fact, the easy availability of Medicaid after the insurable event occurs has enabled the public's denial of LTC risk and cost.

Potential Savings #4: Anything a state can do to discourage Medicaid estate planning, encourage asset spend down and home equity conversion, and incentivize the purchase of long-term care insurance will cause more citizens to take the risk of long-term care seriously and plan

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[75] Ninety-three companies write long-term care insurance coverage in Pennsylvania and 17 companies actively market "long-term care partnership" policies. Pennsylvania's Insurance Department is one of the strongest and most aggressive long-term care insurance regulators in the country. The Department has been at the forefront in combating agent abuse such as churning, or rewriting policies to get higher first-year commissions, in the 1990s; implementing a new "rating law" in the 2000s; and most recently enhancing producer training requirements and implementing a newly passed "internal grievance" law. Pennsylvania has had a disproportionate number of "monoline" carriers specializing exclusively in long-term care insurance, so the Department has led the nation in dealing with challenges from "closed books" of business often associated with such carriers. Citizens of the Commonwealth benefit from the Insurance Department's highly motivated and dedicated regulatory team. (Based on interview with several representatives of the Pennsylvania Insurance Department on July 14, 2010.)

[76] A much higher estimate of LTC insurance market penetration in Pennsylvania was published by the Pennsylvania Senior Care and Services Study Commission: "The Long-term Care Financing Strategy Group estimates LTCI market penetration in Pennsylvania was 36 percent for people ages 55 to 84 with more than $35,000 in annual income." This estimate is misleading because it excludes a large group of people likely to own LTC coverage, *e.g.*, people over 85 years of age; people 45 to 54 years of age, and people with less than $35,000 per year of income. (Pennsylvania Senior Care and Services Study Commission, "Initial Review: Current Care, Services, and Resources for Pennsylvanians Age 65 and Older," Harrisburg, Pennsylvania, April 30, 2009, p. 27.)

[77] Data from 2009 and 2008 Long Term Care Experience Reports published by the National Association of Insurance Commissioners, as cited in "The 2010 Sourcebook for Long-Term Care Insurance Information," indicate there are 250,028 LTC "insured lives" in Pennsylvania as of 2008, up from 244,537 in 2007. Pennsylvania's age 45 plus population, the cohort most likely to own LTC insurance, is 4,755,822. Thus, LTC insurance market penetration in Pennsylvania is 5.3%. (Source for population estimate is The Pennsylvania State Data Center, Table DP-1. Profile of General Demographic Characteristics: 2000 Geographic Area: Pennsylvania, March 25, 2002 from U.S. Census Bureau, Census 2000, http://pasdc.hbg.psu.edu/pasdc/PA_Stats/census_data/census_2000/population/pennsylvania/DP1/State.htm.)

[78] Low market penetration for private long-term care insurance in a state with generous access to Medicaid-funded LTC benefits comports with research findings that confirm the impact of Medicaid "crowd out." For example: "We examine the interaction of the public Medicaid program with the private market for long-term care insurance and estimate that Medicaid can explain the lack of private insurance purchases for *at least two-thirds and as much as 90 percent of the wealth distribution*, even if comprehensive, actuarially fair private policies were available." (Jeffrey R. Brown and Amy Finkelstein, "The Interaction of Public and Private Insurance: Medicaid and the Long-Term Care Insurance Market," National Bureau of Economic Research, December 2004, cited from the paper's "Abstract," http://www.nber.org/~afinkels/papers/Brown_Finkelstein_Medicaid_Dec_04.pdf), emphasis added.

responsibly.[79] Private LTC insurance is actually much more affordable than commonly believed.[80] Stronger promotion of the state's "Long-Term Care Partnership"[81] program and initiation of tax incentives for the purchase of LTC insurance, such as many other states have,[82] would enhance private LTC financing and relieve some of the financial burden on Medicaid. Published research that suggests more private long-term care insurance will not reduce Medicaid LTC costs does not take into account the potential effect of eliminating or reducing Medicaid's huge home equity exemption.[83] It is highly likely that in the absence of Pennsylvania Medicaid's $500,000 home equity exemption or with maximum estate recovery of home values, many more people would choose private long-term care insurance as a means to pay for their care while protecting their entire estates without having to tap their home equity through reverse mortgages.

Query: Why should anyone expect the public to purchase private long-term care insurance when they can ignore the risk and cost of long-term care, avoid the premiums for private coverage, wait to see if they ever need expensive extended care, and if they do, transfer the cost to Medicaid without significant asset spend down or estate recovery liability?

Conclusion

Pennsylvania faces a severe budgetary crisis. The cost of Medicaid, especially its expensive long-term care component, is a big part of the problem. The Rendell Administration, the state legislature, and key public officials have invested heavily in the idea that Medicaid can provide more desirable long-term care services to a growing base of aging recipients while minimizing expenditures through "rebalancing." But caring for more Medicaid-dependent Pennsylvanians in home and community-based settings rather than nursing homes is unlikely to save money, could

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[79] According to interviewees including LTC insurance marketers (meeting on July 15, 2010) and LTC insurance regulators (meeting with Insurance Department representatives on July 14, 2010), Pennsylvania has no tax incentives to encourage the purchase of private long-term care insurance. According to AARP, Pennsylvania is one of only five states with "no state tax break for LTC insurance." (David Baer and Ellen O'Brien, "Federal and State Income Tax Incentives for Private Long-Term Care Insurance," AARP Public Policy Institute, Washington, D.C., November 2009, p. 10; http://assets.aarp.org/rgcenter/ppi/econ-sec/2009-19-tax-incentives.pdf.)

[80] How much do people pay for LTC insurance? Industry representatives say "It's less than you might think." A new survey by the American Association for Long-Term Care Insurance shows that long-term care insurance is surprisingly affordable. More than one-third of the 93,500 new buyers surveyed paid less than $1,499 per year for their coverage. Only 1 in 10 paid more than $4,000 annually. AALTCI stresses that premiums are largely age-dependent and offers buyers suggestions on keeping costs manageable. Read the report, "What People Pay For LTC Health Insurance," here: http://www.aaltci.org/news/long-term-care-association-news/report-what-people-pay-for-ltc-health-insurance.

