

THE SENIOR FINANCIAL SECURITY PROGRAM:

A Plan for Long-Term Care Reform in Wisconsin

Presented

by

LTC, INCORPORATED

"The Long-Term Care Specialists"

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EXECUTIVE SUMMARY

Purpose

The objective of this study was to advise Governor Thompson concerning the techniques people use to qualify for Medicaid nursing home benefits without spending down, the status and growth of this practice, the potential impact on the state budget, and methods to control the damage, reverse the process, and encourage more responsible long-term care planning.

Background

Substantial anecdotal evidence suggests that people with incomes and assets well above Medicaid eligibility limits can shelter or divest their wealth to qualify for the program's expensive nursing home benefit. Federal statutory initiatives to control this practice, such as TEFRA '82, COBRA '86, and MCCA '88, were largely ineffectual. Recent efforts to limit Medicaid costs in Wisconsin compelled a careful review of spousal impoverishment, nursing home eligibility, Medicaid estate planning, liens, estate recovery, and long-term care insurance.

Major Findings

Medicaid nursing home eligibility is so generous in Wisconsin that most seniors who need long-term care qualify financially even without sophisticated legal planning. Anyone else can qualify quickly, often overnight, by using techniques such as joint accounts, trusts, purchase of exempt assets, or multiple divestment. Estate recovery is easy to avoid using joint tenancy with right of survivorship and other techniques. Formal, lawyer-assisted Medicaid estate planning is still fairly limited in Wisconsin, but it is growing rapidly. Predictably, private long-term care insurance is stunted. If the Medicaid census in Wisconsin's nursing homes were to increase by ten percent on account of expanded public benefits planning, it would cost the state \$106 million per year. Conversely, Wisconsin could save \$106 million per year by diverting ten percent of future nursing home caseloads into private pay status.

Recommendations

The state of Wisconsin should undertake to (1) maximize income and asset protections for single and married seniors who need long-term care, (2) eliminate divestiture and estate recovery avoidance, (3) secure property in a beneficiary's possession as a condition of eligibility for publicly financed care, (4) recover publicly financed benefits from estates when dependents no longer need the assets, (5) encourage the sale of long-term care insurance as an alternative to public benefits and estate

recovery, and (6) educate the public on the advantages of avoiding Medicaid dependency and paying privately for care.

The vehicle to achieve these goals is a combination of administrative initiatives, state statutory changes, and a federal waiver called The Senior Financial Security Program.

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LTC, Incorporated 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.

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INTRODUCTION

Project Background

The State of Wisconsin has emerged as the national leader in welfare (AFDC) reform. If Governor Thompson's initiatives are successful, many young families will escape an otherwise inevitable cycle of dependency and public assistance. Ironically, however, in another area of welfare (Medicaid long-term care), public policy in Wisconsin, as elsewhere, unintentionally encourages reliance on public assistance. Seniors and their heirs lack incentives to plan privately for catastrophic long-term care costs, because Medicaid eligibility rules allow them, with the help of attorneys, to qualify virtually overnight for publicly financed nursing home benefits.

Wisconsin officials are aware of this problem and have taken or attempted measures, such as estate recovery and spousal impoverishment modifications, to address it, although to no one's complete satisfaction. In the meantime, the state has very limited information, on (1) the extent of Medicaid estate planning, (2) its principal techniques and practitioners, (3) successful methods to close or constrict eligibility loopholes without hurting the genuinely needy, (4) politically persuasive alternatives to gain support from senior advocacy groups, attorneys and judges, (5) the nontax revenue potential of estate recoveries, and (6) the most successful methods of estate recovery.

The objective of this study is to give Governor Thompson the information he needs to clarify these issues and resolve the underlying problem. The measure of a successful solution is that it must save the state money while improving access to and quality of long-term care for Wisconsin's seniors. The solution must also be acceptable to the principal interest groups with a stake in long-term care: senior citizens and their advocates, the nursing home and home care industries, long-term care insurers, and the taxpayers of Wisconsin.

Field work for this project consisted of nine days on site in Madison, Wisconsin (May 26 to June 5, 1992). It included visits to Racine, Walworth and Dane counties to examine the Medicaid nursing home eligibility determination process. This report begins by explaining the national and state background of the long-term care financing problem. It then discusses Title XIX nursing home eligibility, Medicaid estate planning, liens and estate recoveries, and long-term care insurance. The report concludes with a political analysis of the situation in Wisconsin and with recommendations for short-term and long-term solutions.

National Background

Medicaid began in 1965. Congress and the President intended the program to assure access to mainstream health care for poor women and children. The legislation included a provision, however, to finance institutional long-term care for the aged, blind and disabled. No one expected this part of the program to cost very much; people died much younger back then and the nursing home industry was relatively small. But "form

follows funding," and before long the nursing home portion of Medicaid began to grow rapidly. The combination of an aging population and the availability of government financing led logically and inevitably to rapid growth in the nursing home industry and in Medicaid budgets.

By the early 1980's, public policy makers saw the rise in long-term care costs as serious and threatening. They took two major initiatives to rein in the expansion. One approach was to discourage nursing home utilization and encourage home and community-based care. This effort had considerable success in expanding long-term care options for seniors. Most of the recent academic research indicates, however, that home and community-based services successfully delay institutionalization, but ultimately increase overall long-term care costs. This fact detracts not at all from the desirability of home care, but rather emphasizes the need to find financing for the full continuum of care. That is one of the objectives of this report.

The other major approach to curtailing Medicaid nursing home costs was to target services to the most needy. Before the 1980's, federal law permitted anyone, regardless of wealth, to give away assets to qualify for Medicaid. The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) empowered state Medicaid programs to restrain this practice. TEFRA permitted states to restrict the transfer of assets to qualify for Medicaid, to place liens on property retained during eligibility, and to recover benefits correctly paid from the probate estates of deceased recipients. According to legislative history, the purpose of these TEFRA authorities was to assure that all of the resources available to an institutionalized individual, including equity in a home, which are not needed for the support of a spouse or dependent children will be used to defray the cost of supporting the individual in the institution.

By the late 1980's, it was clear that the intent of Congress in the TEFRA asset control authorities was not being achieved. The Office of Inspector General of the U.S. Department of Health and Human Services (IG) studied the issue in 1988 and published a report entitled Medicaid Estate Recoveries. The Inspector General found lax enforcement of transfer of assets rules, very little use of liens to secure real property, and significant estate recoveries in only a handful of states. The IG also discovered a widespread practice of legal, but unanticipated, divestment and sheltering of income and assets to qualify for Medicaid. In 1989, the General Accounting Office reported similar findings in another national study entitled Medicaid: Recoveries From Nursing Home Residents' Estates Could Offset Program Costs.

A countervailing factor during this same period was widespread concern over catastrophic spend-down of middle class people in nursing homes. The conventional wisdom was that one-half to three-fourths of all people in nursing homes on Medicaid were originally private payers, but spent down--usually very quickly--into impoverishment because of high nursing home costs. Of particular concern were the community spouses of nursing home recipients who were being impoverished because of Medicaid's peculiar treatment of couple's income and assets. The Medicare Catastrophic Coverage Act of 1988 (MCCA) ameliorated this problem by guaranteeing the spouse at

home a minimum of income and assets. MCCA also attempted to address the budding Medicaid estate planning problem by extending the transfer of assets restrictions from two years to thirty months and making them mandatory.

No sooner had MCCA become law, however, than the results of two dozen studies on Medicaid spend-down began coming in. They showed that only 10 to 25 percent of Medicaid nursing home recipients had spent down: one-third of the proportion previously believed. Furthermore, none of these studies accounted for the phenomenon of artificial spend-down through divestment and shelters which was documented in the Inspector General's report. Whatever the yet-undetermined incidence of Medicaid estate planning, it was included entirely in the new, much lower estimates of spend-down. In September 1991, Brian Burwell catalogued the techniques of artificial spend-down and provided additional anecdotal evidence of their prevalence in *Middle-Class Welfare: Medicaid Estate Planning for Long-Term Care Coverage*.

