THE HEARTLAND MANIFESTO:

HOW TO FINANCE LONG-TERM CARE FOR MIDDLE AMERICA

A Case Study in South Dakota

Presented

to

THE SOUTH DAKOTA HEALTH CARE ASSOCIATION

August 1, 1996

by

LTC, INCORPORATED

"The Long-Term Care Specialists"

Stephen A. Moses, Director of Research
with the assistance of Kathryn J. Tjelle
Two Union Square, 22nd Floor
601 Union Street
Seattle, Washington 98101-2363
206-223-0938

TABLE OF CONTENTS

THE HEARTLAND MANIFESTO

South Dakota's legacy as a home for free, independent, self-reliant and pioneering folks is both historical and legendary. This quote from the "Prairie Homestead"[1] audio-tape gives a sense of the deprivations early settlers faced, the values that motivated and sustained them, and the level of assistance they could expect from the government!

> The fact is mid-west homesteaders often had a rough time of it. Imagine if you can living on a prairie that will barely support your livestock because of its frequent draught and life-endangering temperature extremes. You walk among rattlesnakes and grasshoppers.... Across this prairie the wind blows most of the time. You wish it would stop. The few crops that get enough moisture, grow under the threat of marble-size hail, frequent prairie fires, and damaging insects. At times, you seem alone, aching with the isolation of the desolate prairie.... [L]et's not forget to mention the shortages of water, food, fuel, and good doctoring. Due to the dry conditions, there were no nicely kept lawns, and few beds of pretty, cultivated flowers. Add to this the fact that one was leaving the conveniences of a more civilized area to set out for a land of strangers, a land where water was scarce, weather conditions were sometimes extreme, and old friends and family members were a thing of the past. Despondency and despair were surely waiting some of these early settlers. Such grim conditions gave rise to common remarks among grumbling neighbors:
>
> "**The government bets you 160 acres of land against $18 that you'll starve to death before you live on the land 5 years**." [Emphasis added]

The government's role in public assistance has changed considerably since those days of long ago. Something that has not changed significantly, however, is the underlying spirit of independence and personal responsibility among South Dakotans.

---

[1] "Prairie Homestead: Meet the Browns and Their Neighbors," audio-tape prepared by Keith Crew and Douglas Heck, Philip, South Dakota, 1996.

The one theme that came through constantly in all of our interviews for this study was that people should take responsibility for their own long-term care and that the government should help those who cannot help themselves.

The following prescription captures the consensus among respondents to this study regarding the nature of the long-term care financing problem and the most appropriate approach to a solution. I call it...

The Heartland Manifesto

South Dakota has very limited dollars available for public assistance.

The state's first responsibility is to take care of the truly poor and disadvantaged.

The middle class and well-to-do should pay privately for long-term care to the extent they are able without suffering financial devastation.

Prosperous people who rely on public assistance for long-term care should reimburse the taxpayers before giving away their wealth to heirs.

Seniors and their heirs who wish to avoid such recovery from the estate should plan ahead, purchase private long-term care insurance, and pay privately for the care of their choice when the time comes.

On this foundation, the following report proposes to build a politically feasible solution to the long-term care financing problem.

LTC, Incorporated
Seattle, Washington

FOREWORD

by

Richard J. Reding, MURS, Executive Director
South Dakota Health Care Association

The Medicaid program, on which the majority of South Dakota nursing home residents depend for their continued long-term care, is rapidly heading for a crisis. This crisis is being driven by two factors. First, the numbers of elderly South Dakotans seeking Medicaid support for their nursing care is dramatically increasing. At the end of calendar 1994 about 54 percent of nursing home residents in the state were having their care paid for by Medicaid. By the end of calendar 1995 that number had increased to nearly 60 percent. This trend shows no signs of decreasing.

The second factor precipitating this crisis is funding. Congress is presently considering a variety of Medicaid reform proposals. However, all of these plans, both Republican and Democrat, universally agree that the federal dollars supporting Medicaid will be reduced in the future. The implementation of some type of Medicaid reform, including reduced funding, is almost certain to be enacted by the next Congress. Medicaid is also financed with state dollars, but it is unlikely that the state of South Dakota can increase its Medicaid budget sufficiently to replace this loss of federal funds.

The effects of this impending Medicaid crisis are already being felt by South Dakota nursing homes. Historically, Medicaid has paid nursing homes less than their cost of providing care. The typical South Dakota nursing home currently receives $3 to $4 per day less than their daily cost of operation as payment from Medicaid. This has caused cost shifting to private pay patients in order to keep the nursing homes solvent. With the number of private pay patients dwindling and Medicaid payments likely to be further reduced, many nursing homes might fail financially and simply close.

Given that major increases in Medicaid spending by either federal or state governments are not likely, we believe the solution to the Medicaid crisis lies in fundamental reforms to the Medicaid program itself. South Dakota is fortunate to have an active Medicaid recovery program and more stringent eligibility requirements than many other states. However, we believe that considerable "Medicaid planning" is still occurring in South Dakota. Significant numbers of well-to-do seniors are taking

advantage of legal loopholes to make themselves paper paupers for purposes of obtaining Medicaid for their nursing home care.

While "Medicaid planning" is a growing problem, simply closing the current legal loopholes is not the whole solution. The long-term answer to ever-increasing Medicaid expenditures for nursing home care is in removing the perverse incentives in the current Medicaid system that discourage individuals, particularly those in the "baby boom generation," from planning ahead for their own long-term care. The present system allows these individuals to deny the need for such planning, under the assumption that they can easily access the Medicaid program if they should be unfortunate enough to need nursing home care. Congress is already recognizing this problem and is considering certain tax incentives for the purchase of private long-term care insurance.

Recognizing this imminent danger to both seniors and the state's long-term care providers, the Association, has contracted with Mr. Stephen A. Moses, Director of Research for LTC, Inc., and a nationally recognized expert on Medicaid reform, to conduct a study of the Medicaid program in South Dakota. The focus of this study is to make both short and long-term recommendations on how this Medicaid crisis might be averted.

I would also like to thank the members of the legislature, the staff of the Departments of Social Services and Commerce, the representatives of the insurance industry, the elder law attorneys and the nursing home administrators who met with Steve during the week of June 24, 1996 for graciously sharing their time.

ACKNOWLEDGEMENTS AND DISCLOSURES

This project was funded under contract with the South Dakota Health Care Association. The Association assisted the project by facilitating access to private long-term care experts, interest groups, key state staff, public officials and documents. The Association also arranged conference space, photo-copy support, and local telephone service.

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

Stephen A. Moses, the author, is Director of Research for LTC, Incorporated. He writes, speaks and consults extensively on the subjects of Medicaid nursing home eligibility, Medicaid estate planning, liens, estate recoveries, and public/private long-term care financing partnerships. He was previously a Medicaid State Representative (9 years) for the federal Health Care Financing Administration (HCFA) and Senior Analyst (2 years) for the Office of Inspector General of the U.S. Department of Health and Human Services (IG). He directed and authored three national studies for HCFA and the IG on Medicaid estate planning. Mr. Moses was assisted in this project by Kathryn J. Tjelle, Research Coordinator, for LTC, Incorporated. **Steve Moses's e-mail address is 102334.3446@compuserve.com.**

We would like to express our appreciation to the 38 respondents and interviewees who provided the information on which this report is based and especially to Richard J. Reding, Executive Director of the South Dakota Health Care Association, who organized, scheduled, and attended the interviews and contributed valuable insights and knowledge about long-term care in South Dakota.

INTRODUCTION

The purpose of this study was to provide information to the South Dakota Health Care Association and the state of South Dakota on how the state can reduce its Medicaid expenditures significantly while assuring adequate provider reimbursement.

A principal objective of the study was to encourage officials of the state of South Dakota to support a more comprehensive program of Medicaid expenditure reduction, resulting in the eventual implementation of initiatives to save 15 million dollars per year in Medicaid nursing home expenditures, while relieving pressure on reimbursement rates.

In pursuit of this purpose and objective, the contractor (LTC, Incorporated in the person of the company's Research Director, Stephen A. Moses) visited South Dakota during the week of June 24, 1996 and conducted a series of interviews and discussions. Specifically, he met with long-term care policy makers and stakeholders including representatives of the Medicaid program, members of the State Legislature, health care providers, and others. A complete list of respondents and interviewees for the project is provided at the back of this report.