[81] The "Long-Term Care Partnership" program enables Pennsylvanians to purchase qualified policies that allow a dollar-for-dollar increase in the Medicaid asset exemption. In other words, someone who purchases a Partnership policy with $100,000 of coverage and uses up the benefit may then qualify for Medicaid long-term care benefits while retaining an extra $100,000 in assets, *e.g.* $102,400 instead of only $2,400 as otherwise allowed in most cases. Representatives of the Pennsylvania Insurance Department (interviewed on July 14, 2010) told us they were surprised how slowly the LTC Partnership market has ramped up. LTC insurance marketers (interviewed on July 15) complained there was a "big problem with Partnership training; the program was rolled out with no advertising; and no coordination with the agents."

[82] "Specifically, in 36 states and the District of Columbia, people with long-term care insurance may qualify for a state subsidy (including the federal itemized deduction that is carried from the federal return). In 14 states, people who purchase long-term care insurance receive no state subsidy. In 9 of those 14 states, there is no broad-based income tax; in the other 5 states [including Pennsylvania] there is no state subsidy because the states neither carry through the federal itemized deduction nor offer any unique state tax benefits." (David Baer and Ellen O'Brien, "Federal and State Income Tax Incentives for Private Long-Term Care Insurance," AARP Public Policy Institute, Washington, D.C., November 2009, p. 9; http://assets.aarp.org/rgcenter/ppi/econ-sec/2009-19-tax-incentives.pdf.)

[83] For example, see Government Accountability Office, "Long-Term Care Insurance Partnership Programs Include Benefits That Protect Policyholders and Are Unlikely to Result in Medicaid Savings," GAO-07-231, May 2007; http://www.gao.gov/new.items/d07231.pdf.

lead more people to seek Medicaid coverage, and reduces the public's incentive to save, invest or insure privately for long-term care.

With the baby-boomer "Age Wave" about to crest and crash nationally, but especially in states with the biggest aging populations like Pennsylvania, it behooves policy makers to analyze the risk of expanding public financing of long-term care. At least, they should question whether "rebalancing" in the absence of stronger eligibility controls is fiscally wise and they should explore ways to encourage private long-term care financing alternatives such as personal asset spend down, stronger liens and estate recoveries, home equity conversion, and private long-term care insurance.

Medicaid has paid for most expensive long-term care since 1965, but the practical reality is that it cannot do so much longer. Tough questions must be asked and new directions considered. By limiting Medicaid LTC eligibility and encouraging more private financing of long-term care from private sources, Pennsylvania's Medicaid program could realistically hope to provide the home and community-based services most people prefer to a smaller base of recipients without excessively straining limited budget resources.

Query: What measures can Pennsylvania Medicaid officials undertake to change the program from the dominant financer of long-term care for nearly all citizens that it has become into a high-quality, financially viable, social safety net for people most in need?

Recommendations

I. Find out how much potential private long-term care financing is diverted to rising Medicaid expenditures by conducting a "recovery audit"[84] of a valid random sample of LTC cases.[85]

1. Assets transferred before the five-year transfer of assets look-back period.
2. The $500,000 home equity exemption.
3. The business exemption.
4. The automobile exemption.
5. The prepaid burials exemption.
6. The term life insurance exemption.
7. The household goods exemption.
8. Purchase of exempt assets.
9. The "reverse half-a-loaf" technique.
10. Irrevocable income-only trusts.
11. Medicaid friendly annuities.
12. Life estates with special powers.

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[84] "Recovery audits allow private contractors to audit fraud in Medicaid and other programs, and collect from those cheating the system. Recovery audits are a nationally recognized best practice for disbursements management and improving operational efficiency. Additionally, recovery audits will not cost the state any resources, as the contractor's costs are deducted from any dollars recovered, making the recovery audits self-funding. Typically, Medicaid is the largest area where overpayments and fraud are uncovered, but audits have been done in other areas as well." (Elizabeth Stelle, "Welfare Fraud and Abuse," testimony by Elizabeth Stelle, Research Associate, Commonwealth Foundation, Harrisburg, Pennsylvania, June 2, 2010, http://www.commonwealthfoundation.org/research/detail/welfare-fraud-and-abuse.)

[85] Because we were unable to interview or get written questions answered by Pennsylvania Medicaid LTC eligibility policy specialists for this study, we repeat here the list of eligibility "leaks" we identified in a recent study of Rhode Island's Medicaid program. All are potential problems for Pennsylvania as well. See Stephen A. Moses, "Doing LTC RIght," Ocean State Policy Research Institute, Providence, Rhode Island, January 2010; http://www.centerltc.com/pubs/Doing_LTC_RIght.pdf.

13. Purchase of an interest in another's home.
14. Fraud or unintentional misrepresentation of personal finances.
15. Other Medicaid planning techniques.
16. Failure to pursue TEFRA liens.
17. An unmaximized Medicaid estate recovery program.

Based on the findings of this review and analysis, develop a corrective action plan to close eligibility loopholes and discourage abusive Medicaid planning practices.

II. Seek authority through a waiver from the Centers for Medicare and Medicaid Services to reduce Medicaid LTC eligibility exposure and to maximize private LTC financing alternatives.

1. Extend the look-back period during which assets transferred for less than fair market value to qualify for Medicaid incur an eligibility penalty from five years (currently) to ten years (as in Germany, a socialized health care system.)
2. Eliminate or radically reduce the home equity exemption for Medicaid LTC eligibility from $500,000 (currently) to no more than $35,700 (as in the United Kingdom, another socialized health care system.)
3. Preclude the use of trusts, annuities, promissory notes, the "reverse half-a-loaf" strategy and other Medicaid planning techniques to divest or shelter assets from Medicaid LTC financial eligibility limits.