All of these developments took place in the context of widespread study and growing interest in universal health care reform. The Pepper Commission proposed a \$43 billion long-term care financing plan, but failed to provide financing or to mobilize support for it. The National Governors' Association and several states endorsed statewide universal health care programs, but progress has been slow. As time drags on, more and more people doubt that a new public entitlement will solve the problem. They may prefer it, but they are impatient and increasingly cynical. In the meantime, the national debt is \$4 trillion: \$16,000 for every man, woman and child in the country. The budget deficit is \$400 billion per year: another \$1,600 per capita. Service on the debt is soon to become the biggest item in the federal budget. States are staggering fiscally. Half the American people say they will never receive anything from Social Security and Medicare is bankrupt in 2002. The outlook for expanded public financing of long-term care is not at all optimistic.

For this reason, interest has grown steadily in private long-term care financing mechanisms and in public/private partnerships. Over time, these options have boiled down mainly to long-term care insurance and the Robert Wood Johnson (RWJ) experiment to meld private insurance with Medicaid. Until fairly recently, private long-term care insurance had a quite negative reputation. Lately, however, most experts agree that good products, although expensive, are available. The problem is that not enough seniors are buying these products. The RWJ project was designed to encourage people to buy long-term care insurance by offering the incentive of spend-down forgiveness if they ever need Medicaid benefits after all. Unfortunately, this option has the downside, vigorously articulated by the American Association of Retired Persons, of diverting the middle-class toward reliance on public assistance.

In summary, aging demographics promise to push up long-term care costs steadily until the last baby boomer expires in the next millennium. Already, two-thirds of all nursing home residents in America receive Medicaid, while only 12 percent of the elderly are poor. Medicaid nursing home applicants must choose between genuine impoverishment or artificial self-pauperization. Medicaid pays nursing homes less than

the cost of providing the care according to the United Seniors Health Cooperative. This low reimbursement is a drag on access and quality and entices nursing homes to attract private payers while repelling Medicaid recipients. Home care is a desirable alternative but lacks adequate financing and institutional bias remains the rule in Medicaid. State and federal budgets are busting. The prognosis for public financing is dismal while the growth of private long-term care insurance is disappointingly slow. Where do we go from here?

Lincoln said in the "House Divided" speech: "If we could first know where we are and whither we are tending, we could better judge what to do and how to do it." Let us take a fresh look at the situation and see if it points toward a solution.

In America today, seniors and their heirs can ignore the risk of going to a nursing home (and denial is an important part of the problem); they can avoid the premiums for long-term care insurance (and the premiums are big for those who delay until they are old to buy); they can wait and see if they get sick (if they die of a heart attack, they're home free); but if they do get one of the chronic illnesses of old age (such as Alzheimer's, Parkinson's, or Stroke); and if they have to go to a nursing home; then, for less than the cost of one month of privately financed care, they can hire an attorney to shelter all of their income and assets and qualify for Medicaid within 30 days; they can also pass their entire estate to their heirs if their attorney or planner is savvy.

Under the circumstances, is it any wonder that most seniors who need long-term care end up in nursing homes paid for by Medicaid? Wouldn't a sensible solution be to change the incentives in the system to encourage people to plan ahead for long-term care costs and avoid public assistance altogether? Can public policy provide such incentives while simultaneously reducing costs and improving access and quality?

In the aforementioned 1988 report on Medicaid Estate Recoveries and in a case study on Transfer of Assets...in Washington State, the Inspector General of the U.S. Department of Health and Human Services recommended a plan to achieve those goals:

- (1) Change Medicaid rules to permit families to retain and manage property while their elders receive long-term care.
- (2) Strengthen the transfer of assets rules so that people cannot give away property to qualify for Medicaid.
- (3) Require a legal instrument as a condition of Medicaid eligibility to secure property owned by applicants and recipients for later recovery.
- (4) Increase estate recoveries as a nontax revenue source for the Medicaid program while steadfastly protecting the personal and property rights of recipients and their families.

I directed and wrote the IG studies that contained these recommendations. The idea of the plan was to keep income and asset protections as high as possible in order to (1) protect families from catastrophic spend-down and (2) eliminate the need to wangle a way onto Medicaid by hiring an estate planner or getting a divorce. To pay for this

liberalization of the eligibility rules, the plan called for longer and stronger transfer of assets restrictions, liens as a condition of eligibility, and mandatory estate recoveries. The principle is to make access to care more readily available to everyone in exchange for an enforceable agreement to retain (instead of divesting) assets and to repay the program for benefits received. If seniors and their heirs knew Medicaid was not a free ride, they would be more inclined to plan ahead to finance long-term care privately and avoid Medicaid. Heirs, in their peak earnings years, would have an incentive to help their "cash poor, house rich" parents insure the estate, i.e. their own inheritance. Seniors would have a reason to tap the equity in their homes, over \$1 trillion nationally, through reverse annuity mortgages in order to supplement their incomes sufficiently to purchase private long-term care protection.

The relief on Medicaid would be substantial, far exceeding projections (e.g. by Brookings) for savings from long-term care insurance in the absence of changes in the public policy incentives. The nursing home and home health industries would thrive from the additional, full-cost private payers newly financed by insurance. Everyone who could afford it would buy long-term care protection as early as possible, because the biggest obstacle to its marketing would be removed: "You can't sell apples on one side of the street if someone is giving them away on the other."

Finally, and most importantly, seniors would have improved access to better care within a wider continuum of services. With insurance, and as private payers, they would have red carpet access to top quality care in the home, community-based or institutional setting of their choosing. Geriatric care management would become an essential and profitable private business. Even those remaining on Medicaid, would benefit by the additional financial stability that private financing would bring to the long-term care industry.

Everybody would win under this plan including the "yuppie" heirs who, if they do not save or insure for their own long-term care, will surely bankrupt the existing system eventually anyway. They would have the satisfaction of knowing their parents are cared for without welfare (you can't really call it welfare if they are paying it back) and their own senescence would be protected.

The Inspector General's plan was presented to the then-incumbent Secretary of the Department of Health and Human Services, to the Administrator of the Health Care Financing Administration, and to the Congress. Political sensitivity and high hopes for alternative solutions stymied its progress for several years. Today, however, public policy stalemate on long-term care financing and the impending threat of draconian budget cuts have renewed interest in the proposal. In fact, all of the pieces in the puzzle (maximum spousal impoverishment protections, transfer of assets restrictions, liens, estate recoveries, and strong long-term care insurance consumer protections) are in place in Wisconsin. Unfortunately, the program is emasculated by gaping loopholes in federal law that defeat its purpose. The remainder of this report describes the situation today in Wisconsin within this context and proposes a solution in the form of an experimental

Medicaid waiver to make the system work the way it was originally intended to do. I call this proposal the "The Senior Financial Security Program."

Wisconsin Background

Wisconsin's experience in long-term care financing mirrors the nation's in microcosm. The state's Medicaid program is possibly the most generous in the country. It covers all but one optional service and uses the most charitable eligibility criteria permitted under federal law.

Likewise, and relatedly, Wisconsin has long had a reputation for nursing home over-bedding. The state ranks second in the nation in nursing home residents as a percentage of population 65 years of age and over (7.54 percent) . As in the country at large, Medicaid financing for institutional long-term care fostered the growth of this industry. In time, policy makers became alarmed by growing costs. Again in parallel with the nation, however, Wisconsin acted strongly and effectively in the early 1980's to divert many frail seniors from nursing homes to home and community-based care. The state's Community Options Program (COP) is widely credited with contributing to a 19 percent drop in Medicaid-funded nursing home days while the national average increased 24 percent. A surprisingly low two percent growth rate in Medicaid nursing home expenditures over the past several years attests to the fiscal success of this initiative.

Just as in the nation as a whole, however, community diversion alone will not suffice in Wisconsin. Although the state's proportion of nursing home residents receiving Medicaid dropped from 69.6 percent in 1986 to 64.9 percent in 1989, it crept back up to 65.2 percent in 1990. At roughly two-thirds of all residents, Wisconsin's Medicaid nursing home caseload is almost indistinguishable from the national proportion of 67.3 percent. Thus, although Wisconsin's Medicaid nursing home proportion has dropped and the nation's has increased, they have met in the middle at a very high level. If, as this analysis suggests, Wisconsin may already have squeezed most of the savings from the community diversion option, then the implication is that pressure on Medicaid nursing home costs, will probably increase. Anticipating that other cost-saving approaches would be necessary, the State of Wisconsin took a close look over the years at private long-term care insurance, including the RWJ public/private partnership. In the early 1980's, the state had a national reputation for excessively strong regulation of the private nursing home insurance market. Later, the Insurance Commission loosened the rules to re-attract insurers. Then, it tightened them up again in a healthy effort to strike a balance between consumer protection and product availability and affordability. Wisconsin's romance with the RWJ idea foundered on the rocks of advocates' doubts about the quality of long-term care insurance products and the appropriateness of targeting the middle-class toward ultimate dependency on Medicaid. Today, everyone seems to have a much more sanguine, though ever-skeptical, attitude toward long-term care insurance than before.