Each group of respondents received a packet of background information on the project including a copy of the reports on similar, but much more detailed and lengthy, studies conducted in Illinois and Maryland. A brief presentation introduced all study participants to a new approach to analyzing the long-term care financing system. Finally, each interviewee was asked to respond to extensive questions in a prepared interview schedule.

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

Given the severely limited scope of this project--one week of field work and one week to write the report--we probably raise more questions herein than we answer. Therefore, if additional work or research is needed to identify a problem or craft a solution, the report recommends how this might be done.

THE PROBLEM

The Medicaid and long-term care financing crises in America have not impinged as severely on South Dakota as they have on other areas of the country. Nevertheless, problems and trends more associated with the coasts, mid-west, and deep south are beginning to show up in this state. The time to confront and resolve these issues is now before the walls close in any further.

Status Quo

The best way to start is to describe and understand the Medicaid and long-term care financing status quo in South Dakota. The facts reveal some ominous tendencies. For example, total Medicaid recipients in South Dakota increased from 39,718 in State Fiscal Year (SFY) 1990 to an estimated 66,226 in SFY 1996, an increase of 66.2%. In the same period, total Medicaid program costs increased from $47.3 million to $105.8 million, an increase of 123.7 percent. State general fund revenue on the other hand went up by only 48.5 percent in these years. The disproportionately high increases in Medicaid costs have caused this one program to surge from only 11.1 percent of state general fund revenues in SFY 1990 to an estimated 17.7 percent in SFY 1997. At this rate, Medicaid could quickly start to squeeze out state financing for education, highways, corrections and other desirable programs. Despite this rapid escalation in costs, however, South Dakota's Medicaid program unfortunately covers only 34.4 percent of the state's poor people, as compared to the national average of 49.0 percent.[2]

These numbers arouse some foreboding but they take an even scarier turn when we look specifically at Medicaid nursing home data. While total Medicaid recipients jumped by two-thirds between SFY's 1990 and 1996, Medicaid nursing home recipients increased by only 6.8 percent (from 4,350 to 4,648). Despite this minimal growth in institutionalized recipients, however, Medicaid nursing home expenditures grew by 92.0 percent (from $51.0 to $97.9 million) in the same period. If dollar costs are growing so rapidly even with relatively level caseloads, what will happen if, as everyone expects, the frail elderly population (and concomitant caseloads) start increasing faster and faster in

[2] Amanda H. McCloskey, Jennifer Woolwich, and Danielle Holahan, *Reforming the Health Care System: State Profiles 1995*, American Association of Retired Persons, Washington, D.C., 1995, p. 175.

the future?[3] We will return to this question in a moment.

Table 1:
South Dakota Department of Social Services
Title XIX Expenditure History for Nursing Facilities
By State Fiscal Year
($ in Millions)

	State Funds	Federal Funds	Total
FY 90	$14.7	$36.4	$51.0
FY 91	$16.4	$41.1	$57.5
FY 92	$19.2	$50.2	$69.4
FY 93	$22.3	$54.0	$76.3
FY 94	$27.3	$62.8	$90.1
FY 95	$29.5	$63.6	$93.0
FY 96 - Estimated	$32.3	$65.5	$97.9

Source: South Dakota Health Care Association, June 1996

Federal Financial Participation

Concurrent with this escalation in costs, federal financial assistance to the state Medicaid program is starting to decrease. South Dakota's "Federal Financial Assistance Percentage" (FMAP) is scheduled to drop from 72.59 percent in 1995 to 70.27 percent in 1996 and to 69.5 percent in 1997.[4] Thus, the state will have less federal money to work with in the near future even if Medicaid block grants (which will cut federal assistance much further) fail to pass anytime soon. Given that the Medicaid and long-term care financing problems described here are even worse at the federal level, thoughtful policy makers must assume that

[3] Data in the preceding two paragraphs came from tables provided by the South Dakota Health Care Association.

[4] Erwin Brown, Jr., *Facts and Trends: The Nursing Facility Sourcebook, 1996*, American Health Care Association, 1996, p. 56.

federal financing of Medicaid will continue to recede rapidly for the foreseeable future and may disappear entirely at some point. This danger, and a very strong concern about it by policy makers and administrators, was one of the most frequently voiced themes in the interviews conducted for this study.

Demographic Dangers

Financing, however, is not the only long-term care problem South Dakota faces. The state will soon confront some dramatic demographic realities that will ultimately make the fiscal problems far worse. For example, South Dakota's percent of population aged 75-84 was 5.2 percent as of 1994, fifth highest in the nation.[5] The state's percent of population over the age of 85, was 2.0 percent, third highest in the nation.[6] Curiously, however, South Dakota's rate of increase in the population over age 85 between 1985 and 1995 was only 19.6 percent as compared to 34.9 percent for the United States as a whole.[7] Thus, unless the state's high concentration of 75 to 84 year-olds starts moving out or dying off very soon, South Dakota's even higher percentage of 85 year-olds and up may quickly begin to increase disproportionately. Of course, the 85-plus age group is by far the most prone toward expensive long-term care institutionalization.

Furthermore, South Dakota's long-term care service delivery system could hardly have been designed intentionally to exacerbate these demographic and financial problems more than it actually does. The system relies disproportionately on institutional nursing home care. Although the number of nursing home beds per thousand elderly persons has declined from 80 in 1988 to 74 in 1995, the current rate is still almost 40 percent higher than the national average of 53 beds per thousand.[8] South

---

[5] The national average is 4.2 percent of the population aged 75-84. Erwin Brown, Jr., *Facts and Trends: The Nursing Facility Sourcebook, 1996*, American Health Care Association, 1996, p. 5.

[6] The national average is 1.4 percent of the population over age 85. Erwin Brown, Jr., *Facts and Trends: The Nursing Facility Sourcebook, 1996*, American Health Care Association, 1996, p. 5.

[7] Amanda H. McCloskey, Jennifer Woolwich, and Danielle Holahan, *Reforming the Health Care System: State Profiles 1995*, American Association of Retired Persons, Washington, D.C., 1995, p. 172.

[8] South Dakota Department of Health and South Dakota Department of Social Services, "Status of Long Term Care Beds in

Dakota spends 30.1 percent of its Medicaid budget on nursing home care as compared to the national average of only 20.4 percent. Only four other states spend a larger proportion of Medicaid funds on nursing home care.[9] The state's 8,227 skilled nursing facility beds are 92 percent to 96 percent occupied depending on the data source one consults, considerably higher than the national average. A three-year moratorium on construction of new nursing home beds instituted by the Governor in 1988 and extended in 1991, 1993 and 1995 practically guarantees a continuation of high occupancy rates.

Nursing Home Resident Acuity

Another important point is that the occupants of South Dakota's nursing home beds are not as high-acuity patients as compared to nursing home residents in other states. According to a fact sheet supplied by the South Dakota Health Care Association: "Nursing facility resident data indicates an average of 16% of all residents are relatively high-functioning and could possibly reside at a lower level of care such as Assisted Living." On the key activities of daily living, South Dakota's nursing home residents rank second lowest among the states based on total dependency in bathing; lowest in dressing, transferring, and toileting; and fourth lowest in eating.[10] In other words, fewer nursing home residents in South Dakota are totally dependent for assistance in these activities of daily living than in most other states.

In fact, South Dakota's elderly population is a very able-bodied group whether inside a nursing home or not. Only 133 out of 1000 South Dakotans over the age of 65 have difficulty in mobility of self-care, the lowest rate of any state in the country.[11] Despite these facts, the number of assisted living

---

South Dakota: Report to Governor Janklow and the 1995 South Dakota Legislature," undated, p. 2.

[9] Erwin Brown, Jr., *Facts and Trends: The Nursing Facility Sourcebook, 1996*, American Health Care Association, 1996, p. 53.

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

[11] Amanda H. McCloskey, Jennifer Woolwich, and Danielle Holahan, *Reforming the Health Care System: State Profiles 1995*, American Association of Retired Persons, Washington, D.C., 1995, p. 221.

beds in South Dakota has only drifted upward since 1987 from 435 to 678. The state's home and community-based services infrastructure, another important alternative to nursing home care, is also underdeveloped and only meagerly financed. Elder law attorneys interviewed for this study said "institutional care is much more available" and "I would not know where to call" for home care services.