III. Enhance Pennsylvania's estate recovery program.[86]

1. Establish a TEFRA lien program to secure recovery of value from houses not needed by an exempt dependent relative.[87]
2. Hire more estate recovery personnel until the marginal rate of return is reached, i.e. add staff as long as each new hiring increases lien and estate recoveries.[88]
3. Require nursing homes to report deaths of Medicaid dependent residents to the estate recovery unit in order to supplement and expedite current methods of death notification and probate initiation.
4. Do not automatically waive recovery of estates with gross values of $2,400 or less. Pursue all estates for which recovery is cost effective.[89]
5. Seek passage of the "uniform probate code" by the state legislature.[90]

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[86] We were not given the opportunity to interview Pennsylvania Medicaid estate recovery staff. We did receive answers to written questions on which these recommendations are based.

[87] TEFRA liens allow state Medicaid programs to place liens on otherwise exempt houses to secure their value for later estate recovery if and only if no surviving exempt dependent relative resides in the home and the Medicaid recipient has been medically determined to be unable to return to the home within six months. For a detailed explanation of Medicaid lien and estate recovery laws and regulations, see Stephen A. Moses, "Medicaid Estate Recoveries: National Program Inspection," OAI-09-86-00078, Office of Inspector General, Seattle, Washington, June 1988; http://oig.hhs.gov/oei/reports/oai-09-86-00078.pdf. Some of the laws and regulations governing liens and estate recoveries have changed since the publication of this report.

[88] Pennsylvania Medicaid's estate recovery benefit to cost ratio is 17 to one. In other words, the program recovers $17 for every $1 invested in the recovery effort. More staff and stronger recovery efforts should be added to maximize total recoveries.

[89] Oregon's average estate recovery was only $2,000 during a period of highly successful total recoveries. By arbitrarily passing up all estates of $2,400 or less, Pennsylvania could be missing nearly half of potential recoveries for this reason alone.

[90] "The **Uniform Probate Code** (commonly abbreviated **UPC**) is a uniform act drafted by National Conference of Commissioners on Uniform State Laws (NCCUSL) governing inheritance and the decedents' estates in the United States. The primary purposes of the act were to streamline the probate process and to standardize and modernize the various state laws governing wills, trusts, and intestacy." (Wikipedia, cited July 28, 2010, emphasis in the original.)

6. Continue to seek authority as authorized in the Omnibus Budget Reconciliation Act of 1993 (OBRA '93) to recover from assets that do not pass through formally probated estates, *e.g.* assets that pass through joint tenancy with right of survivorship.[91] Aggressive pursuit of the following recommendation may help.
7. Establish the moral high ground of estate recovery by educating the public, the bar, and the judiciary about the importance of ending the use of Medicaid as "free inheritance insurance" for heirs.[92]
8. Track and seek recoveries from the estates of deceased spouses of Medicaid's cost of care paid for their predeceased spouses on Medicaid, AKA "spousal recoveries." GAO estimated in 1989 that pursuing spousal recoveries could increase California's total estate recoveries by 70% from $15.8 million to $26.8 million.[93]
9. Seek stronger authority to capture accounts held by nursing homes in the Medicaid recipients' names until estate liability is determined.
10. Establish a system to recover hard assets, including investment-grade property, from recipients' estates before the property is taken by heirs.
11. Expand repayment plans whereby families can satisfy their estate recovery liability over time. Allow them to retain ownership of homes or other property if they wish by repayment with interest through open-ended mortgages or contracts on deeds.
12. Conduct a study of successful estate recovery programs, especially Oregon's, and implement best practices. Seek state legislative authority for changes that require it.
13. To eliminate all cost to the state and maximize recoveries, consider hiring an outside contractor on contingency to do estate recoveries in exchange for a percentage of the amount recovered.

IV. Educate Pennsylvanians about the importance of planning for long-term care.
1. Explain the risk and cost of long-term care in the media and in public meetings.
2. Publicize what the state will and will not pay for and for whom under new, stricter eligibility rules.
3. Describe measures taken to restrict access to Medicaid LTC and why they are necessary to ensure access to quality care for the needy, as public funds diminish.

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[91] The Medicaid estate recovery unit reports that "Pennsylvania has previously attempted to increase our authority to the recovery of non-probate estate assets. It has failed each time it has been proposed."

[92] To its credit, the Pennsylvania Estate Recovery Program has been active in this regard already, having trained over 1000 people this year and provided information about estate recoveries on the Web and by distributing brochures statewide. Nevertheless, this explanation from program officials is telling and suggests further education of legislators, policy makers, and the public would be well advised: "Estate Recovery Program is always sensitive due to the nature of the recovery work. When you are collecting from the estates of deceased MA clients it causes a strong response. During the last legislative session the Department had proposed an expansion of the Program which garnered a very strong reaction from the general public. The proposed expansion was not passed and there is no current discussion to move forward with expansion any time soon. Families will contact their legislators or call the Estate Recovery Program directly to lodge complaints and ask for special dispensation. The Elder Law Bar is very active in Pennsylvania and frequently publishes articles on the Estate Recovery Program. Not all of the articles cast a positive light on the Program."

[93] "Spousal recoveries," *i.e.*, recoveries from the estates of spouses of predeceased Medicaid recipients of the Medicaid spouse's cost of care, can be very substantial. According to GAO: "Because about one-third of Medicaid nursing home residents who own a home have a spouse living in the community, a significant portion of potential recoveries is lost unless a state authorizes recoveries from the estates of surviving spouses. For example, GAO estimates that California will recover about $15.8 million from the estates of Medicaid recipients admitted to nursing homes in 1985 under its existing recovery program. But it could recover an additional $11 million if the state enacts legislation to authorize recoveries from the estates of the surviving spouse when he or she, in turn, dies." (GAO, "Medicaid: Recoveries from Nursing Home Residents' Estates Could Offset Program Costs," GAO/HRD-89-56, March 1989, p. 4; http://archive.gao.gov/d15t6/138099.pdf.)

4. Emphasize the fact that stronger lien and estate recovery rules will ensure everyone who can pay will pay for long-term care, either up front as a private payer or after the fact through Medicaid estate recovery.

V. Implement measures to encourage the use of reverse mortgages and private long-term care insurance to fund long-term care privately.