In the meantime, despite the good performance on nursing home expenditures, overall Medicaid costs in Wisconsin skyrocketed.

In 1972, state government spent only \$43.1 million in Medicaid....This year, \$753.6 million in state taxes will be spent on Medicaid -- a 1,648% increase in 20 years...Put another way: In 1972, Medicaid got 3% of all state government tax funds. In 1992, it will grab 11.5%. The state is constantly faced with potential shortfalls in the Medicaid budget. This problem is not peculiar to Wisconsin and reflects, yet again, a national fiscal crisis.

As this impending problem approached, the State of Wisconsin took thoughtful action early on to maximize auxiliary nontax revenues. Following up on the Inspector General's 1988 recommendations, the state studied, proposed and ultimately implemented a system of liens and estate recoveries. We examine this newly established system in detail below.

Despite this initiative, however, Wisconsin needed to find even more savings. An attempt was made to conserve \$10 million by retrenching from the state's policy of allowing maximum spousal impoverishment protections. This plan would have dropped Wisconsin from among the most, to among the least generous states on the treatment of income and assets for community spouses of Medicaid nursing home applicants. Advocates objected to this approach and to the practice of imposing liens and estate recoveries on non-institutionalized elderly Medicaid recipients. They won on both counts, but acknowledged two critical points: (1) Medicaid benefits should go to those who need them most and (2) Medicaid resources should not be used merely to indemnify heirs. In other words, they endorsed the principle of eligibility controls, liens and estate recoveries in the context of, and as a buttress to, a generous Medicaid nursing home eligibility system. This compromise represents an historic opportunity for long-term care financing reform in Wisconsin.

To bring us up to date, the risk of future budget shortfalls remains. The big question is: "Where to cut?" There is no question that Medicaid nursing home costs are on the fiscal butcher's block.

While about 7% of MA-eligible beneficiaries are nursing home residents, an estimated 43% (\$712 million) of total MA benefits was paid to nursing homes in 1991. This is the single largest share of MA costs. The specter of Medicaid estate planning, which we discuss in detail below, threatens to swell the ranks of nursing home residents on public assistance.

The state really has only two possible options: keep more people off Medicaid or cut the rate of increase in nursing home reimbursements. The latter alternative holds limited promise. The average Medicaid nursing home reimbursement rate was \$62.51 as of 1990; the average private pay rate was \$77.42. Thus, private payers are already subsidizing Medicaid nursing home residents by almost one-fourth of the Medicaid rate. Advocates say access for Medicaid recipients is already problematical. Quality of care is certainly threatened ultimately if the gap in reimbursement rates widens. Finally, pushed to the wall in other states, the nursing home industry has successfully used Boren

Amendment lawsuits to drive rates up. No one, least of all the industry, wants that to happen in Wisconsin.

What about the option of diverting people from Medicaid dependency? Could it reduce program costs significantly? The following table suggests that it could.

Actual and Projected Nursing Home Expenditures by the Proportion of Residents on Medicaid in Wisconsin

Payor Type	Actual			Projected		
	Number of Residents	%	Average Rate	Estimated Revenues	10% More Medicaid	10% Less Medicaid
Medicaid	30,322	65.2	\$62.51	\$692,059	\$798,237	\$585,882
Private	13,920	29.9	77.42	393,356	261,853	524,858
Medicare	1,722	3.7	99.49	62,532	62,532	62,532
Other	562	1.2	79.87	16,384	16,384	16,384
Total	46,536	100	N/A	\$1,164,331	\$1,139,006	\$1,189,657

Note that while total statewide nursing home costs remain relatively unchanged, Medicaid nursing home expenditures increase or decrease by approximately \$106 million per year depending on whether 75 percent or 55 percent, instead of the existing 65 percent, of residents are on Medicaid. Even with no rate increases, a 10 percent increase in Medicaid residents would be fiscally catastrophic for the state of Wisconsin. On the other hand, a 10 percent decrease in Medicaid participation would be a great boon to the state.

Clearly, a critical key to lowering Medicaid costs is to get more people to pay privately for nursing home care. It is also an important factor in sustaining and improving access to and quality of care. But is it feasible to maintain, much less reduce, current Medicaid nursing home participation levels? Can it be done without compelling catastrophic spend-down for recipients and dragging their dependents below a minimally adequate standard of living? What about the growing impact of Medicaid estate planning? We will now address these difficult questions. The first order of business is to show that, despite what most people think, the majority of Wisconsin's seniors qualify for Medicaid nursing home benefits--if they need the care--even without fancy legal planning.

MEDICAID NURSING HOME ELIGIBILITY

Two-thirds of the elderly poor and half of all poor children in America are not covered by Medicaid even for preventive, acute, or emergency medical care. Medicaid eligibility criteria are very strict indeed--unless one needs nursing home care.

For elderly people who need long-term care institutionalization, the rules are much more lenient. In Wisconsin, for example, otherwise categorically eligible people can qualify for Medicaid nursing home benefits if their income is inadequate to meet their institutional care costs, plus their health insurance premiums, plus their other medical and remedial costs, plus a few other expenses. Everyone is allowed to keep \$40 per month as a personal needs allowance, although additional income must go to offset Medicaid's cost of care. In other words, people with substantial incomes can qualify for Medicaid nursing home benefits in Wisconsin if they are "medically needy."

The asset test for Medicaid nursing home eligibility is another story altogether. It seems far stricter than the income test at first. Single recipients, for example, may retain only \$2,000 in countable liquid resources. This fact masks the reality, however, that vast amounts of assets held by the elderly are totally exempt from Medicaid's eligibility limits. Non-countable resources include a home and contiguous property, personal items and home furnishings, an automobile, pre-funded burials, cash value life insurance worth up to \$1,500, and several other less significant assets.

Most people think of Medicaid as a poverty program that requires impoverishment to qualify. Let us set aside conventional wisdom and legislative intent for a moment, however, and look at how Medicaid nursing home eligibility works in the real world. Consider the income test first. The average monthly private-pay nursing home rate in this state is \$2,372 or \$28,464 per year. Thus, someone in an average nursing home could have this much income plus the other deductions mentioned above (let's estimate \$30,000 per year total) and still qualify for Medicaid. According to survey data supplied by the Department of Health and Social Services, however, only five percent of single women over the age of 60, 14 percent of single men, and 25 percent of couples have more than \$30,000 per year in income. Of course, couples' incomes are split for eligibility purposes which makes members of even more couples eligible than the data suggests. Also, income tends to decline with age, so nursing home candidates who are most likely older, would tend to have lower incomes than the surveyed group. The bottom line is that the vast majority of seniors in Wisconsin qualify for Medicaid nursing benefits based on income without any pre-planning whatsoever.

Next, consider the asset test. Medicaid's asset limit is \$2,000. According to DHSS survey data:

Most older people report some liquid assets. Nearly all married couples and four-fifths of single people have at least \$2,000 in liquid assets...A small proportion of all groups reported assets of \$60,000 or more: thirteen percent of women, twenty-one percent of men and twenty-five percent of couples.

So no one qualifies for Medicaid, right? Wrong; we have to take into account exempt assets. According to the survey, at least 61 percent of single women, 54 percent of single men, and 38 percent of couples over the age of 60, have liquid assets under \$20,000. Given Wisconsin's generous spousal impoverishment protections, which permit community spouses to retain \$68,700 in addition to the institutional spouse's \$2,000, assets are not an obstacle to Medicaid nursing home eligibility for the vast majority of couples. After all, only 25 percent of couples have liquid assets over \$60,000 according to the survey.