Medicaid Eligibility Bracket Creep

In addition to growing problems with financing and service delivery, South Dakota faces a rapid increase in Medicaid dependency, a kind of eligibility bracket creep. The proportion of nursing home beds in South Dakota financed by Medicaid increased from 51.0 percent in 1985 to 59.9 percent in 1995.[12] Although South Dakota's proportion of Medicaid financing is still far below the national average of 68.7 percent[13], the trend is very worrisome. According to the Program Administrator of Provider Reimbursement and Audits at the Department of Social Services, a further ten percent increase in Medicaid eligible recipients would cause an increase in nursing home expenditures of $9.6 million per year. Another problem with the rapidly increasing Medicaid census in nursing homes is that Medicaid reimburses less than the cost of providing the care, according to nursing home administrators interviewed for this study. "Costs are $2.45 higher than the Medicaid rate," said one respondent, "$8 higher," said another. Although a definite figure is hard to establish because of South Dakota's rate setting methodology, study respondents estimated that Medicaid pays only about 75 percent to 80 percent of the private-pay rate.[14] Who makes up the difference? "Private payers have to pay more because Medicaid pays less. Private payers pay twice: once for themselves and again for the Medicaid recipients." If one counts the state and federal taxes contributed during their lifetimes by private-pay residents in nursing homes, then, technically speaking, they pay three times for their nursing home care.

Medicaid Estate Planning

---

[12] Source: Table provided by the South Dakota Health Care Association.

[13] Erwin Brown, Jr., *Facts and Trends: The Nursing Facility Sourcebook, 1996*, American Health Care Association, 1996, p. 35.

[14] This is closely in keeping with the national average of 80 percent.

No one knows for sure what accounts for the rapid increase in Medicaid-eligible nursing home residents. One possible explanation is a gradual increase in Medicaid planning, the practice of sheltering or divesting assets to qualify for Medicaid nursing home benefits without spending down. We found considerable evidence that this practice occurs in a growing number of Medicaid cases in South Dakota. Department of Social Services (DSS) headquarters staff indicated that, despite statewide efforts to train eligibility workers to discern and discourage Medicaid planning, adult children of frail elders and their attorneys contact the agency frequently inquiring about and testing ways to qualify for assistance without spending down in the appropriate way.

These quotes from DSS staff in Pierre give a sense of the problem of creative qualification for Medicaid benefits: eligibility workers "are badgered by attorneys who try to get the information...Calls are daily from all over the state...The attorneys don't even read the rule books; they just call and ask us questions in a certain way to get the answers they want...I talk to [even] more financial planners now than attorneys...It is not the people in the nursing home [that are behind this], it is the adult children who are the heirs. They say it is their right...The adult children see their inheritance going out the window...word is spreading...just give everything away thirty-six months in advance...we are talking big properties with big values...we have seen a few homes renovated from $80,000 to $150,000...Grandchildren get graduation cars...we have seen a couple of Grand Cherokees recently, about $35,000 each...Life estates are awful...we see everything from pure life estates for the house to life estates in the production of the ranch or the crops...people can give away $2,496 every month" with impunity.

The following advertisement, published on page 22 of the May 15, 1996 issue of *Senior Lifestyles* (part of a free Sioux Falls weekly called *The Shopping News*) provides a good idea of the kinds of Medicaid Planning techniques and advertising that are spreading in South Dakota. This ad is recreated here verbatim as originally published. The same emphasis was in the original.

Warning...If You Are Retired!!
"To The Retiree Who Wants To Protect Your Money, Income, And Assets From Being Wiped Out!"

by Argus West

You <u>Can</u> Lose Everything You Own!

Retirees who have not set up proper strategies can, and

often do, have all of their net worth wiped out when someone in the family goes into a nursing home. The government can literally take your CD's, your house, your Social Security and pension checks, your investments, IRA's...you name it!

The Myth of Medicare!

One of the biggest misunderstandings around, is that Medicare will pay for nursing home expenses. This is completely WRONG! Medicare, is a *health insurance* program, not a *nursing home/long term care* program! In fact, Medicare usually pays NOTHING towards the costs of staying in a long term facility! YOU are responsible for every dime of long term care expenses...not Uncle Sam!

Medicaid will NOT PAY Until You've Lost Everything... And Are Flat Broke!

Many people think that Medicaid will pick up the monthly costs of being in a nursing home. That's true. But, *they will only pay after you've lost nearly everything you own!* You virtually have to be penniless before they kick in a dime!

The Average Family Will Lose Everything!

The cost of long term, nursing home care is outrageous! The national average is over $40,000 per year! How long would your assets last you if you had to pay that kind of money? And, even if you could go for a while, *why would you want to?* No one wants to see their whole life savings evaporate right in front of your eyes! Every day, we see people being wiped out...needlessly. There are solutions to this horrible problem. But, you won't find them in any magazine, or from your accountant or attorney!

Find Out What You MUST Know About Protecting Your Estate... Before It's Too Late!

A financial advisory firm is offering a FREE report that will teach you:

·10 legal ways to transfer assets out of the "countable" category, into the "uncountable" category!
·How to virtually bullet proof your home, so it may never be taken away!
·How to take steps that may prevent your CD's and other bank accounts from being frozen!
·How to virtually assure your Social Security and pension income will be kept in your hands...not Uncle Sam's!
·The biggest mistake retires [*sic*] make on how their money and assets are titled...and how to avoid this deadly trap!
·Little known loopholes to legally avoid being forced to sell your assets, or surrender your money to Medicaid!

FREE Report Reveals The Secrets To Protecting Your Money From Medicaid!

You deserve the peace of mind and security that protecting your assets from Medicaid achieves! You can learn what you need to know by getting a FREE copy of a new report called, **"How To Protect Your Life's Savings From Being Taken By Medicaid!"** You

can get your copy by calling **1-800-225-3293, 24 hrs., for a FREE recorded message.** Call NOW, before it's too late!

Nevertheless, the incidence and impact of Medicaid planning in South Dakota is clearly much less than in other parts of the country. Local eligibility workers in Sioux Falls discounted the frequency and cost of this practice. They see "relatively little Medicaid planning" and do not "see any field level attorneys being creative enough to circumvent" the rules. Local staff acknowledged, however, that they refer most of their complicated eligibility cases and all of their trust cases to the experts in Pierre to handle. They also indicated that "we tell applicants that they can buy something [with their excess assets], but cannot give their money away." In other words, local Medicaid eligibility staff routinely advise applicants whose resources exceed the asset limits necessary to qualify for assistance that they can spend their money on exempt resources to bring them down to the required levels. Such exempt resources include home improvements, home furnishings, prepaid burial plans, and many other products and services. When applicants have too much income (as opposed to excess assets) to qualify for assistance, the local workers "do the Miller Trusts if they do not have enough money to pay for private [nursing home] rates."[15] Thus, since the Omnibus Budget Reconciliation Act of 1993 authorized Miller income trusts, fewer and fewer Medicaid applicants are disqualified on the basis of excess income.

Nursing home administrators interviewed for this study also weighed in on the Medicaid planning issue. They said 15 percent to 20 percent of the residents in their facilities have done some Medicaid planning. They also insisted that Department of Social Services staff "help people plan and the agency admits it privately." They said Medicaid planning is on the increase as evidenced by the growth of television and print advertisements by financial planners and lawyers. They stated that the most commonly used technique of Medicaid planning is when a healthy spouse gives a home or ranch to the "kids" after eligibility has been established for the ill, institutionalized spouse. One nursing home administrator said "I had a millionaire who was in

[15] Miller income trusts were authorized by the Omnibus Budget Reconciliation Act of 1993. They permit people whose income exceeds 300 percent of the SSI limit, $1410 as of 1996, to qualify for Medicaid nursing home benefits. Miller trusts eliminate the notorious "Utah gap" problem whereby people with too much income to qualify for Medicaid and too little income to pay private nursing home rates fell through the safety net.

my home [on Medicaid] but I do not know how he did it." The clear consensus among study respondents representing the nursing home industry is that Medicaid census and Medicaid planning are on the rise, while Medicaid reimbursement is already inadequate and increasing at too slow a pace.

Long-Term Care Insurance

One last point to make about the long-term care financing system in South Dakota is that very few people have insurance to pay for the cost of home care, assisted living or nursing home care. This fact may contribute to the gradual increase in Medicaid nursing home census and the seductive appeal of Medicaid estate planning. Approximately 15 percent of seniors in South Dakota have purchased long-term care insurance according to the Health Insurance Association of America.[16] Although this is a relatively high market penetration by national standards, most study respondents thought that private long-term care insurance could play a much larger role in ameliorating South Dakota's long-term care financing problem than it does.