1. Consider both tax and Medicaid eligibility incentives to promote the use of reverse mortgages to fund long-term care privately.
2. Consult the National Council on the Aging's (NCOA) report titled "Use Your Home to Stay at Home" for additional ways to encourage the use of home equity conversion to fund LTC.[94]
3. Publicize and expand Pennsylvania's Long-Term Care Partnership program.
4. Consider and implement tax incentives to encourage the purchase of private long-term care insurance.

Queries Listed

As explained in the "Introduction," we have interspersed questions we would like Pennsylvania Medicaid officials to answer throughout this report. Those queries are compiled here:

Query: How do Pennsylvania Medicaid officials justify their confidence that rebalancing program services from dominantly institutional care (with its economy of scale) to mostly home and community-based care (dispersed and labor-intensive) will save money in spite of the evidence adduced here to the contrary?

Query: How can Medicaid sustain access to and quality of long-term care as the baby-boomer generation ages without paying adequate reimbursement levels to long-term care providers at all levels of care?

Query: As Pennsylvania Medicaid rebalances from nursing home care citizens would rather avoid to home and community-based care they'd much prefer, how can the program avoid "reverse cost-shifting" away from free care currently provided by families and private LTC financing toward Medicaid?

Query: Given that eligibility for Medicaid-financed long-term care is easy to obtain without significant personal spend down after expensive, extended care is needed, wouldn't it follow that the public may be desensitized to the risk and cost of long-term care? Could that explain why most people fail to plan, save, invest or insure for LTC?

Query: How do Pennsylvania Medicaid officials justify or rationalize leaving potential estate recoveries uncollected from deceased recipients when "It is their children, after all, who stand to inherit whatever property remains after the costs of long-term care are paid and who currently reap the windfall of Medicaid subsidies." (USDHHS Inspector General Study, 1988)

Query: Is the purpose of Medicaid to ensure access to quality care for people in need or to shelter baby-boomer inheritances from the cost of their parents' long-term care?

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[94] Barbara R. Stucki, "Use Your Home to Stay at Home: Expanding the Use of Reverse Mortgages for Long-Term Care: A Blueprint for Action," The National Council on the Aging, January 2005, http://www.reversemortgagetimes.org/guides/reverselongterm.pdf.

Query: Why should anyone expect the public to purchase private long-term care insurance when they can ignore the risk and cost of long-term care, avoid the premiums for private coverage, wait to see if they ever need expensive extended care, and if they do, transfer the cost to Medicaid without significant asset spend down or estate recovery liability?

Query: What measures can Pennsylvania Medicaid officials undertake to change the program from the dominant financer of long-term care for nearly all citizens that it has become into a high-quality, financially viable, social safety net for people most in need?

Appendix A: The CLASS Act

The Community Living Assistance Services and Supports (CLASS) Act became law when President Obama signed the Patient Protection and Affordable Care Act, otherwise known as "health reform," on March 23, 2010.

CLASS is a program intended to provide a source of private financing for long-term care services enabling beneficiaries to purchase the kind and level of care most appropriate for their needs. For this reason, some believe CLASS, when fully implemented, will be an important new source of LTC financing that will relieve that burden on Medicaid.

Medicaid management staff strongly articulated that opinion during a meeting with us on July 13, 2010. They said: "We see optimism in CLASS. Maybe in our lifetimes, CLASS will be a major viable alternative to finance long-term care, a sleeping giant similar to Social Security and Medicare in potential. We don't see any downside." Is this optimism justified?

Insurance Department representatives conveyed a far more reserved opinion in our meeting with them on July 14, 2010. The insurance regulators opined that most people would probably opt not to participate in the program for the same reason few buy private long-term care insurance. But, they indicated, the very existence of CLASS "could soothe people into thinking they are protected" and thus impede growth of the private LTC insurance market.

Who is right? Medicaid management's optimism and insurance regulators' skepticism about CLASS led us to conclude that this report must contain some facts and evaluation about the new program.

Facts about CLASS

- CLASS is Title VIII of the Patient Protection and Affordable Care Act of 2010.[95]
- CLASS advocates define it as a "New voluntary nationwide long term services and supports insurance program for persons with disabilities and seniors with chronic illness."[96]
- CLASS is "effective" January 1, 2011, but is not expected to become operational until late 2012 or 2013.
- Enrollment in CLASS of eligible employees is automatic, either administered by employers who agree to participate or by other means to be determined.
- Anyone may opt out of CLASS anytime.

[95] Patient Protection and Affordable Care Act (Enrolled as Agreed to or Passed by Both House and Senate) [PDF], AKA "Health Reform," AKA "ObamaCare," signed by President Obama on March 23, 2010.
[96] Definition attributed to the American Association of Homes and Services for the Aging, a trade association of nonprofit LTC providers.

- To be eligible for CLASS, a person must be 18 years of age or older, employed earning at least $1,120 per quarter, and not in a nursing home on Medicaid or in jail.
- Premiums will be determined by the Secretary of the U.S. Department of Health and Human Services (hereinafter "the Secretary") based on what the program can afford but are expected to average $125 per month, varying by age.
- No medical underwriting is allowed.
- Participants must pay into CLASS for five years before becoming eligible for benefits.
- Benefit triggers include the verified need for help with 2 or 3 "activities of daily living"[97] depending on what the Secretary decides the program can afford and/or cognitive impairment.
- Benefit levels will depend on what the program can afford as determined by the Secretary, but by statute they can be no lower that $50 per day.
- Benefits will be paid electronically into a debit card daily or weekly with no aggregate lifetime limit.
- Benefits may be used to purchase home modifications, assistive technology, accessible transportation, homemaker services, respite care, personal assistance services, home care aides, nursing support, but also assisted living or nursing home care.
- CLASS benefits will be coordinated with Medicaid so that CLASS beneficiaries will be able to keep more than the small "personal needs allowance" Medicaid otherwise allows.[98]
- CLASS benefits are disregarded in determining eligibility "under any other Federal, State, or locally funded assistance program," *i.e.*, Medicaid, etc.
- Premiums paid by participants go into a CLASS "Life Independence Account" that is required by the statute to operate like Social Security's trust fund.
- Various audits must be performed at intervals to ensure that the CLASS remains solvent for the next 75 years.
- Administrative costs for CLASS may not exceed 3% of premiums collected.