But what about those singles, over half of whom have assets up to \$20,000? Can they qualify for Medicaid nursing home benefits? First, as before, we must observe that by the time the over-age-60 cohort in the survey reaches its mid-eighties when institutionalization is most likely, its assets will be somewhat lower still. Second, at least 18 percent of single women and 17 percent of single men have liquid assets below \$2,000 according to the survey and are unequivocally eligible already. Finally, and most importantly, we must consider what transpires at the point of application for Medicaid nursing home eligibility. County workers who conduct the interviews and make the eligibility determinations told me that they routinely inform all applicants about ways to reduce countable assets. They explain the option to purchase exempt resources, such as burial funds, life insurance, automobiles, furniture or television sets; they ask if applicants have any bills to pay off; they explain that there are experts, such as attorneys and financial planners, who know how to protect additional assets. Literally everyone who comes in to inquire about Medicaid nursing home eligibility has access to information on how to shelter assets. There is absolutely nothing inappropriate about this. Everyone is entitled to know, and to take advantage of, whatever the law allows. The only point in focusing on the process is to show that asset limits are no obstacle to Medicaid nursing home eligibility for most ailing elder Wisconsinites. It does not take a great legal mind to spend the last few thousand dollars of Grandma's money to remodel the bathroom or buy a new car (titled of course in Grandma's name) instead of paying privately for nursing home care.

Keep in mind that this analysis has excluded the single most important asset seniors possess--home equity. Nationally, 75 percent of the elderly own their homes and 83 percent of these own them free and clear of debt. Home equity held by seniors today exceeds \$1 trillion and constitutes almost 70 percent of the net worth of the median elderly household. Homes are totally exempt for purposes of Medicaid nursing home eligibility unless the recipient does not intend to return to the residence. Currently, Wisconsin policy makes the home a countable asset if it is unoccupied by an exempt relative and if return by the recipient is medically infeasible. This stricter state policy has been challenged by senior advocates recently. Thanks to Wisconsin's new lien and estate recovery program, conversion to the more liberal federal interpretation of the home exemption might not increase program costs significantly in the long run. The value of newly exempted homes can, at least theoretically, be recovered later from the estate. As we will see below, however, recovery is by no means a sure thing under existing federal rules.

Thus, it is clear that the average elderly Wisconsinite--in terms of income and assets--can qualify for Medicaid nursing home benefits without heroic legal interventions. But, what about the relatively small proportion of seniors in Wisconsin who have countable income and assets well above Medicaid limits? Do they have to spend down to qualify? Or can they divest or shelter assets quickly and cheaply? That is the subject of the next section.

MEDICAID ESTATE PLANNING

Medicaid estate planning is the practice, with or without formal legal advice, of manipulating income and assets in order to qualify for Medicaid nursing home benefits. Almost no one likes Medicaid planning. Some people think it is degrading and unethical. Others consider it a necessary evil in the absence of rational social policy. Still others fear that it will destroy Medicaid's ability to help the poor. The following quotations indicate a range of sentiments shared by interviewees during this study:

We sell the Medicaid program as if it were for poor people. We do not have truth in advertising if we permit the well-to-do easier access than the poor. (DHSS headquarters staff)

Medicaid estate planning substitutes the law of the jungle for rational public policy. It allows the smartest, savviest, and richest to qualify more easily than the genuinely needy. (DHSS headquarters staff)

Huge loopholes exist now. It's really easy to set up a joint account and have the kids pull the money out. There's no waiting period...money is fungible. (Private attorney)

[Those who do Medicaid planning] are real influential people...; they tend to work for the state. A lot of nursing home employees also know the ropes. Attorneys and bankers call routinely asking about the rules. (Eligibility worker)

State policy should make it easier for low income people to get on Medicaid and harder for people with higher assets, but we have done exactly the opposite. (Eligibility expert)

[There is a] lingering and growing and unfair perception that old folks don't need anything because they are giving all their money to their kids. (Advocate)

A nursing home lawyer once told me that "divestment is contrary to public policy." That is ridiculous. Divestment is public policy. (Private Attorney)

What is the current status of Medicaid estate planning in Wisconsin? I visited three counties to find an answer to this question: Racine (blue collar), Walworth (rural), and Dane (urban). The incidence of formal Medicaid planning (i.e. planning that goes beyond the routine asset shelters discussed in the previous section) is still relatively minor in Racine County. It is even less in Walworth County. In Dane County, however, approximately one-fourth to one-third of all nursing home eligibility cases involve Medicaid planning. This practice has been relatively slow to develop in Wisconsin. A DHSS attorney speculated that the state's conversion to community property laws four years ago may have undercut the trusts and estates bar from which Medicaid planners sometimes emerge. The legal services bar is even more likely to produce Medicaid

planners, however, and it is very active in Wisconsin. Whatever the reason for the slow development of Medicaid planning, it is certainly growing rapidly now.

The mass media, including books, magazines, television, and radio, convey information throughout the United States on how to do Medicaid planning. One "how to" volume, readily available in Wisconsin for under \$30, contains step-by-step instructions and tear-out boilerplate trusts. For example:

So is there any practical way to juggle assets to qualify for Medicaid--before losing everything? The answer is yes! By following the tips on these pages, an older person or couple can save most or all of their savings, despite our lawmaker's best efforts. Here are the best options: Hide money in exempt assets. Transfer assets directly to children tax-free. Pay children for their help. Juggle assets between spouses. Pass assets to children through a spouse. Transfer a home while retaining a life estate. Change wills and title to property. Write a durable power of attorney. Set up a Medicaid Trust. Get a divorce."

Another mass marketer of Medicaid manipulation has been known to advertise his book on the radio with a toll-free number for credit card purchases. A local entrepreneur placed this ad in the Milwaukee Sentinel on June 2, 1992: "Are Mom & Dad's Assets Protected if they Need Nursing Home Care?...Get sound advice and avoid costly mistakes including Title 19 [Medicaid] disqualification."

Not all Medicaid planning is this egregious. Most of it is quite sedate and proper. The Wisconsin State Bar Association offers trainings at least annually on Medicaid planning. There is a strong sense within the county welfare departments that whatever techniques the bar trains on spread quickly: multiple divestment, purchase of exempt assets, and more lately, the joint account gambit, for example.

I talked to two private attorneys who help to conduct this training and who have their own private elder law practices. A composite of their replies indicated an average of 10 to 12 Medicaid planning clients per month, who pay \$150 per hour to protect an average of \$50,000 to \$100,000 over Medicaid's spousal impoverishment limits in addition to a home owned free and clear. The position of the private bar in Wisconsin seems to be that Medicaid estate planning is both legal and ethical. In fact, an attorney might be vulnerable to malpractice for failing to get a client everything the law permits.

Even the highly respected Elder Law Center of the Coalition of Wisconsin Aging Groups has published a book entitled "Medical Assistance & Divestment." In fairness to the Elder Law Center, however, it has withstood pressure from the bar to train on Medicaid planning, except for the technique of multiple divestment which is fully explained in the state's medical assistance handbook anyway. The Center's policy is not actually to do Medicaid divestment for clients except to help people who have done it wrong themselves and who have gotten into trouble.

Inquiries about Medicaid rules and exemptions from private attorneys to the DHSS's headquarters "wizards" (client service specialists), county eligibility staff, and state attorneys are on the rise. Various eligibility staff called these inquiries "pretty demoralizing...very irritating...a pain in the neck." Imagine the frustration of an eligibility worker making \$8 an hour who is unable to stretch the rules to qualify a poor person for Medicaid but has to help a savvy senior's attorney shelter \$100,000. "We feel like we are expected to be lawyers," lamented one worker.

Medicaid Estate Planning Techniques

Clearly, the practice of Medicaid estate planning is growing and becoming more sophisticated. The federal and state Medicaid programs have only begun to examine this complex area of the law. The purpose of this section is to explore the current status of Medicaid planning techniques in Wisconsin. I will attempt a diagnosis, but a case-by-case treatment plan is beyond the scope of this project. One would have to examine each of the techniques discussed below in the context of federal law and regulations, state statutes and policy, judicial interpretations, fair hearing precedents, and political feasibility. To close each of these loopholes singly would be like trying to patch a tire after driving over a nail spill. Therefore, I will suggest a comprehensive waiver approach later instead.