According to long-term care insurance agents interviewed for this study, only approximately 100 to 250 insurance agents in South Dakota sell long-term care insurance as one of their "hub businesses." Several respondents (including state legislators, Insurance Division staff in the Department of Commerce, Medicaid staff, nursing home administrators, and long-term care insurance agents) indicated that the state of South Dakota has no policies to encourage the marketing of this product. Many respondents recommended that the state consider tax incentives, such as a partial inheritance tax forgiveness, to encourage the purchase of private insurance. The opinion was almost universal that the state and the insurance industry should each play appropriate roles in educating the public about the risk of long-term care, the difficulties of relying on public financing, and the importance of planning ahead.

---

[16] Susan Coronel and Craig Caplan, *Long-Term Care Insurance in 1994*, Health Insurance Association of America, Washington, D.C., 1996, p. 20. Although this figure (15 percent) places South Dakota among the six states in the country with the highest long-term care insurance market penetration, several caveats are in order. No one interviewed for this study thought South Dakotans are especially heavy purchasers of this product and everyone thought the 15 percent estimate was probably too high. Furthermore, this optimistic estimate does not account for policy lapses which are quite commonplace with the product.

Synopsis of the Problem

For many years, South Dakota has experienced rapid growth in total Medicaid rolls, general Medicaid program costs, and nursing home costs specifically. Just as Medicaid financing pressures are reaching crisis proportions, the federal government has begun to cut back on its contributions to the program. Demographic trends guarantee that the need for all levels of long-term care will increase rapidly in the future. Yet, South Dakota's long-term care delivery system is heavily weighted toward expensive nursing home care and very lightly concentrated on the less expensive home and community-based services that most seniors prefer. Simultaneously, and in direct contradiction of the common sense notion that level of care should be proportionate to level of medical need, South Dakota's nursing home residents as well as the state's general elderly population, are relatively less dependent and more able-bodied than the same groups in most other states. Finally, South Dakota's Medicaid nursing home census is increasing rapidly; Medicaid estate planning is on the rise as well; and long-term care insurance is spreading very slowly if at all.

THE ANALYSIS

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

The Roots of the Problem[17]

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

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

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

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

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

Capping bed supply, however, predictably drove up price and demand. The nursing home industry merely raised charges to compensate for the limitation on new beds. Government costs grew faster than ever. So Medicaid capped reimbursement rates too. This move compelled the nursing home industry to increase private-pay reimbursement rates to compensate. So began the highly problematical differential between Medicaid rates and private-pay rates. Today, Medicaid pays only 80 percent of private-pay rates on average nationally. South Dakota's case mix reimbursement system complicates this analysis somewhat, but the bottom line is the same.

Eligibility Inflation

Higher private rates made Medicaid more attractive to private payers and this led to pressure on legislators to liberalize Medicaid eligibility. A long process of eligibility expansion gradually made Medicaid nursing home benefits available even to upper middle class people who had or could obtain the expertise to manipulate Medicaid's highly elastic eligibility rules. A whole sub-practice of law--Medicaid estate planning--developed to take advantage of this new opportunity. Although Medicaid estate planning is clearly less prevalent in South Dakota than in other parts of the country, the practice is undoubtedly seeping into the state. A long-term care insurance agent interviewed for this study reported that "a local attorney who vacationed in Arizona went to a seminar that taught you don't need long-term care insurance because they have a $1,500 program to guarantee you Medicaid using a living trust."

With the supply and price of nursing home beds capped by government fiat and with Medicaid eligibility increasingly generous, nursing home occupancy skyrocketed to an average of 95 percent nationally. AARP's Public Policy Institute reports that South Dakota's nursing home occupancy rate was 97.6 percent as recently as 1992.[18] With high demand and severely limited supply,

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

nursing home operators could fill their beds easily with low-paying Medicaid patients. To achieve adequate operating margins, however, nursing homes had to attract a sufficient supply of full-paying private patients or they had to cut costs drastically.

The Origin of Quality and Discrimination Problems

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

Such trends have not developed as far or as fast in South Dakota as they have in other states. Everyone we interviewed for this study, inside and outside the nursing home industry, indicated that quality of care in the state's nursing homes is good. Some objective outside evidence supports this judgment. South Dakota averaged only 2.27 "nursing deficiencies" based on federal survey reviews as compared to a national average of 3.57 deficiencies.[19] Furthermore, all respondents said that Medicaid and private-pay nursing home residents are treated the same throughout South Dakota almost without exception. The reason that quality and discrimination problems have not yet become as severe in South Dakota as elsewhere is probably that the state has maintained comparatively high Medicaid reimbursement rates heretofore. Fiscal pressures to restrict rates more severely in the future, however, could give rise to the same kinds of problems that have plagued other states already.

Boren Battles

Caught between the proverbial rock and a hard place, the nursing home industry put up a strong fight. Armed with the

---

p. 172.

[19] Cowles, C. McKeen, *Nursing Home Statistical Yearbook: 1995*, Johns Hopkins University Press, Baltimore, Maryland, 1995, pps. 118-9.

Boren Amendment, a federal law that requires Medicaid to provide reimbursement adequate to operate an efficient nursing facility, many state nursing home associations took the battle to court. By this time, however, state and federal Medicaid expenditures were rising so fast and taxpayers were so reluctant to pay for growing public spending that large increases in nursing home reimbursement were out of the question.

The nursing home financing problem did not escalate into a destructive legal battle in South Dakota, and at this stage, it never will. Soon, the Boren issue will be moot. Everyone expects the law to be repealed in the near future. Unfortunately, however, Congress cannot repeal the underlying problem any more than it can repeal the law of gravity. "You cannot get a silk purse out of a sow's ear." If South Dakota tries to solve the long-term care financing problem by indefinitely restricting Medicaid nursing home reimbursements and bed supply, the state will pay the price in quality and discrimination problems sooner or later as so many other states already have.

Home and Community-Based Services Waivers

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

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

Synopsis

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

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

THE SOLUTION

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

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

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

solution in broad scope. The Recommendations section provides somewhat more detailed guidelines.

Preserve the Social Safety Net

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

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

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

Restrain Medicaid Estate Planning

The second step, therefore, is to prevent middle class people who suddenly confront a long-term care crisis from jettisoning their wealth to qualify for Medicaid nursing home care. We need longer and stronger transfer of assets restrictions that will encourage seniors to retain their resources and pay for their own care as long as possible. We

need to eliminate the existing incentive under Medicaid for heirs to expropriate their parents' assets in order to qualify them for publicly financed nursing home care.

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

Fortunately, South Dakota has enforced such rules and restrictions as are available under current law to control asset transfers and shelters, including the new authorities contained in the Omnibus Budget Reconciliation Act of 1993, with dedication and thoroughness. In this arena, therefore, the main problem is that federal law restricts the state's ability to establish and enforce asset control methodologies that will actually achieve the objective of preventing excessive asset transfers and shelters. The primary focus of reform must be to plan for the opportunity to lengthen and strengthen the transfer of assets rules either under a federal waiver or under a block grant. In the meantime, there are still many measures South Dakota can take under existing law to enhance this area of eligibility control. We will explore measures South Dakota can take under a waiver, block grant or existing law in the Recommendations section. Further study and research is necessary, however, to assure that South Dakota is doing everything reasonably and cost-effectively possible to control the spread of Medicaid planning.

Security of Collateral as a Condition of Eligibility

The third step to reform South Dakota's long-term care system is to assure that people receiving assistance, who have retained income or assets protected by the system's generous eligibility rules, do not divest this wealth while they are receiving publicly financed benefits. The principle here is that people who have wealth to protect, but who need Medicaid to help them finance long-term care because their monthly cash flow is inadequate to pay for their care, should receive public benefits as a loan, not a give-away or welfare. Those who care to may liquidate their wealth and purchase red-carpet access to top-quality care in the private long-term care marketplace until they have nothing left of their estates. But those who choose to

retain a home, car and other assets exempted by the Medicaid program for the benefit of their immediate dependents (such as a healthy spouse or disabled child) should expect to repay Medicaid for benefits received after the assets are no longer needed to support these dependents.