General Criticism of CLASS

- The program is "one size fits all," unadaptable to individual needs.
- The Secretary decides premium levels, benefit triggers, benefit levels, and everything of importance based on the program's solvency. Participants won't know until much later what they will get from CLASS.
- Participants have no "contract" or "policy" as with a private long-term care insurance product.
- CLASS ignores "risk management" by applying no medical underwriting. It is vulnerable to adverse selection because of this "guaranteed issue" policy.
- The CLASS requirement that participants must pay premiums for 5 years before becoming eligible for benefits is an unusually long "elimination period."
- The CLASS "trust fund" will be used immediately to fund other federal government operations. It will contain only treasury bonds, so that when CLASS claims come due, the government will have to repay the bonds' principal plus interest in order to pay the program's promised benefits.

[97] Activities of daily living (ADLs) mentioned in the CLASS statute include Eating, Toileting, Transferring, Bathing, Dressing, and Continence.
[98] CLASS beneficiaries who are on Medicaid will be able to retain 5% of their benefit if in a nursing home and 50% if receiving home and community-based services.

- CLASS premiums collected but unspent during the program's first ten years were treated as an offset to the federal deficit instead of being secured as reserves to pay claims later.
- CLASS's guaranteed eligibility, guaranteed benefits, and guaranteed lifetime coverage leave the program vulnerable to rapid actuarial insolvency.

Comments on CLASS by Professional Actuaries

- "In general, voluntary, unsubsidized, and non-underwritten insurance programs such as CLASS face a significant risk of failure as a result of adverse selection by participants… . This effect has been termed the 'classic assessment spiral' or 'insurance death spiral.'" (CMS Chief Actuary, April 2010)[99]
- "While the eventual effects of complex financial programs are difficult to forecast, the CLASS Act as currently structured is conspicuous because it introduces guaranteed-issue LTC benefits without installing the kinds of protections necessary to minimize adverse selection risk." (Allen Schmitz of Milliman)[100]
- "We estimate that about 2.8 million persons would participate in the program by the third year. This level represents about 2 percent of potential participants, compared to a participation rate of 4 percent for private long-term care insurance offered through employers." (CMS Chief Actuary, November 2009)[101]
- "In our view, the opt-out and guaranteed issue provisions of the plan will attract a disproportionate share of higher-risk individuals such that, in a relatively short time period, future increases in premiums and/or reductions in benefits may be required to make the program sustainable." (American Academy of Actuaries, November 2009)[102]
- "Our actuarial analysis indicates that the proposed structure and funding approaches in the CLASS Act, as introduced on June 9th, will not only be unsustainable within the foreseeable future, but are unlikely to cover more than a very small proportion of the intended population." (American Academy of Actuaries, July 2009)[103]

Published Critiques of CLASS

- The CLASS Act: Repeal Now, or Face Permanent Taxpayer Bailout Later, Heritage Foundation, July 23, 2010. Quote: "Healthy individuals rationally intend to bypass CLASS because it is a bad deal for them, especially compared to insurance policies they could purchase on the open market." (p. 4)
- CLASS Act: Madoff Would Be Proud, May 18, 2010, report of the Senate Joint Economic Committee Republicans. Quote: "Obamacare includes a new long-term care entitlement called CLASS that masks health care reform's full costs. CLASS will add to

[99] April 22, 2010 report by Centers for Medicare and Medicaid Services Chief Actuary Richard S. Foster titled "Estimated Financial Effects of the 'Patient Protection and Affordable Care Act,' as Amended," p. 15; http://camp.house.gov/webreturn/?url=http://republicans.waysandmeans.house.gov/UploadedFiles/OACT_Memorandum_on_Financial_Impact_of_PPACA_as_Enacted.pdf.

[100] Allen Schmitz, "Adverse Selection in the CLASS Act," Milliman Health Reform Briefing Paper, December, 2009, p. 1; http://publications.milliman.com/research/health-rr/pdfs/adverse-selection-class-act.pdf.

[101] November 13, 2009 report by Centers for Medicare and Medicaid Services Chief Actuary Richard S. Foster titled "Estimated Financial Effects of the 'America's Affordable Health Choices Act of 2009' (H.R.3962), as Passed by the House on November 7, 2009," p. 15; http://camp.house.gov/UploadedFiles/OACT_Memorandum_on_Financial_Impact_of_H_R__3962__11-13-09_.pdf.

[102] American Academy of Actuaries, "Critical Issues in Health Reform: Community Living Assistance Services and Supports Act," November 2009, pps. 2-3; http://www.actuary.org/pdf/health/class_nov09.pdf.

[103] American Academy of Actuaries July 22, 2009 letter to U.S. Senate Committee on Health, Education, Labor and Pensions regarding "Actuarial Issues and Policy Implications of a Federal Long-Term Care Insurance Program.," p. 1; http://www.actuary.org/pdf/health/class_july09.pdf.

federal deficits within 15-20 years. It is financially unsustainable due to poor design. Fixing it will require premium hikes, benefit cuts, and/or mandatory participation." (p. 1)

- The Other New Health Entitlement, article on CLASS in *Facing Facts Quarterly*: *A Report about Entitlements & the Budget* from The Concord Coalition, Volume V, Number 3, New Series, December 2009. Quote: "As it stands, the CLASS Act embodies the worst sort of budgetary and actuarial chicanery. It pretends that premiums can be double-counted both as a near-term budget offset and as long-term savings. And it violates the most basic principles of sound insurance design by failing to provide for either underwriting or a mandate and by underfunding the oversight needed to detect fraud." (p. 2)
- Lori Montgomery, "Proposed long-term insurance program raises questions: Opponents warn plan could require vast infusions of cash," *Washington Post*, October 27, 2009. Quote: "Sen. Kent Conrad (D-N.D.) [Chairman of the U.S. Senate Budget Committee] called the CLASS Act 'a Ponzi scheme of the first order, the kind of thing that Bernie Madoff would have been proud of,' and he vowed to block its inclusion in the Senate bill."