Divestment

Medicaid nursing home eligibility can be achieved by getting rid of disqualifying income and assets (divestment) or by converting countable resources into non-countable resources (shelters). Divestment is of two kinds: legal or illegal. Illegal divestment occurs (1) when an applicant fails to disclose income sources, property ownership or transfers or (2) when financial abuse of the elderly results in the disenfranchisement of a vulnerable senior. We have little evidence on how widespread illegal divestment is, but we know it occurs. Wisconsin does not verify real property ownership or transfers unless they are reported by the applicant or unless the eligibility worker is suspicious of concealment. The state's Medicaid handbook strictly prohibits "over-verification." Nevertheless, examples of concealment of resources show up frequently on the automated eligibility data match system (IEVS). Case workers reported that theft or diversion of recipients' resources are commonplace: "The kids are just taking the money and running (Racine County)." Corrective actions Wisconsin should consider include: (1) inform all applicants that eligibility reviewers search a national income and asset data base (IEVS) to verify the accuracy of applications; (2) check assessor's and recorder's records for real property ownership or transfers on all cases (IEVS does not capture this information); and (3) petition the court to appoint private attorneys on contingency as conservators in financial abuse cases to reverse illegal transfers, relitigate abusive divorce decrees, invade inappropriate trusts, and partition undivided, i.e. inaccessible, property. These techniques will reduce illegal divestment, protect vulnerable seniors from financial abuse, and pay for themselves many times over.

The techniques of legal divestment to qualify for Medicaid nursing home benefits are myriad. The simplest approach requires a little planning. Anyone (no matter how wealthy) can give away anything (no matter how valuable) at least 30 months before applying for Medicaid and qualify for nursing home benefits. Dane county workers called this approach "real common." They said "people quitclaim the deed on the house and call us in advance wanting to know how many months until they're eligible. Then they come in the day after the 30 months is up." Ten percent of one worker's long-term care cases used this technique. We know that the average period of time from onset to death in Alzheimer's Disease is eight years. Anyone with the foresight (or legal advice) to transfer assets at the first sign of cognitive impairment faces no financial obstacle to Medicaid nursing home eligibility. Furthermore, there is no transfer of assets penalty in the first place to qualify for non-institutional Medicaid benefits. This is federal law, unchangeable by the state without a waiver.

Joint accounts are the quickest and easiest approach to Medicaid divestment for people who have not planned ahead. Wisconsin permits anyone to divest an account of any size instantaneously without any penalty. Nothing could be easier. The senior or the power of attorney simply adds another name to the elder's individual account. Because joint accounts are treated as equally available to either owner, the new co-owner can remove and take sole possession of all the assets. This leaves the elderly person "impoverished" and eligible for Medicaid. No penalty applies. Ironically, if the senior approves the divestment officially by personally removing the funds or by signing a withdrawal slip, it becomes a transfer of assets subject to penalty. This gambit only works if it is done without the senior's formal consent. Currently, the technique is wide open, although still not rampant, and it does not require an attorney. Examples include a "power of attorney" in Dane County who took all the money from a senior's account; got caught; returned the money; created a joint account; and withdrew it all again legally. Racine County workers cited a \$250,000 example of divestment by joint account. Walworth County workers were "astounded that it is not happening more. It is right in the medical assistance handbook." A Dane County respondent said she was "cynical enough to think that the reason [this technique has not been used more] is that there are no billable hours [for attorneys] in joint accounts." Actually, members of the private and legal services bar told me they were unaware of the joint account technique until recently. They assumed that the creation of such an account would constitute an illegal transfer of assets in itself. Apparently, however, this is not the opinion of Wisconsin's legal council nor of certain fair hearings decisions. The equal availability of joint accounts to either owner is fully supported by federal law and interpretation as articulated in the "Streimer rule." Wisconsin's policy of allowing joint accounts to be created without triggering a transfer of assets penalty is not mandated, however, by federal law and most other states are not so generous. This is a potentially huge problem that Wisconsin should research and correct immediately before it gets out of control.

Trusts are a very popular way to divest assets to qualify for Medicaid. Congress tried to control the use of trusts in the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA). COBRA said that any income or assets within the discretion of a trustee to release had to be treated as available resources for purposes of determining the

Medicaid eligibility of a grantor. The law was retroactive, so it spoiled a sweet deal for many clients and their attorneys. Before long, however, lawyers found many ingenious new ways around the more restrictive rules. For example, the following are boilerplate passages that show up regularly in Wisconsin's "Medicaid qualifying trusts (MQT's)" :

Accordingly, the Trustee shall make distributions to or for the benefit of [the grantee] in a manner that preserves [his or her] eligibility for county, state or federal benefits....

However, it shall be an abuse of discretion for the Trustee to pay to or on behalf of the Grantor any funds or transfer any property which would result in the Grantor being declared ineligible for the Wisconsin Medical Assistance program or any other form of Federal, State, or Municipal assistance. The idea, of course, is to delimit the trustee's authority to release funds in such a way that eligibility for public benefits is adversely affected. Trust law and its interface with Medicaid eligibility are extremely complicated. Suffice it to say here that Wisconsin's interpretation of the rules, as reflected in legal opinions and fair hearings, is very generous. According to one respondent, the recipient "has to be able to walk up to the bank and withdraw the money, otherwise we treat it as inaccessible....The onus is on us to prove that the resources are available." The creation of a trust is not even treated as a transfer of assets subject to penalty. In addition to MQT's for seniors who need nursing home care, supplemental needs and "luxury" trusts for accident victims or disabled adult children are also leniently treated and they sometimes protect millions of dollars in accident or malpractice settlements at the expense of public benefits programs. Wisconsin should compare its policy on trusts with other states' and consider tightening up the rules to the limited extent feasible under federal law.

Multiple or pyramid divestments are much less powerful than the foregoing techniques. They are far more commonly used, however, and, therefore important. Some background is necessary to explain multiple divestment. A Medicaid applicant with excessive resources is supposed to spend down for private care until the eligibility asset level is reached, i.e. no more than \$2,000 for a single person and \$2,000 for a married person after the \$68,700 spousal transfer allowed by MCCA has been made. If someone gives money away instead of spending down, Medicaid denies eligibility for a period of time equal to the amount of assets transferred for less than fair market value divided by the average cost of private-pay nursing home care, i.e. \$2,372 per month in Wisconsin. Thus, someone who gave away \$100,000 would be ineligible for two and one-half years--\$100,000 divided by \$2,372 is 42 months which must be reduced to the maximum penalty of 30 months. The idea behind multiple divestment, however, is to give away progressively smaller amounts of assets month after month so that transfer penalties run concurrently and the overall duration of ineligibility is thereby minimized. Medicaid estate planners have designed simple charts to show the most effective multiple divestment plan for any given amount of excess resources. The transfer of assets penalty on \$100,000, for example, can be reduced from 30 to 8 months by giving away \$19,916 in the first month, \$17,703 in the second month and so on, according to one attorney's chart. Using this approach, one would have to give away \$1,000,000 before triggering

the maximum penalty. Multiple divestment is thoroughly explained in Wisconsin's Medicaid handbook. The bar and even the Elder Law Center train on the technique. Divestment of both homestead and non-homestead property in this manner is significant and increasing in all three counties I visited. State legal and policy staff are trying to curtail the practice of multiple divestment by changing the rules to require sequential, instead of concurrent transfer of assets penalties. Under federal law (the Social Security Act), however, penalties must begin at the time of the transfer, so this gambit--even though it was recommended by the Health Care Financing Administration--may be vulnerable to a legal challenge. Even if multiple divestments were eliminated, however, Medicaid planners would still have the "half a loaf" strategy as a fall-back position, i.e. give away half the money and spend down the rest in order to reduce the penalty originally intended by Congress by half. HCFA is reputedly drafting a statutory correction of these problems, but waiting for it while multiple divestment continues to spread in Wisconsin would not be wise.

Numerous other divestment strategies are practiced in Wisconsin. Many more are equally feasible, but not yet discovered or used. As long as the joint account, trust and multiple divestment schemes are available, it is difficult to imagine why anyone would bother with anything else. As the state and federal governments begin to whittle away at these approaches, however, others will arise to take their place. Ultimately, the only solution is a comprehensive policy that deals with all divestment and shelter strategies. If something is not done soon, Medicaid census in Wisconsin's nursing homes will certainly begin to increase more rapidly.

Shelters

One does not necessarily have to divest assets to qualify for Medicaid nursing home benefits without spending down. It is equally effective to convert countable resources into exempt assets while retaining them. This approach is called "sheltering." The only disadvantage of sheltering is that retained assets may be vulnerable to recovery from the recipient's or the spouse's estate. Medicaid estate planners easily avoid estate recovery, however, and we will therefore review the techniques they use to do so in this section also.