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

Although current federal law does not permit the use of liens as a condition of eligibility, it does allow the placement of liens on real property under certain circumstances while a Medicaid recipient is receiving benefits. In fact, South Dakota recently implemented this kind of "TEFRA"[20] lien program. Unfortunately, only 395 of the state's 4500 Medicaid nursing home recipients have retained homes and only 25 of these are not occupied by dependents who render the property exempt from a TEFRA lien. Thus, in the area of liens, South Dakota's objective should be, first, to expand the state's authority to use liens more fully either under a federal waiver or a block grant. Second, the state should explore ways to assure that Medicaid recipients do not divest homestead property before it can be secured by a lien.

As explained above, the single most common Medicaid planning technique in South Dakota as reported by respondents to this study is the practice of transferring a home from a well spouse of a Medicaid recipient to some other individual outside the reach of a lien or later recovery. Inasmuch as the home

[20] Named after the Tax Equity and Fiscal Responsibility Act of 1982 which originally authorized this kind of lien.

represents 70 percent of the net worth of the median elderly household, most of the private capital available to finance long-term care in South Dakota is vulnerable to loss unless this loophole is closed. The potential is staggering. According to the Census Bureau's 1990 "Census of Population and Housing," South Dakota has 66,532 householders over the age of 65, of whom 73.3 percent own their homes, which homes have a mean value of $43,392 for householders aged 65 to 74 and $34,534 for those aged 75 and over. If South Dakota is to solve the long-term care financing problem, a foolproof method must be found to prevent the divestiture of this wealth at the expense of the state's medical welfare program. To find such a method will require additional study.

Medicaid Estate Recovery

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

The primary contribution of Medicaid estate recoveries to an efficient long-term care system, however, is not revenue, but rather to send a strong message to the public that long-term care financing is a genuine risk. This is the message that a strong estate recovery program sends to the general public: You either "pay now or pay later." That is, plan ahead, buy insurance, or pay privately for home and community-based services. Otherwise, if you take advantage of the publicly financed program, you absolutely, positively will pay every nickel back before any remainder value in your estate passes to your heirs. This is not bad. This is very good. It means you can protect your home or the family farm from the immediate ravages of catastrophic long-term care costs, because the government has a wonderful new program to lend you a hand. But it also means that over time, your heirs will have to pay back the state for the cost of your care (up to the value of your estate which they otherwise would

have received intact). Without this requirement, the government program could not remain solvent financially. If you or your heirs do not want to have to pay back the cost of your care, then you have a strong incentive to seek alternatives to relying on Medicaid to pay your long-term care costs.

Once again, it is good to report that South Dakota has laid a fine foundation on which to build in the area of estate recovery. The state implemented a well-planned program shortly after estate recoveries were mandated by the Omnibus Budget Reconciliation Act of 1993. Making a virtue of necessity, staff of the Department of Social Services carefully researched and designed an excellent program modeled after successful systems in Oregon, Wisconsin, and other states.[21] In its first year of operation, South Dakota's new estate recovery program generated $245,000 in recoveries. The first eleven months of the next year generated $731,000. The program has over $300,000 in outstanding claims awaiting probate and staff estimate that total recoveries of up to $1 million can be realistically anticipated for the coming year. Although these results are still far from the $5 million per year that could theoretically be anticipated as a top-end goal for the program, one must realize that any enterprise of this kind has a long learning curve and that so far the program employs less than two full-time equivalent staff. The Recommendations section of this report will offer several suggestions to enhance the recovery potential from liens and estates. Further study is warranted and necessary, however.

Public Education

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

---

[21] I am proud to observe that state staff acknowledged having used some of my own earlier research and reports in the design of the new estate recovery program.

This public education campaign should (1) explain the risk of long-term care, *i.e.*, a nine percent probability that a person will spend five years or more in a nursing home after age 65 at a cost of $30,000 or more per year; (2) describe the difficulties associated with qualifying for and receiving Medicaid nursing home benefits including (a) income and asset restrictions, (b) lien and estate recovery requirements, and (c) the possibility that future financial crises may limit access to and quality of care for public welfare recipients; and (3) elaborate the alternatives that families have available to finance long-term care privately including (a) home and community-based services to help the elderly remain at home as long as possible, (b) long-term care insurance to spread the risk of catastrophic costs widely among eligible (*i.e.*, relatively, younger and healthier) policy holders, and (c) home equity conversion to tap seniors' primary source of wealth by generating a cash flow from an otherwise illiquid asset to help pay for HCBS and insurance premiums.[22]

---

[22] Research shows that 57 percent of home owners could purchase long-term care insurance with nothing more than the proceeds of a reverse annuity mortgage. Nevertheless, according to a tape recorded program on home equity conversion presented at a recent conference of the National Academy of Elderlaw Attorneys in Cambridge, Massachusetts, not a single reverse annuity mortgage has been taken out by anyone in South Dakota yet despite the fact that no regulations stand in the way of such instruments in the state. The main reason home equity conversion has lagged as a source of long-term care funding throughout the United States is that Medicaid exempts the home and all contiguous property, regardless of value, whether or not the home is occupied, and whether or not the Medicaid recipient can reasonably be expected

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

---

ever to return to the home. Why tap the equity in the home to pay for long-term care or insurance when the government will pay and protect the home as well (as long as one legally avoids estate recovery which is still relatively easy to do)?

CONCLUSION

The state of South Dakota faces a long-term care financing problem of significant scope. To a large extent, however, the problem is self-inflicted. Unforseen consequences of unintended incentives in long-standing public policy plague the long-term care financing system here as elsewhere. People can ignore the risk of long-term care, avoid the premiums for private insurance, shelter or divest their income and assets, and shift the enormous financial burden of long-term care onto the Medicaid program with ease. They can, so some do, and many more will unless important changes are made in public policy.

South Dakota should not try to solve the long-term care financing problem by denying the succor of medical care to more of her citizens. She should not address these issues by reducing provider reimbursement rates below the minimum required for adequate care. She should not correct the system by plunging ever more of the taxpayer's money into the black hole of institutional long-term care. All of these conventional remedies will only made the situation worse.

The real solution is simple, economically sound and politically feasible. Merely change the incentives in the system so that South Dakotans plan ahead for long-term care, purchase private long-term care insurance, tap the equity in their homes, and utilize private home and community-based services. Divert them from the sorry fate of ending up in nursing homes on welfare prematurely by default. By so doing, the state can save Medicaid for the truly needy who cannot manage without it, relieve the overburdened taxpayers, empower the providers of long-term care with more private payers, and supercharge the financial services and long-term care insurance industries.

Many of the long-term care stakeholders interviewed for this study endorsed this analysis and these conclusions. Everyone from the state legislators to the Medicaid eligibility staff to a representative of the American Association of Retired Persons supported the principle that scarce public welfare resources should be targeted to those who need them most. General agreement, shared even by the elder law attorneys closest to the problem, confirmed the need for longer and stronger transfer of assets restrictions, liens and estate recoveries. Most promising is the opinion expressed by one or more of the state legislators that restricting Medicaid planning abuse is politically feasible, that home and community-based services are critical to any long-term care reform, that private long-term care insurance should be encouraged, that home equity conversion is an important new

private financing source, and that inheritance tax relief should play a role in encouraging private financing of long-term care. All of these agreements represent key factors in the reform program recommended here.

This report suggests numerous ways to achieve these objectives. It is only the barest beginning, however. The state should start immediately to build on this foundation. Bold action now will assure that the historical legacy of today's long-term care financing problem in South Dakota will be action and success rather than immobility and defeat.

RECOMMENDATIONS

The fiscal objective of these recommendations--assuming they are first refined into a well-researched, highly coordinated, and aggressively enforced plan of action--is to reduce Medicaid nursing home utilization in South Dakota from 60 percent of all residents to 50 percent (the actual level as recently as 1985) over a period of three to five years. This is a conservatively achievable goal and could save the state of South Dakota $15 million per year or approximately 15 percent of the Medicaid nursing home budget (in combination with enhanced lien and estate recoveries). If the state does nothing and Medicaid nursing home utilization continues to creep up to 70 percent,[23] South Dakota will need to spend an extra $9.6 million per year for nursing home care not counting inflation adjustments.[24]

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

The following recommendations are presented in two groups. Those actions that would require either a waiver of federal law or the wider state authority anticipated under a block grant are presented first. These recommendations come first because, although more difficult to implement, they are probably necessary to achieve a fully successful reform of the long-term care system. Fortunately, the Health Care Financing Administration and the Clinton Administration have become much more amenable to creative ideas and experimental waivers recently. The immediate likelihood of the block grant option has declined in recent months, but will likely increase again because it is driven by the federal Medicaid financing crisis which shows no signs of

---

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

[24] This estimate is based on data provided by the Program Administrator of Provider Reimbursement and Audits of the South Dakota Department of Social Services.

mediating. For more detail on one possible block grant approach, see the section entitled "Model State Statute Explained: Long-Term Care Financing Under a Medicaid Block Grant."