Appendix B: Medicaid Planning in Pennsylvania

Following are examples of Pennsylvania Medicaid planners, their advertising claims, and some of the techniques they use to impoverish clients artificially to qualify them for Medicaid long-term care benefits.

One of the more egregious purveyors of Medicaid planning advice is national in scope but claims to provide Pennsylvania-specific recommendations here: http://www.medicaidhelp.com/pa/. The following information was extracted from this website on July 26, 2010.

"Don't give all the assets to the nursing home or to Pennsylvania Medicaid...
You don't have to!!!"

"Learn how Pennsylvania patients can qualify for Medicaid (using approved 2010 Pennsylvania Medicaid eligibility rules), while protecting assets, even if already in care."

"TEST YOUR PENNSYLVANIA MEDICAID KNOWLEDGE... True or False?
* The new Deficit Reduction Act (DRA) rules will keep you from protecting assets from Pennsylvania Medicaid? - False
* You must 'spend down' everything on care before qualifying for Medicaid? - False
* If you give away assets, you are automatically disqualified from Medicaid for 5 years? - False
* It is illegal to give away assets to qualify for Medicaid? - False
* You can give each of your children and grandchildren up to $13,000 without affecting Medicaid eligibility? - False
* A Living Trust will protect assets from Medicaid? - False
* Once in a nursing home, there is nothing you can do to protect assets from Pennsylvania Medicaid? - False
If you believe any of these myths, you need to find out how the Medicaid program really works!!! Our video will teach you the real rules of Medicaid eligibility!"

"**But did you know that you can easily learn how (using approved Federal and State MEDICAID eligibility rules) to transfer assets and qualify for nursing home or other long-**

term care MEDICAID - quickly! Anyone can do it - you just need to learn how!" [Emphasis added.]

The following information was extracted on July 26, 2010 from the website of Robert C. Gerhard III**,** Esquire, Gerhard & Gerhard Law Offices, 222 S. Easton Road, Suite 104 Glenside, PA 19038 (near Phil.), http://www.paelderlaw.net/home/.

"So many times clients come to our office under the mistaken impression that there is nothing that can be done to protect assets from nursing home costs. Much of the popular literature gives readers the idea that unless assets are given away three years prior to a nursing home placement, it just about all goes to the nursing home. The answer actually depends upon the specific facts of your case. Though recently enacted legislation significantly restricts the use of some techniques, other asset protection strategies remain viable, especially for married couples where one spouse requires long-term care. **Mr. Gerhard can guide you through the Medicaid application process (for home care under the PDA 60+ Waiver Program or nursing facility care) and enable you to shelter what can be protected under the law**." [Emphasis added.]

"Whether you are just planning ahead, facing an increasingly difficult time providing care at home, or have determined placement in a nursing facility to be unavoidable, Mr. Gerhard can help. Protecting a lifetime of savings, or at least as much as is legally possible, from nursing home costs does not happen by accident; it takes careful planning."

Medicaid Planning Law Center, 201 Penn Center Blvd., Suite 400, Pittsburgh, PA 15235, information extracted July 26, 2010 from http://www.medicaidplanninglawctr.com/MedicaidPlanningandAssetProtection.shtml.

"It is possible to arrange your assets to protect them from nursing home costs and qualify for Medicaid assistance. With nursing homes in Pennsylvania averaging $8,000 a month, assets can dwindle rapidly. Our Asset Protection Attorneys care about you and your family. You do not have to go broke while paying for your loved one in a long-term care facility. We will help you maximize your legal strategies of transferring assets, protect your assets, and protecting the quality of life of your loved ones both in and out of the nursing home.

"There are many options to protecting your assets from nursing home costs.
*** Irrevocable trusts**
*** Gifting**
*** Converting non-exempt assets into exempt assets**
*** Legal spend downs**
*** Purchasing annuities and long-term care insurance** [Emphasis added.]

"We welcome you to contact the Medicaid Planning Law Center to learn more about the options we have available for protecting your assets and planning for Medicaid."

The Elder Law Firm of Robert Clofine, 120 Pine Grove Commons, York, Pennsylvania 17403-5151, http://www.estateattorney.com/index.html, information extracted July 26, 2010.

"Because the Welfare Department is waiting to collect upon your death, there are rules designed to keep you from giving your house away while you are alive. If you are about to enter a nursing home and still own a residence, you may be able to transfer the house to another family member so that it will not have to be sold when you die. Without advance planning, however, the options are limited.

"First, the home can always be transferred to your spouse. Second, you can transfer the house to a child if the child is under age 21, or is blind or disabled. Third, transfers to a brother or sister are allowed if the sibling had an equity interest in the home and resided with you in the house for at least 1 year before you enter the nursing home. Finally, a transfer to a child is permitted if the child lived with you for at least 2 years before you go to the nursing home and the child provided care which allowed you to stay at home, rather than enter a facility. **If you don't fall into these categories, a transfer of the home may render you ineligible for medical assistance unless the transfer was properly planned in advance of your medical assistance application**." [Emphasis added.]
(http://www.estateattorney.com/elderlaw-articles/medicaid-preservingyourhome.html)

Pennsylvania Care Management, 49 East Fourth Street Williamsport, PA 17701, http://www.paannuity.com/, information extracted July 26, 2010.

"**PaANNUITY.COM provides Pennsylvania attorneys with Medicaid Qualifying Annuities to help their clients qualify for Medicaid**. We work with Pennsylvania attorneys to provide annuities that conform to Federal and State Medicaid laws and regulations. [Emphasis added.]

"PaANNUITY.COM has the knowledge and experience to guide you and your clients in the right direction. Matthew Parker, the President of the company is a Certified Elder Law Attorney. He specializes in helping his clients obtain Medicaid benefits for long-term care. He was the attorney for the community spouse in James v. Richman, the case that serves as the precedent for the use of community spouse Medicaid Qualifying Annuities in Pennsylvania.

"If you are a Pennsylvania Elder Law or Estate Planning attorney whose clients may be able to benefit from the purchase of a Medicaid Qualifying Annuity, PaANNUITY.COM is your trusted source."

Law Office of Adam S. Bernick, 2047 Locust Street Philadelphia, PA 19103 http://www.bernicklaw.com/, information extracted July 26, 2010.