The most widely used sheltering technique in Wisconsin is pre-funding of burials and burial trusts. State policy exempts such trusts up to \$2,000 in value. Additionally, Medicaid applicants are allowed to prefund burial expenses in any amount. This includes buying a plot or vault and casket. The latest twist is prepaid "gold key" burial plans funded by single-premium term life insurance policies. These too are unlimited in value and any remainder after actual funeral costs passes to heirs outside the probate estate, thus evading recovery liability. "Everybody does burial trusts," according to Racine County staff. Each county routinely advises applicants of this option to protect assets. Some level of exemption for burial expenses seems perfectly appropriate and is allowed under federal law. Unlimited pre-funding, however, raises a sensitive issue. The more money people can shelter without estate recovery, the more money Medicaid has to spend for their care. Should funds appropriated for the medical care of the needy be used to

subsidize high-cost burials and inheritances? Even a funeral home owner in Dane County complained about this practice: "I am a taxpayer too," he said.

The purchase of exempt assets is another effective sheltering technique. One respondent estimated that 15 to 25 percent of all nursing home cases in Wisconsin use it. Some commonplace examples include the purchase, remodeling, or repair of an exempt home. Paying off a mortgage (or any other debts for that matter) achieves the same purpose. Eligibility workers routinely ask if an applicant has any bills that could be paid off to reduce countable assets. The purchase of an automobile is another effective shelter. Walworth County supplied the example of a \$20,000 van purchased with the Medicaid applicant's money for a nephew who was supposed to "take her for rides," but didn't. Dane County recounted the story of a daughter who bought a vehicle with her mother's money, but titled it to herself. When the case was denied, the daughter changed the title to joint ownership. Medicaid lost the case in circuit court and had to pay attorney's fees. Personal belongings and furnishings are exempt including rings, rugs and radios, which if purchased discerningly can shelter very large amounts of money indeed. The abusive accumulation of obvious investments such as diamonds, Persian carpets, antiques, or other items of unusual value would be disapproved if reported or caught. In reality, however, the purchase of exempt assets is a very easy and effective way to protect many thousands of dollars. With the exception of the value of the home, most such exempt assets are not being recovered by Wisconsin's estate recovery program. Even the value of the home is easily diverted from recovery under existing law.

Asset sheltering is not limited to excess resources of single applicants. After the eligibility "snapshot" that results in an exempt transfer of \$68,700 to the community spouse under MCCA, Congress expected the institutionalized spouse's share of the couple's remaining assets to be spent down on care. The idea was to protect the community spouse from impoverishment, while requiring the nursing home spouse to pay privately for care until the money was gone. Instead, Medicaid planners use asset sheltering techniques to protect the institutionalized spouse's share of the joint assets also. According to Walworth County staff, this practice is routine:

The community spouse uses the institutionalized spouse's share to pay her expenses, buy a new roof, purchase groceries, pay taxes, etc. Racine County reported a case that used the ill spouse's share of assets to purchase exempt rental properties. Such techniques are difficult to monitor and control, even when law and policy are violated or stretched. A much more effective approach would be to permit people to retain the assets openly in exchange for an enforceable agreement to repay the state later. But that is not achievable under existing lien and estate recovery rules.

Annuities are a hot new sheltering ploy in Wisconsin. Excess resources placed into an annuity are not an illegal transfer of assets, because the annuitant receives full market value in the form of a cash flow. Although the income from the annuity must go to a spouse or toward the cost of care under Medicaid, the principal is protected, the recipient locks in Medicaid's low nursing home rates, and Medicaid pays the full range of

optional services that Wisconsin generously offers, but which Medicare refuses to cover. The state allows immediate, but not deferred annuities.

In the long run, sheltering techniques are ineffectual for recipients and their families if the state recovers sheltered assets from estates. In reality, however, "the vast majority of all real property will pass outside of formal recoverable estates in Wisconsin" according to one expert respondent. This is also true for other forms of sheltered resources besides real estate. Most assets in America are held in joint tenancy with right of survivorship. Medicaid planners will often convert a client's assets into this form of ownership if they are not already so held. Such assets do not pass through a formal probated estate. Only assets that pass through an estate, however, are subject to recovery by the Medicaid program. This interpretation of federal law has been confirmed by the ninth circuit court of appeals. Thus, asset sheltering techniques are often highly effective and estate recovery is hobbled from the beginning. Nevertheless, liens and recoveries can generate significant nontax revenues for the Medicaid program even under existing restrictions. We turn to that subject next.

LIENS AND ESTATE RECOVERIES

Liens and estate recoveries are the most important part of the puzzle we are trying to solve. A state Medicaid program that can afford to provide unlimited access to top quality long-term care for everyone regardless of wealth does not need to recover from estates. On the other hand, a program that would retain generous spousal impoverishment protections and ample personal property exemptions without driving costs through the roof must keep some incentive in the system for people to pay or insure privately. That is the role of liens and estate recoveries. They generate nontax revenue to support the Medicaid program, but more importantly, they send a message. The message is that the State of Wisconsin provides good care to everyone who needs it without forcing them to sell everything they own prematurely. But, there is no free lunch! When you and your dependents no longer need the assets you have sheltered, expect to pay back the cost of your care so that something is available for others in their time of need. If you wish to avoid dependency on Medicaid and recovery of costs from your estate, then plan ahead to pay privately by saving your money or buying insurance. That is the theory. Where do things stand in practice?

The Inspector General's report on Medicaid Estate Recoveries was published in June of 1988. Later that year, the IG wrote to Governor Thompson estimating that Wisconsin could save between \$4 and \$18 million per year by implementing an estate recovery program. The lower estimate reflected achievement at the rate of the top ten recovery states in the country; the higher figure equaled achievement comparable to the most successful state in the country. Updated to 1990 dollars, the IG's estimate equals \$6 to \$27 million in potential program savings annually. The General Accounting Office's report appeared in 1989. It estimated \$18 million per year in savings for Wisconsin. Inspired by these reports, the state began actively to research the potential of estate recoveries. Wisconsin Act 81 in 1989 mandated the Department of Health and Social Services to study the issue and report by March 31, 1991. From that point on, things moved very quickly. The law authorizing liens and estate recoveries passed in August 1991 to be effective on the 15th of the same month. Actual implementation occurred on October 1, 1991. But only benefits paid after that date were recoverable so the first collection did not occur until somewhat later, February 1992. Recently, Wisconsin backed away from estate recoveries for non-institutionalized recipients in consideration of objections strongly held by advocates of the aging.

Despite the importance of liens and estate recoveries, most states give the program short shrift if they implement it at all. Fortunately, this was not the case in Wisconsin. From the initial research through the first few months of recoveries, the state's planning process has been very effective. For example, Wisconsin staff carefully reviewed the IG and GAO work; they thoroughly examined recovery programs in Oregon and Minnesota; and, consequently, they anticipated many important issues and problems that handicap less thoughtfully prepared start-ups. Thanks to this preliminary research, Wisconsin's initial law contained many important features that other states have had to retrofit or go without. For example, spousal recovery authority is critical, usually overlooked, but included in Wisconsin's initial legislation. Authority to recover small

account balances by "affidavit" is a seemingly inconsequential collection technique used to great effect by Oregon and adopted wisely by Wisconsin. Recognition of the need for county assistance and compensation, as well as the importance of training eligibility staff to support liens and recoveries smoothed the way for implementation in Wisconsin. Other examples of attention to detail include obtaining state priority in the probate process, mandating notification of probate by personal representatives, and getting the question of whether or not the deceased was ever a Medicaid recipient printed on the formal application to the court for probate. Wisconsin's careful preplanning of liens and estate recovery and its strong law will help the state confront the inevitable problems of implementation.

Lien Procedure

When an individual enters a nursing home on Medicaid in Wisconsin, the state makes a preliminary determination whether or not the person will be able to return home. If not, and if there is no spouse or other dependent relative (as specified in state and federal law) residing in the home, then the state gives notice of its intent to file a lien on the property. The recipient has 45 days to request an administrative hearing to contest the placement of a lien. If no hearing is requested, the state files the lien with the Register of Deeds in the appropriate county. The value of the encumbrance is equal to the amount of benefits paid by Medicaid for care of the recipient. Once the lien is filed, the encumbered property cannot be sold or transferred without satisfaction of the state's claim. Usually, a title search preliminary to sale discovers the Medicaid lien and leads to notification of the state. The state computes the precise value of services rendered to the recipient up to the date of sale, receives a check at closing, and releases the lien.