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

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

I. **RECOMMENDATIONS THAT WOULD REQUIRE A WAIVER OR BLOCK GRANT**[25]

1 **Retain a Generous Public Long-Term Care Financing Program**

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

1.1 Adopt the "Senior Financial Security Program" (SFSP) outlined below in the section entitled "Model State Statute Explained: Long-Term Care Financing Under a Medicaid Block Grant." The SFSP assures access to high quality, publicly financed long-term care while retaining strong incentives for families to plan ahead for private financing of home, community-based, and nursing home services.[26]

2 Control Divestiture and Medicaid Estate Planning

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

2.2 Limit the amount that Medicaid applicants can shelter in prepaid burial accounts to no more than the cost of a decent disposal of remains and a simple service, perhaps $2,500. Currently, there is no effective limit on how much money can be sheltered in this way and 60 percent to 70 percent of Medicaid nursing home recipients in South Dakota take advantage of this loophole.[27]

---

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

[27] The public policy issue involved here is whether scarce welfare resources are appropriately used to subsidize expensive funerals for people who could otherwise have afforded to pay longer for their own long-term care. Is it proper, in other words, to use money appropriated for public assistance to indemnify heirs against the cost of burying their parents? The state should study (or retain a private contractor on contingency to examine) this issue. South Dakota should also build on and add to its model practice negotiated with the state's funeral industry whereby funeral homes refund excess prefunded burial costs that are eventually unspent, instead of refunding these funds to the heirs. (This policy eliminates the incentive for heirs to minimize burial or cremation costs and pocket the difference which

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

3 **Enhance Asset Security**

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

4 **Strengthen Estate Recovery**

4.1 Require all recipients to agree in writing as a condition of eligibility that all proceeds from the sale of everything they own[28] will go to pay for the cost of their care upon the death of their last, surviving exempt dependent relative and that all property of a predeceased Medicaid recipient will be encumbered by a lien until such time as it is recoverable from the estate of a dependent relative.

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

5.1 All of the actions necessary under this category may be accomplished under existing federal law. Nevertheless,

---

had been exempted as a funeral cost for purposes of determining Medicaid eligibility.)

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

the additional state authority potentially available under a waiver or block grant would empower any public education program enormously.

II. RECOMMENDATIONS ACHIEVABLE UNDER CURRENT FEDERAL LAW

1 Retain a Generous Public Long-Term Care Financing Program

1.1 Explore the possibility of implementing a medically needy eligibility determination system. Consider adopting the federal maximum spousal impoverishment standards which allow all community spouses to retain $76,740 instead of half of joint assets up to that amount as currently applies. Review and consider other measures to make Medicaid more "user friendly" for middle class families who lack the cash flow to pay for long-term care. Measures such as these are necessary to make the rest of these recommendations more politically saleable. Although this recommendation will increase costs to South Dakota's Medicaid program, it will also make the program more efficient and eliminate the subsidy to Medicaid planning attorneys that is implicit in the "Miller income trusts" currently employed to circumvent Medicaid income limits. Additional costs incidental to implementing this recommendation should be more than amply compensated by savings from the other measures proposed below.

2 Control Divestiture and Medicaid Estate Planning[29]

2.1 The Department of Social Services has already

[29] It should be noted that South Dakota's Department of Social Services has acted quickly and relatively aggressively (compared to many other state Medicaid programs) to implement the new authorities in the Omnibus Budget Reconciliation Act of 1993 which empower states to close some Medicaid eligibility loopholes. Of course, much, much more needs to be done. It is not within the scope of this project to detail all of the missed opportunities to close eligibility loopholes that South Dakota might address. The bibliography of this report, however, cites numerous studies of a similar nature conducted in much more detail in other states. Many of the observations and recommendations in these studies will apply equally to South Dakota's Medicaid program.

implemented a training program for field eligibility staff to discourage inappropriate Medicaid planning. The Department should further strengthen training, procedures and legal support to assist field eligibility staff in dealing with Medicaid estate planning attorneys, general practitioners, and other representatives of Medicaid applicants who seek "loopholes" in current law.

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

2.3 Conduct a valid random sample of Medicaid nursing home eligibility cases in South Dakota to determine the incidence and cost of asset divestiture and other techniques of Medicaid estate planning (such as trusts, annuities, purchase of exempt assets, life estates, dubious claims of exempt transfers, etc.). Compensate the contractor for this study on contingency from the savings incidental to its findings so that the state has little or no cost. To date, no such study has been done and the Department of Social Services has no estimate of program losses caused by the legal stretching or illegal breaking of nursing home eligibility rules by applicants or their representatives.

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

2.5 Clamp down on the use of annuities and life estates to

shelter excess resources. According to state eligibility staff, this loophole is wide open in South Dakota. The subject is extremely complicated, affected by new guidelines published by the Health Care Financing Administration (HCFA), and requires extensive further study. There may be much more South Dakota can do than it already is doing. A review of federal policy and restrictions utilized by other state Medicaid programs is needed.

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

2.7 South Dakota should take full advantage of the legal interpretation that Medicaid estate planning may violate the common law of fraudulent conveyances. In other words, a transfer in contemplation of avoiding a future possible creditor, *i.e.* Medicaid, may be a fraudulent conveyance even if it otherwise complies with Medicaid rules. This idea is fertile with potential, but will require considerable additional research.

2.8 The South Dakota Medicaid program should subscribe to and carefully review elder law publications such as John Regan's Tax, Estate and Financial Planning for the Elderly and Clark Boardman Callaghan's *Advising the Elderly Client*. These publications are full of Medicaid estate planning techniques that lawyers are using to circumvent Medicaid eligibility rules. Publications like these supply vital clues on where to focus efforts to control and contain Medicaid estate planning abuses.

2.9 State eligibility staff should attend all major elder law conferences including the annual Joint Conference on Law and Aging held in Washington, D.C. and the semi-annual symposiums and institutes of the National Academy of Elder Law Attorneys (NAELA) held at various locations throughout the United States. Join NAELA and participate so you know what the Medicaid planners are planning. This is an excellent way to monitor old and new Medicaid estate planning techniques. It also provides an opportunity to convey the Medicaid program's point of view on Medicaid estate planning to professionals in the field and to enlist their help in correcting problems. Alternatively, the Medicaid program can obtain advice from consultants or attorneys who attend these meetings and study the Medicaid planning literature.

3 Enhance Asset Security

3.1 South Dakota has implemented a TEFRA lien program that shows significant promise. We cannot venture any suggestions on how to improve this program without additional study and review. It is true, however, that most South Dakotans are unaware of the lien program and that state staff have made only limited efforts to publicize it. Thus, for lack of this information, few people are motivated to buy insurance or purchase home and community-based services to avoid the lien liability on their homes incidental to receiving Medicaid nursing home benefits. To maximize such cost avoidance savings, the state should publicize its lien program as widely and promptly as possible.

4 Strengthen Estate Recovery

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

4.2 Lien and estate recovery staff should train field eligibility staff in techniques to identify unreported property or asset transfers. South Dakota cannot collect liens or estate recoveries from property that was divested by Medicaid recipients to qualify for assistance in the first place. Integrating the front-end eligibility process with the back-end lien and estate recovery program is absolutely essential but largely unachieved at present.

4.3 Draft and pass state legislation to require nursing homes to remit the proceeds of personal needs accounts of Medicaid recipients who die directly and immediately to the state. The current system whereby nursing homes notify the Medicaid program upon the death of a resident receiving benefits works fairly well. (As a result of this study, the South Dakota Health Care Association has encouraged its members to expedite the transmission of this vital information by faxing it instead of mailing it.) As soon as the information is received, the state takes action to file an affidavit to collect the personal needs account and to initiate a probate claim. Nevertheless, states that require nursing homes actually to remit the personal needs accounts directly to the state upon the death of a Medicaid recipient have found that the system saves a lot of time and money and prevents heirs from diverting resources to themselves that should be used to reimburse the state for the cost of care already provided.