"Planning is Critical: Rising costs and increasingly complex regulations make it critical to have a skilled Medicaid planning attorney help you evaluate your options. **Medicaid planning involves finding ways to preserve assets while receiving medical care. Ideally, this process is undertaken years in advance. However, even if an emergency arises, and you or a loved one are forced to go from the hospital into a nursing home, there are ways we can help you**. [Emphasis added.]

"What if I Don't Plan in Advance?: Even if it is too late to shelter all your assets, our skilled Medicaid planning lawyer can help. For example, you can learn from him what medical, personal, and nursing home expenses can be reimbursed, or are exempt from spend-down requirements. We can investigate nursing home plans that preserve some assets. Some

techniques that we have used in Medicaid planning include reverse mortgages and annuities. Other approaches may include selling some assets, for which our attorney hires an appraiser on your behalf. Finally, if you or your family is required to reimburse the state for Medicaid expenses, our skilled attorney has been successful negotiating for a lesser amount. In all of these efforts to protect your assets, our skilled Medicaid planning lawyer attends hearings, reviews documents, and works hard to help you protect those assets you worked so hard to accumulate." (http://www.bernicklaw.com/PracticeAreas/Medicaid-Planning.asp)

Cantor & Meyer, P.C., 2 S. Orange Street (above the Sovereign Bank branch), Suite 201, Media, PA 19063, information extracted July 26, 2010 from http://www.cantormeyer.com/PracticeAreas/Elder-Law.asp.

"Many people fear that nursing home care will deplete their estate and deny their children an inheritance. **With advance planning under the advice of qualified legal counsel, it is possible to preserve assets for a spouse or heirs and still receive quality care**. Elder law attorney Neil Meyer will sit down with you to explore your options." [Emphasis added.]

"Couples are typically required to spend down nearly all of their assets to qualify for Medicaid coverage for nursing home care. Recent changes in federal law have made it harder -- but not impossible -- to gift assets to children, transfer property, or preserve wealth in trusts. Neil Meyer advises clients on options to legally safeguard assets, including gifting within the allowable time frame, and "In Trust For" accounts that retain limited control of assets."

Sikov and Love, PA**,** 14th Floor, Lawyers Building, 428 Forbes Avenue Pittsburgh, PA information extracted July 26, 2010 from http://www.sikovandlove.com/PracticeAreas/Medicaid-Medical-Assistance.asp.

"Our long term care planning services include helping you prepare a Medicaid plan that is specific to your personal situation. **A plan for an individual with modest assets can be quite different from a plan for a person with substantial assets**. We thoroughly evaluate your entire situation--including income, savings, and assets. We are highly skilled in helping individuals protect assets and qualify for Medical Assistance." (Emphasis added.)

Zachariah & Brown Elder Law Attorneys, 4500 Walnut Street, McKeesport PA, 15132, information extracted July 26, 2010 from http://www.pittsburghelderlaw.com/medicaidplanning.html.

"**Typically we can preserve somewhere between 40% to 100% of the assets and assist in obtaining Medicaid much faster**." [Emphasis added.]

"For Single Individuals there are 30 strategies which can be employed to protect assets, married couple, there are 60. We walk you through each of them to see which ones work for you and appeal to you. At the end of the meeting we know what is involved and can quote you a flat fee for our services. This fee will be your only legal bill for service. Medicaid application and filing fees are extra."

"We first begin by making final gifts in order to bring the estate down to the allowable $2,400.00 level. There is a fee for this which is in addition to the initial fee."

"Timing is very important. Each month that passes can cost you thousands of dollars. Many people think to start planning 3 years ahead of time, but the truth is that the earlier you start, the more you can protect!"

Levandowski & Darpino, LLC, 17 Mifflin Ave., Suite 202, Havertown, PA 19083, information extracted July 26, 2010 from http://www.levandowskidarpino.com/medicaid.php4.

"For all practical purposes, in the United States the only social 'insurance' plan for long-term institutional care is Medicaid. . . . Medicaid . . . is a form of welfare - or at least that's how it began. So to be eligible for Medicaid, you must become 'impoverished' under the program's guidelines."

"**Those who are not in immediate need of long-term care may have the luxury of distributing or protecting their assets in advance. This way, when they do need long-term care, they will quickly qualify for Medicaid benefits**." [Emphasis added.]

"Levandowski and Darpino specializes in elder law and elder care planning. Let us help you to:

* Plan in advance to limit the devastating expense of long-term care.
* Protect your home and life savings.
* Preserve the financial security of your spouse and dependents.
* Legally transfer assets to children and grandchildren.
* Minimize private payments of nursing home costs.
* Maximize public benefits from Medicare, Medicaid, and other programs.
* File the complicated Medicaid application. . . .

"If you wait, it may be too late to take some of the steps available to preserve your assets." (http://www.levandowskidarpino.com/elder-law-attorney.php4)

Dugalic & Landau, PC, 901 Carroll Road, Wynnewood, PA, 19096, information extracted July 26, 2010 from: http://www.dugalicandlandau.com/PracticeAreas/AssetProtection.aspx.

"There are a number of Medicaid asset protection strategies that can be utilized in order to engage in Medicaid asset protection planning. One, in particular, is a Medicaid asset protection trust. This type of trust is an irrevocable trust meaning that you would have to give up control of your assets to a trustee named in the trust. The trustee is able to be appointed by you but once the assets are transferred to the trust that trustee now controls the assets for your benefit. In addition, there are rules and regulations that must be followed in order to shield the assets of a Medicaid asset protection trust from an attempt by Medicaid to spend them down in order to qualify for Medicaid benefits.

"**Protecting your assets from a Medicaid spend down requires you to take action now regarding your Medicaid asset protection planning**. There are time limits as to when certain planning no longer becomes a viable option in the protection of assets. You should be aware of

these time limits in order to put yourself in a position to protect your assets from a Medicaid spend down. [Emphasis added.]