This process is fraught with potential problems. The house may be sold during the 45-day period of intent to file the lien, thereby defeating the state's claim. This problem will diminish, however, as liens are filed on all new applicants before they accumulate big debts to the state that would motivate quick sales. Another issue is that, so far, most homes exceed the value of the state's lien, which is estimated at \$47 per day since the beginning of eligibility or October 1, 1991, whichever is earlier. In time, however, the value of the liens will sometimes exceed the value of the homes thereby diminishing the heir's incentive to maintain the property. The state will need to arrange for maintenance and sale of such properties. Another problem arises with the potential change, mentioned above, of intent to return rules. If Wisconsin is no longer able to compel people to list and sell their homes as a condition of eligibility when return to the home is medically infeasible, more houses will remain lienable longer thereby complicating the whole system, reducing lien recoveries, and increasing estate recoveries. These and many other practical problems must and can be solved, by learning from the experience and the best practices of other states.

Estate Recovery Procedures

When a Medicaid nursing home recipient enters the system (or at redetermination), the county eligibility worker completes a "disclosure sheet." This sheet

itemizes all of the recipient's real and personal assets and provides complete identifying information. It is sent immediately to the Estate Recovery Program in Madison where it is kept on file. When a recipient dies, the disclosure sheet helps the program to identify recoverable assets and to initiate recovery. The Estate Recovery Program may learn of a recipient's death by notification from (1) the county worker, (2) the attorney or personal representative in a formal probate as required by law, or (3) once implemented, from an automated data match with records of the Bureau of Vital Statistics. The program usually has 60 to 90 days to file a claim on an estate. It tags the deadline on a calendar and waits until two weeks before. This is done to maximize the state's total claim as the costs of the last illness continue to trickle in. The state cuts a check for \$3 to pay the filing fee, copies the attorney for the estate with the Register of Probate's letter, and obtains a receipt for filing. The priority of claim is established in law, beginning with the cost and expenses of administration, reasonable funeral and burial expenses, provisions for the family of the decedents, reasonable and necessary expenses of the last sickness of the decedent including compensation of persons attending him or her, all debts, charges or taxes owing the U.S., this state, or a governmental subdivision or municipality of this state, etc. This last is the Medicaid program's position in the priority of claim. An alternative scenario occurs if the recipient has a spouse. The state has no claim on the recipient's estate until the spouse dies. The program plans to use its data match with vital statistics to learn of a surviving spouse's death and to trigger recovery from the spousal estate. The same method will trigger recovery from estates of recipients who go off Medicaid before they die.

This process has fewer problems than one might expect. Most cases are routine, unchallenged, and highly cost effective. (The average ratio of recoveries to costs of recovery in other states that have such programs is \$14.42 to \$1.) The trick in the start-up phase is to prioritize, systematize, and compromise. Staff should work the most promising cases first; routinize the process as much as possible; and earn a reputation with the probate bar for reasonableness and fair play. Wisconsin's lien and estate recovery implementation has followed this advice admirably so far, but may be able nevertheless to simplify and streamline considerably. Some action must be taken if actual recoveries are to achieve expectations.

Projections and Results

The original Act 39 projection for recoveries from liens and estates for Fiscal Year 1992 (ending June 30, 1992) was \$1,597,400. Act 269, which dropped the over-65, non-institutionalized group from estate recovery liability, ironically increased the original projection for FY '92 to \$1,611,300. The original projection for FY '93 was \$12,746,900, but it increased to \$20,852,100 to be collected by the end of June 1993. To reach this level of success, Wisconsin would have to achieve the same rate of return in one year that it took the leading estate recovery program in the country (Oregon) twenty years to accomplish.

Not surprisingly, actual recoveries are not on a trajectory to achieve these projections. As of June 4, 1992, Wisconsin's lien and estate recovery program had billed

\$542,000, collected \$280,000, and written off \$33,000 leaving a balance due of \$229,000. The program also had liens on 143 properties owned by nursing home recipients with a value of \$1,328,000. There is nothing wrong with these numbers considering the handicaps under which the program labors:

(1) Collections are limited to benefits received after October 1, 1991. Therefore, the maximum lien or estate recovery as of June 4, 1992 was only \$11,656, i.e. \$47 per day times the number of days since program implementation. No matter how large the estate, the maximum recovery was still under \$12,000 eight months into the program.

(2) Liens and estate recoveries are highly labor-intensive with a very steep learning curve. It takes time to develop procedures, test them, adapt them, and sometimes drop them and start over. Estate recovery is as close to running a business as government gets. Most businesses do not reach break-even, much less full capacity in the first year.

(3) The recovery program cannot collect assets that are not there. With the almost unrestricted growth in techniques to divest assets entirely or to divert sheltered resources from recovery, collectible estates are definitely shrinking. As an expert on transfer of assets told me during this study: "...estate recovery is like closing the gate after the horse is out."

Wisconsin can achieve and exceed the original projections for the lien and estate recovery program. With the help of modifications in the state's treatment of divestment and shelters, this goal could be achieved much sooner than otherwise. In the meantime, there are several measures that the lien and recovery program should consider undertaking independently.

Suggestions

The biggest mistake an estate recovery program can make is to waste time early on manipulating big data bases. The most successful programs follow the classic rule: "Keep it simple, stupid." The secret is to find estates to recover and then recover them. Programs that started small, learned from their failures, and built on their successes found that (1) eligibility staff are the best source of information on deceased recipients and (2) depending on a match with a central records data base to trigger a recovery is like "waiting for the gun to go off before you duck." (You get the information too late to act.)

I would suggest the following changes to Wisconsin's estate recovery program. Relieve the burden on county eligibility workers by requiring them to fill out property "disclosure forms" only on deceased recipients instead of, as currently, on all nursing home recipients. Emphasize instead the importance of (1) discovering and reporting recipients' deaths as soon as possible, (2) helping the central recovery unit to verify property after the recipient's death, and (3) filing the notices of intent to lien on a timely basis in every appropriate case. Use a funnel approach to the recovery process. Start with all the recipients who die. Eliminate those for whom Medicaid has paid little or nothing by checking case payment records. For the remaining cases that have assets, track down the estate by established methods and file the claim. For those cases on

which Medicaid has paid substantially, but there are no assets reported or no disclosure form received, verify at a minimum real property ownership or transfer in the county of residence immediately prior to institutionalization. People do not necessarily disclose this information in the eligibility process. Delay the design and implementation of a data match with the Bureau of Vital Statistics until this simplified approach has achieved maximum return.

LONG-TERM CARE INSURANCE

In any discussion of long-term care financing, private insurance is always the poor relation. No one expects to need it, because nobody expects to go to a nursing home. Even rich people say it costs too much. Consumer advocates lambaste its benefits and features; and Medicaid pays for anyone who lacks insurance but has a good attorney. No wonder only four percent of seniors have long-term care insurance, although 75 percent have Medicare supplemental policies. Next to liens and estate recoveries, however, private long-term care insurance is the most important weapon in Medicaid's cost-containment armory. If we want to divert people from Medicaid dependency, there must be affordable, high quality private options available. Somehow, these issues have to be handled.

Fortunately, long-term care insurance is well known and strongly regulated in Wisconsin. According to the Insurance Commissioner's staff that I interviewed, Wisconsin has the "most comprehensive long-term care policies available anywhere in the country." The Director of the Market Regulation Bureau told me:

If you're asking, is there a viable long-term care insurance market in Wisconsin, the answer is yes. Is meaningful coverage available? Yes. Have the main marketing abuses been addressed? Yes. Are we done with regulating? Probably not. Companies with approved long-term care policies in Wisconsin include nine that offer nursing home insurance, six with home health care insurance policies, and four that have long-term care riders to life insurance policies. By comparison, 130 companies were selling long-term care insurance nationally as of 1990 according to the Health Insurance Association of America.

Clearly, a reasonable selection of long-term care insurance policies deemed at least adequate by a relatively strict regulatory agency are readily available in Wisconsin. The real problem is that people are not buying them. Currently, only 25,000 long-term care insurance policies are in force in Wisconsin, although the state has 658,000 residents over the age of 65. With 3.8 percent of its elderly population insured for long-term care, Wisconsin is just below the national average. Imagine the impact on Medicaid costs, if a significant proportion of the state's 1,538,000 residents over the age of 45 insured privately for long-term care.