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

4.5 South Dakota should begin a systematic and comprehensive system of accounts receivable. For example, the state could avoid liquidating certain illiquid assets in the probate process in order to

preserve more of their value and in order to help families retain the assets (such as homesteads or family farms) by repaying the Medicaid program over time. Oregon recovers over $85,000 per month from accounts receivable of this and many other kinds. If occasionally it becomes necessary to receive real property that will not sell quickly in a down market, consider placing the property in management with fees paid by rental income until the real estate market improves.

4.6 Reintroduce state legislation that failed last year to authorize recovery from the estates of spouses predeceased by Medicaid recipients. This is an enormous source of non-tax revenue currently lost by the state. By not pursuing spousal recoveries, South Dakota allows substantial wealth to pass unencumbered to heirs regardless of how much money Medicaid contributed toward the recipient's care. (A recent court case in Wisconsin has brought the practice of spousal recoveries into question under federal law. This is a legal matter that should be watched very closely. States that continue to recover from spousal estates should be contacted for advice on the issue and to develop a state legislative strategy. In any case, spousal recoveries will be much easier to achieve under waiver or block grant authority.)

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

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

5.2 Draft an executive proclamation for Governor Janklow to deliver at a press conference declaring that the "Heartland Manifesto" articulated at the beginning of this report is the official policy of the state of South Dakota. In other words, Medicaid in South Dakota is for the genuinely needy, measures are being taken to discourage Medicaid estate planning, restrictions on divestiture of assets are being tightened, a strong estate recovery program is in effect and expanding, and seniors and heirs should carefully examine private

long-term care financing options.

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

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

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

5.6 Develop a systematic, statewide, well-financed initiative to educate the public about the risk of long-term care, the cost of institutionalization, and the availability of private long-term care insurance to prepare in advance. If necessary, tap a percentage of lien and estate recovery revenues to finance this initiative. Seek and obtain the cooperation and assistance of the Chamber of Commerce and the various public and private employee unions in this effort. Headquarters Medicaid eligibility staff believed strongly that insurance companies that market private long-term care insurance should also take a lead in educating the public about the risks of relying on Medicaid, a means-tested public assistance program, for

their long-term care financing needs. The Medicaid program and the long-term care insurance industry should find ways to work together in their common interest and in the common interest of their mutual clients. This is not a conflict of interest. It is a confluence of interests.

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

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

5.9 Explore the possibility of encouraging the purchase of private long-term care insurance by granting inheritance tax relief. This option was strongly recommended by several state legislators interviewed for this study. One legislator recommended specifically a $50,000 reduction in the taxable estate if someone buys at least a three-year long-term care insurance policy. Another legislator suggested letting someone else besides the insured party, *e.g.* an heir, get the tax credit if he pays the premium for the insurance policy for another, *e.g.* a parent.

5.10 South Dakota should research private geriatric care management and find ways to encourage it. Geriatric care managers (GCMs) help seniors to use their income and savings to remain at home as the seniors prefer. GCMs assess seniors' care needs, identify necessary services, retain caregivers, manage cases, and place worried (often out-of-state) relatives' minds at ease. The National Association of Professional Geriatric

Care Managers is a valuable resource for information on this profession. Seniors whose assets are not divested or sheltered to qualify for Medicaid nursing home benefits can often remain at home for long periods by paying privately for home and community-based services guided by professional geriatric care management.

RESPONDENTS/INTERVIEWEES

Martha Armstrong, Administrator, Office of Recoveries and Investigations, Department of Social Services, Pierre

Jack Billion, State Representative, South Dakota House of Representatives, Sioux Falls

Loren Boyens, President, Sioux Falls Association of Life Underwriters, Lutheran Brotherhood, Sioux Falls

Tim Dardis, Long-Term Care Insurance Agent, Howalt-McDowell Insurance Agency, Sioux Falls

Jim Ellenbecker, Secretary, Department of Social Services, Pierre

Warren Graber, Agent, Graber & Associates, Sioux Falls

Tom Graves, Administrator, Highmore Healthcare Center, Inc., Highmore

Jim Hanson, Legislative Liaison, American Association for Retired Persons, Pierre

Tim Heerts, Long-Term Care Insurance Representative, General Electric Capital Assurance Company, Sioux Falls

Joyce Helkenn, Administrator, Clark Care Center, Clark

Rolland Hostler, Program Specialist, Office of Recoveries and Investigations, Department of Social Services, Pierre

Bernie Hunhoff, State Senator, South Dakota Senate, Yankton

Dennis J. Jarabek, State Legislation Chairman, South Dakota Association of Life Underwriters, Sioux Falls

Merle Johnson, Attorney at Law, Woods, Fuller, Shultz & Smith, Sioux Falls

Donna Keeler, Assistant Administrator, Office of Assistance Payments, Department of Social Services, Pierre

Sarah Richardson Larson, Attorney a Law, Davenport, Evans, Hurwitz & Smith, Sioux Falls

Darla L. Lyon, Director, Department of Commerce, Division of Insurance, Pierre

Randy Moses, Enforcement Coordinator, Department of Commerce, Division of Insurance, Pierre

Michael Myers, Professor, University of South Dakota Law School, University of South Dakota, Vermillion

Roger Nickeson, Assistant Program Administrator, Provider Reimbursements, Department of Social Services, Pierre

Beth O'Toole, Division Counsel, Department of Commerce, Division of Insurance, Pierre

Michael L. Parker, Staff Attorney, Office of Recoveries and Investigations, Department of Social Services, Pierre

Denny Pelkofer, Administrator, Office of Assistance Payments, Department of Social Services, Pierre

John R. Peterson, Long-Term Care Insurance Agent, North Central Insurance Center, Sioux Falls

Damian Prunty, Program Administrator, Provider Reimbursement and Audits, Department of Social Services, Sioux Falls

Richard J. Reding, Executive Director, South Dakota Health Care Association, Sioux Falls

Joe Reedy, State Representative, South Dakota House of Representatives, Vermillion

Rosemary Robertson, Long-Term Care Insurance Representative, General Electric Capital Assurance Company, Brookings

Doug Schmidt, District Manager, General Electric Capital Assurance Company, Sioux City

Sharon Sonnenschein, Program Management, Office of Assistance Payments, Department of Social Services, Pierre

Ron Staebell, National Committeeman, South Dakota Association of Life Underwriters, Sioux Falls

Carolyn A. Thompson, Attorney at Law, Boyce, Murphy, McDowell & Greenfield, Sioux Falls

Margaret Turner, Long-Term Care Insurance Agent, American Family Life Assurance Company, Sioux Falls

Mike Vogel, Division Director, Division of Program Management, Department of Social Services, Pierre

Bruce Ward, Case Worker, Department of Social Services, Mitchell

Mary Lee Williams, District Program Supervisor, Department of Social Services, Sioux Falls

Todd Wilson, Administrator, Marshall Manor, Britton

Merle Wollman, Long-Term Care Insurance Agent, Williams Agency, Sioux Falls

BIBLIOGRAPHY

General References

Brown, Erwin, Jr., *Facts and Trends: The Nursing Facility Sourcebook, 1996*, American Health Care Association, 1996.

Coronel, Susan and Craig Caplan, *Long-Term Care Insurance in 1994*, Health Insurance Association of America, Washington, D.C., 1996.

Cowles, C. McKeen, *Nursing Home Statistical Yearbook: 1995*, Johns Hopkins University Press, Baltimore, Maryland, 1995.

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

South Dakota Department of Health and South Dakota Department of Social Services, "Status of Long Term Care Beds in South Dakota: Report to Governor Janklow and the 1995 South Dakota Legislature," undated.

Chronological List of Research Studies and Publications by Stephen A. Moses on Related Subjects

Long-Term Care Public Policy & the Future of Seniors Housing, American Seniors Housing Association, Washington, D.C., 1995.

The Long-Term Care Financing Crisis: Danger or Opportunity? -- A Case Study in Maryland, LTC, Incorporated, Seattle, Washington, 1995.

The Magic Bullet: How to Pay for Universal Long-Term Care, A Case Study in Illinois, LTC, Incorporated, Seattle, Washington, 1995.

The Perils of Medicaid: A New Perspective on Public and Private Long-Term Care Financing, LTC, Incorporated, Kirkland, Washington, 1995.

The Florida Fulcrum: A Cost-Saving Strategy to Pay for Long-Term Care, LTC, Incorporated, Seattle, Washington, 1994.