"The law office of Dugalic & Landau, PC offers valuable Medicaid asset protection services. Call us today in order to speak with a Medicaid asset protection attorney about how implementing Medicaid asset protection strategies and protecting your assets can help you preserve the wealth you have worked so hard to obtain. Our Medicaid asset protection attorneys are experienced and knowledgeable in legal asset protection and Medicaid asset protection planning. Call today in order to speak directly with a Medicaid asset protection lawyer who will help you understand and implement a plan that will enable you to protect your assets."

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Interviewees and Respondents

1. Michael A. Baker, Director, Brokerage & Affinity Markets, Target Insurance Services
2. Ronald L. Barth, President/CEO, Pennsylvania Association of Non-Profit Homes for the Aging
3. Eric Beittel, Certified Financial Planner, Enders Insurance Associates
4. Colin Blair, LTC Specialists, URL Financial Group
5. Donna Boyar, Director of Community Services, JEVS Supports for Independence
6. James Boyar, Director of Attendant Care, JEVS Supports for Independence
7. Peter P. Camacci, Jr., Director, Bureau of Accident and Health, Pennsylvania Insurance Department
8. Chris Coady, Senior Director of Marketing, United Security Assurance Company of Pennsylvania
9. Jeffrey Cooper, Managing Partner, Great Oak Lending Partners
10. Gwenn Dando, Assistant State Director, National Federation of Independent Business
11. Samuel Denisco, Director, Government Affairs, Pennsylvania Chamber of Business and Industry

12. Melissa Fox, Deputy Press Secretary, Pennsylvania Insurance Department
13. Ronald A. Gallagher, Jr., Deputy Insurance Commissioner, Pennsylvania Insurance Department
14. David J. Gingerich, Special Assistant to the Secretary, Department of Aging
15. Beth Greenberg, Regulation Affairs & Research, Pennsylvania Association of Non-Profit Homes for the Aging
16. Anne Hart, Consultant, Bravo Group
17. Susan Heinle, Owner/President, Visiting Angels Living Assistance Services
18. Vicki Hoak, Executive Director, Pennsylvania Homecare Association
19. Dale Hornberger, Human Services Program Specialist, Department of Public Welfare
20. Ted Janeczek, Executive Vice President & Chief Financial Officer, Country Meadows Retirement Communities
21. Stephen J. Johnson, Deputy Insurance Commissioner, Pennsylvania Insurance Department
22. Eric Kiehl, Public Affairs Director, Pennsylvania Homecare Association
23. Erica Koser, Intern, Pennsylvania Association of Non-Profit Homes for the Aging
24. Gregory S. Landes, Licensed Representative, United Security Assurance Company of Pennsylvania
25. Holly Lange, Senior Vice President, Philadelphia Corporation for Aging
26. Crystal Lowe, Executive Director, Pennsylvania Association of Area Agencies on Aging
27. Carl Marrara, Issue Manager, Pennsylvania Business Council
28. Anna McCauslin, Government Relations Representative, Manufacturer & Business Association
29. W. Russell McDaid, Vice President & Chief Public Policy Officer, Pennsylvania Association of Non-Profit Homes for the Aging
30. Robert J. McNamara, Director, Policy and Strategic Planning, Departments of Public Welfare/Aging
31. Diane Menio, Executive Director, Center for Advocacy for the Rights and Interests of the Elderly
32. Carolyn Morris, Director, Bureau of Accident and Health, Pennsylvania Insurance Department
33. Ward R. Moyer, Agent, Genworth Financial
34. Carole Procope, Director of Third Party Liability, Department of Public Welfare--Estate Recovery Program
35. Ray Prushnok, Deputy Secretary for Aging, Department of Aging
36. John Radford, Senior Advisory Team Member, Kistler Tiffany Benefits
37. Yonise Roberts Paige, Chief, Life & Health, Market Action Examiner, Pennsylvania Insurance Department
38. Ross Schriftman, Employee Benefits Consultant, Kistler Tiffany Benefits
39. Dennis L. Shalters, Financial Representative, Northwestern Mutual Financial Network
40. Dale Shuey, Reverse Mortgage Loan Officer, Fulton Mortgage Company (Fulton Bank)
41. Rick Stoner, Supervisor, Bureau of Accident and Health Forms, Pennsylvania Insurance Department
42. John Whitman, Executive Director, The TRECS Institute
43. John Young, Reverse & Forward Mortgage Consultant, American Home Bank

LTC Legislative Briefing Attendees

On Thursday, July 15, 2010, Stephen Moses delivered a one-hour briefing on long-term care financing and the CLASS Act for members and staff of the Pennsylvania legislature. Vince Phillips of Phillips Associates, who represents the Pennsylvania Association of Health

Underwriters, planned and organized the event. Attendees were promised and will receive a copy of this report.

1. Valerie Barowski, PA House Health and Human Services Committee (R)
2. Greg Beckenbaugh, Senator Waugh's Office (R)
3. Maureen Bereznak, Media Relations (R)
4. Nancy Cole, Representative Stern's Office (R)
5. Don Craine, Jr., Phillips Associates
6. Lee Derr, Senator Eichelberger's Office (R)
7. Gail Dull, PA House Aging and Older Adult Services (R)
8. Allison Dutrey, Senator Don White's Office (R)
9. Matt Franchak, Senator Stack's Office (D)
10. Hon. Tim Hennessey (R)
11. Jim Hertzler, Senator O'Pake's Office (D)
12. Cheryl Hull, Policy Office and Senator Erickson's Office (R)
13. Nilda Jenkins, Representative Ken Smith's Office (D)
14. Neeka Jones, Senator Hughes' Office (D)
15. Kathy McCormac PA House Insurance Committee (R)
16. Arthur McNully, PA House Insurance Committee (D)
17. Vince Phillips, Phillips Associates
18. Charles Quinnan, PA House Aging and Older Adult Services (D)
19. Mark Rosenstein, Senator Orie's Office (R)
20. Geri Sarfert, Senator Mensch's Office (R)
21. Amy Segina, The Middletown Home
22. Judy Smith, PA House Insurance Committee (R)
23. Owen Thomas, Senator Vogel's Office (R)
24. Gail Wilkinson, PA House Insurance Committee (R)
25. Katie Zerfuss, Representative Mundy's Office (D)