If quality and availability are not insuperable problems in Wisconsin, but people are still not buying the products, let us focus instead on need and affordability. Forty-three percent of seniors will spend some time in a nursing home and nine percent will spend five years or more. So much for the self-deceit that "it will never happen to me!" What about affordability? If one in ten houses burned down, fire insurance would not be cheap either. The greatest risk of nursing home institutionalization is at older ages, however. People who buy long-term care insurance when they are young can reduce the cost radically. This makes sense. At age 65, only one percent of seniors live in nursing homes, but the proportion of people institutionalized rises steeply until it levels off at 22 percent for people over 85. It only makes sense that long-term care insurance would be

less expensive at age 60 than at age 80. The key, therefore, is to get people to buy at an age when the product is still relatively inexpensive.

Finally, studies which conclude that most seniors cannot afford nursing home and home health insurance are misleading. They assume that elderly people have nothing but their residual incomes with which to pay premiums and that is untrue. We know, for example, that seniors are "cash poor, and house rich." Most seniors own homes and 57 percent of homeowners could purchase long-term care insurance with the proceeds of a reverse mortgage disbursement. Many seniors are over-insured for life insurance or Medicare supplemental protection. They might be able to drop their life policies or reduce their Medi-gap coverage to catastrophic-only protection and use the savings to pay for long-term care insurance. In fact, why should seniors have to insure their own estates anyway? Today's elders struggled through the Depression; they scrimped and saved their whole lives; why can't their heirs, who are now in their own peak earnings years, help with the cost of insurance to protect their inheritances? The "kids" have the income; the folks have the assets; sharing the cost of long-term care insurance premiums is an ideal inter-generational contract.

This gets us down to the real, underlying reason why people do not buy long-term care insurance: if they don't, Medicaid pays the bills anyhow. In the course of the field work for this study, I interviewed two long-term care insurance agents. One told me that, compared to Illinois where he started, people in Wisconsin have an "entitlement mentality," which makes private insurance very hard to sell. The other told me that it is "very difficult for anyone to make a living in Wisconsin selling long-term care insurance full time." Again, you can't sell apples on one side of the street when someone is giving them away on the other. Under the circumstances, it takes a con man or a masochistic genius to sell this product in Wisconsin. Consequently, we see a lot of market abuse and only a few dedicated, full-time professionals in the field. By closing divestment loopholes and requiring recovery from estates, the State of Wisconsin can send a message that will impel many more people to investigate, and ultimately to purchase private long-term care insurance. Ideally, the state would borrow an idea from the Robert Wood Johnson approach without giving away the whole farm: educate the public and encourage the purchase of quality long-term care insurance products. As for honest, knowledgeable, hard-working agents selling quality products full time: "Build it and they will come."

THE SENIOR FINANCIAL SECURITY PROGRAM

The politics of aging is changing in America (and in Wisconsin). Today, we are in the latter stage of "third rail" politics. To criticize a senior benefit can still bring instantaneous political death--like touching the middle rail on the subway. But things are beginning to change. The 1989 repeal of the Medicare Catastrophic Coverage Act was the watershed that brought us into the first phase of "greedy geezer" politics. One can already foresee the time when (no matter how inaccurate, unfair, and over-simplified the charge) some politician will lose an election for lavishing one more benefit on "wealthy" seniors at the expense of the long-suffering middle class. The latest furor over Generational Accounting is only an early skirmish in the on-coming intergenerational war. The only way to avoid the inevitable carnage in our public benefits programs is to bring all the interested parties to the bargaining table now and begin the diplomacy and negotiation. We have to give something to everybody without undercutting anybody.

Who are the main parties to the long-term care financing debate and what do they want? Seniors want access and quality in home or institutional care without impoverishment or welfare. Taxpayers, and their stewards in government, want limits on Medicaid's explosive growth. Nursing homes and home care providers want more private patients at full-pay, non-Medicaid rates. Long-term care insurers want a level playing field without the competition of free public benefits for the upper middle class. Younger and future generations want to inherit more than a huge public debt. Today, these constituencies are pulling in opposite directions, drawing and quartering the broader public interest. What could harness their energies in a common purpose?

First, we must establish in principle a moral high ground on which everyone can stand with pride and agreement. This is the common philosophy that I found in Wisconsin:

We have very limited dollars available for public assistance; we must take care of the truly poor and disadvantaged first; 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 Medicaid 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 and purchase private long-term care insurance.

Next, we must imagine a program structure that achieves everyone's goals without violating these principles. Such a program would have to do six things:

- (1) Maximize income and asset protections for single and married seniors who need long-term care.
- (2) Eliminate divestiture and estate recovery avoidance.
- (3) Secure property in a beneficiary's possession as a condition of eligibility for publicly financed care.

(4) Recover publicly financed benefits from estates when dependents no longer need the assets.

(5) Encourage the sale of long-term care insurance as an alternative to public benefits and estate recovery.

(6) Educate the public on the advantages of avoiding Medicaid dependency and paying privately for care.

Finally, we must show how this program delivers the key values that each constituency wants to achieve. By maximizing income and asset protections, the program eliminates catastrophic spend-down for seniors. By requiring a pay-back from estates, it removes the stigma of welfare. By making people pay their own way (pay me now or pay me later), the program creates an incentive (now nonexistent) for people to purchase private insurance. By empowering people to pay privately for care with insurance, it diverts families from dependency on Medicaid. By sending the home care and nursing facilities more full-pay private patients, the program enhances the providers' commercial viability and reduces their reliance on public financing. By infusing new money into long-term care, it enhances the industry's ability to provide good access to quality care for all patients, private-pay and Medicaid alike. By making people spend their own money, i.e. their insurance benefits, on care, the program encourages a wide continuum of cost-effective home, community-based, and institutional options. By stimulating heirs to plan ahead for their own long-term care needs and to protect their parent's estates (i.e. their own inheritances), the program ameliorates the biggest danger we face as a nation from the aging of the baby boom generation.

The State of Wisconsin has already wisely introduced most of the features of this program. The problem is that gaping loopholes in federal law, regulation, and policy have emasculated it as explained in this report. The federal government is aware of the problem, is trying to understand it, and may act some day to fix it. Unfortunately, changing public policy at the national level is like turning an aircraft carrier around in a pond. Given the current fiscal crisis, state Medicaid programs cannot afford to wait. What is needed is an innovative experiment in the laboratory of one forward-looking state.

The Ten Most Important Things to Do:

(1) Appoint a "team-Taurus" task force in DHSS to review the full range of issues discussed in this report and to develop a corrective action plan within 90 days.

(2) Mobilize the key players (advocates, providers, insurers, etc.) into an advisory group to review proposals from the task force and generate consensus.

(3) Activate top management to fix the problems that can be solved under existing state and federal law, to initiate changes necessary in state statutes, and to investigate, design, request, and obtain a waiver of federal Medicaid law as required.

(4) Act immediately to plug the fiscal "black hole" of joint accounts.

(5) Find out how other states are controlling trusts and implement their best practices quickly.

(6) Look for short-term ways to control burial accounts, annuities, multiple divestment, intent to return, purchase of exempt assets, and joint tenancy with right of survivorship. Invite a panel of civic-minded, "code-breaker" attorneys to help on a pro bono basis with items 4, 5 and 6.

(7) Support the lien and estate recovery program with full-time legal help, field visits to top-ranked recovery programs in other states and performance-based incentives. Set up a central unit of legal and eligibility experts in the Estate Recovery Program to handle difficult divestiture and shelter cases strongly and uniformly while relieving field staff of the burden of such complicated cases.

(8) Use every forum, including a mailing to family-members of current recipients, to recommend the purchase of private long-term care insurance products approved by the Office of the Insurance Commissioner.

(9) In cases of suspected financial abuse of the elderly, petition the court to appoint conservators to retrieve expropriated assets on contingency through formal legal action.

(10) Educate the general public, eligibility workers, fair hearings officers, attorneys, and judges that Medicaid is public assistance, it has limited resources, and those who can must be encouraged to pay privately.

Bottom Line

A leading Medicaid estate planner and the top Medicaid staffer in the United States Congress agree on at least one thing. In ten years, Medicaid will no longer be there for the middle class. We will either close the loopholes or the program will collapse. The Senior Financial Security Program is a rational alternative that solves the problem by modifying public policy incentives without hurting anyone.

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