Long-Term Care in Montana: A Blueprint for Cost-Effective

Reform, LTC, Incorporated, Kirkland, Washington, 1993.

Medicaid Estate Recoveries in Maine: Planning to Increase Non-Tax Revenue and Program Fairness, LTC, Incorporated, Kirkland, Washington, 1993.

Medicaid Estate Planning: Analysis of GAO's Massachusetts Report and Senate/House Conference Language, LTC, Incorporated, Kirkland, Washington, 1993.

Medicaid Estate Planning in Kentucky: How to Identify, Measure and Eliminate Legal Excesses, LTC, Incorporated, Kirkland, Washington, 1993.

"Planning for Long-Term Care Without Public Assistance," *Journal of Accountancy*, Vol. 175, No. 2, February 1993, pps. 40-44.

"Health and Long-Term Care Insurance," chapter in Louis A. Mezzullo and Mark Woolpert, editors, *Advising the Elderly Client*, Clark Boardman Callaghan, New York, 1992.

A Minnesota Prospectus for the Senior Financial Security Program, LTC, Incorporated, Kirkland, Washington, 1992.

The Senior Financial Security Program: A Plan for Long-Term Care Reform in Wisconsin, LTC, Incorporated, Kirkland, Washington, 1992.

Medicaid Loopholes: A Statutory Analysis with Recommendations, LTC, Incorporated, Kirkland, Washington, 1991.

The Myth of Medicaid Spend-Down, LTC, Incorporated, Kirkland, Washington, 1991.

"The Fallacy of Impoverishment," *The Gerontologist*, Vol. 30, No. 1, February 1990, pps. 21-25.

Medicaid Estate Recoveries in Massachusetts: How to Increase Non-Tax Revenue and Program Fairness, LTC, Incorporated, Kirkland, Washington, 1990.

Transfer of Assets in the Medicaid Program: A Case Study in Washington State, Office of Inspector General, OAI-09-88-01340, Washington, DC, 1989.

Medicaid Estate Recoveries: A Management Advisory Report, Office of Inspector General, Office of Analysis and Inspections, OAI-09-89-89190, Washington, DC, December 1988.

Medicaid Estate Recoveries, Office of Inspector General, Office of Analysis and Inspections, OAI-09-86-00078, San Francisco, California, June 1988.

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

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

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

A. Preserve generous eligibility

1. Status Quo

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

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

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

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

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

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

(4) end up in nursing homes subsidized by Medicaid.

2. Senior Financial Security Program

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

3. ***Model State Statute***

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

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

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

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

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

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

"Other exempt resources and limitations to be delineated."

B. Prohibit divestiture

1. Status Quo

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

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

2. Senior Financial Security Program

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

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

with expensive long-term care benefits.

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

3. ***Model State Statute***

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

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

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

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

C. Require legal security as a condition of eligibility

1. Status Quo

Exempt assets divested legally or illegally while on Medicaid are lost forever as a source of long-term care financing for seniors. Nor can such divested resources

serve as a non-tax revenue source to the program. Under the existing Medicaid program, states are permitted--but not required--to place liens on the homes of recipients under certain highly restrictive circumstances. Very few states use the lien authority to secure assets for later recovery. Even states that utilize liens have limited success enforcing and collecting on them because of extensive exclusions in the federal law. Consequently, exempt and non-exempt assets held openly or concealed by Medicaid recipients routinely disappear during the period of eligibility either legally or illegally as relatives, friends and others take advantage of the senior's incapacity to relieve them of their resources.

2. Senior Financial Security Program

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

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

3. ***Model State Statute***

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

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

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

D. Require estate recoveries

1. Status Quo

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

2. Senior Financial Security Program

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

3. ***Model State Statute***

"Every participant in the Senior Financial Security Program must agree in writing to pay back the entire cost of care from his or her estate or from the proceeds of sale of real or personal property during program eligibility up to

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

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

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

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

1. Status Quo

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

2. Senior Financial Security Program

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

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

3. **Model State Statute**

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

F. Educate the public

1. Status Quo

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

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

2. Senior Financial Security Program

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

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

3. ***Model State Statute***

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

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

II. Conclusion

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

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

Appendix A

Model State Statute for a Senior Financial Security Program

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

I. Eligibility System

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

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

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

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

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

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

"Other exempt resources and limitations to be delineated."

II. Divestiture Policy

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

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

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

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

III. Lien Security

"As a condition of eligibility for the SFSP, all participants must allow the state to place a lien on their exempt property. The lien shall apply to all real and personal property

retained by the participant with the exception of the $2,000 liquid asset exclusion and certain highly private personal property such as original wedding rings.

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

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

IV. Estate Recovery

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

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

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

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

"The purpose of the Senior Financial Security Program is to

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

VI. Public Education

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

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

Appendix B:

Long-Term Care Insurance Carriers Marketing in South Dakota: 1996

Aid Association for Lutherans

Allianz Life Insurance Company of North America

Allied Life Insurance Company

American Family Life Assurance Company of Columbus

American Travellers Life Insurance Company

Bankers Life and Casualty Company

Combined Insurance Company of America

Continental Casualty Company

General Electric Capital Assurance Company

John Hancock Mutual Life Insurance Company

Life Investors Insurance Company of America

Network America Life Insurance Company

PFL Life Insurance Company

Transport Life Insurance Company

Travelers Insurance Company

Union Bankers Insurance Company

Appendix C:

Project Proposal: Controlling Medicaid Long-Term Care Costs

Submitted to the State of South Dakota
by
Stephen A. Moses, Director of Research
LTC, Incorporated

I. **Objective**: Produce a step-by-step plan to save the State of South Dakota $15 million per year in Medicaid nursing home expenditures while simultaneously assuring universal access to top quality long-term care for rich and poor citizens alike across the whole spectrum from home and community-based to nursing home care.

II. **Problem**: Medicaid nursing home expenditures in South Dakota nearly doubled from $47.7 million in 1989 to $86.3 million in 1994. This rapid cost increase severely impairs the state's ability to maintain generous Medicaid nursing home eligibility criteria, to expand the home and community-based services often preferred by seniors, and to sustain adequate financing for other critical state services such as corrections, education, and highways.

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

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

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

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

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

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

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

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

E. Analyze South Dakota' lien and estate recovery statutory

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

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

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

receive an information pack of articles and reports on the topic similar to the one enclosed herewith. (80 hours Moses; 20 hours Tjelle)

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

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

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

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

L. The preceding time estimates are based on the assumption

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

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

VII. **Schedule**: We recommend beginning this project by September 1, 1996 and completing it by December 1, 1996.

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

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

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

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

Travel expenses: 25 days times $275 (inclusive of all travel expenses including air and ground transportation) equals $6,875

Total: $110,425

This bid covers all costs to the state of South Dakota incidental to this project.

X. **Experience and Credentials**: All tasks related to this project will be performed by Stephen A. Moses or Kathryn J. Tjelle of LTC, Incorporated as delineated below:

A. LTC, Incorporated is a private firm specializing in long-term care financing and insurance. The company also provides consulting services to state Medicaid agencies and publishes a well-known and highly respected national newsletter called LTC News & Comment.

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

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

Since leaving federal service in 1989, Mr. Moses has published over four dozen articles on Medicaid estate planning, nursing home eligibility, transfer of assets, liens and estate recoveries; he has consulted on these subjects in over 25 states and spoken at innumerable national conferences; and he has testified before two dozen state legislatures. As Director of Research for LTC, Inc., Mr. Moses has directed and authored studies on Medicaid nursing home eligibility, asset and resource transferring techniques, methods to control divestiture, estate recoveries, and how to implement OBRA '93 in numerous states, *e.g.*: Medicaid Estate Recoveries in Massachusetts: How to Increase Non-Tax Revenue and Program Fairness, December 1990; The Senior Financial Security Program: A Plan for Long-Term Care Reform in Wisconsin, June 1992; Medicaid Estate Planning in Kentucky: How to Identify, Measure and Eliminate Legal Excesses,

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

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

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

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

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

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

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

E. Wisconsin State Contact: Gene Kussart, Executive Assistant, Department of Health and Social Services, P.O. 7850, 650 One West Wilson St., Madison, WI, 53707, 608-266-9622.

F. Inspector General contact: Michael Mangano, Principal

Deputy Inspector General, Office of Inspector General, Room 5246 Cohen Building, 330 Independence Ave., S.W., Washington, DC, 20201, 202-619-3146.

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

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