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PLAIN(S) TALK ON MEDICAID LONG TERM CARE IN KANSAS:
A CASE STUDY OF MEDICAID AND LTC FINANCING IN KANSAS

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Executive Summary

- Since 1965, government (mostly Medicaid) has paid for the vast majority of all professional long-term care (LTC) services (mostly nursing home care) without requiring significant spend-down of personal assets. The public thereby largely became anesthetized to the risk of LTC. Individuals rarely buy insurance, for instance, or use home equity to pay the expenses associated with care. Instead, they too often end up depending on public financing. The result is that the whole system is teetering on financial collapse, unable to fund care of consistently high quality either in nursing homes or in less institutional settings.
- Demographically, Kansas is no worse off than most states and better off than many.
- Kansas has cost-effectively evolved its LTC service delivery and financing system toward less nursing home and more home care so far, but future prospects for continued success are questionable.
- Medicaid's LTC and other medical services for the elderly place a heavy strain on state finances, divert resources from other priorities such as children, and pose a fiscal challenge for the future.
- Generous and elastic Medicaid LTC eligibility criteria bode ill for Kansas' ability to fund home-based and nursing home care in the future.
- Although operating a reasonably successful Medicaid estate recovery program, Kansas is clearly not maximizing potential recoveries. To the extent recoverable wealth remains unrecovered, Kansas Medicaid is operating as "inheritance insurance" for heirs instead of as a LTC safety net for people in need.
- Home equity conversion is an enormous but largely untapped potential funding source for LTC in Kansas that could substantially relieve fiscal pressure on Medicaid and state taxpayers except that Medicaid exempts the home and all contiguous property up to as much as $750,000.
- Although quality affordable LTC insurance is available in Kansas, too few people buy it. This is partially because of the cost and complexity, but mostly because consumers do not perceive that LTC is a big financial risk for them. In fact, they are right because of the generous availability of Medicaid-financed care.
- Kansas should implement, enforce, and publicize new federal rules and guidelines from the Deficit Reduction Act of 2005 in order to restrict Medicaid LTC eligibility, discourage Medicaid estate planning, and encourage private financing alternatives like home equity conversion and LTC insurance.

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I. Introduction

The following report recounts the findings and recommendations of a study conducted jointly by the Kansas-based Flint Hills Center for Public Policy and the Center for Long-Term Care Reform in Seattle, Washington. This is not a primer on Medicaid or LTC financing. It assumes a working knowledge of both subjects. The text of the report references earlier studies that explain the basics and provide similar reviews of Medicaid and LTC in other states.[1]

The best policy is to oscillate between a broad and a narrow analytical focus, between theory and practice, between national and state-level perspectives. That's what this report attempts to do in order to avoid both pitfalls: overcomplicating or oversimplifying the problem and the solution.

For example, from the broadest perspective, LTC is a very complicated national challenge. America has a rapidly aging generation of baby boomers who will soon place enormous stress on the country's social insurance and welfare programs. Yet our LTC service delivery system is already severely dysfunctional and under-financed.

Consider the following: We rely too heavily on nursing home care. Our home and community-based services infrastructure is underdeveloped. We fund the system mostly with public welfare. Few people buy LTC insurance and fewer still tap their biggest asset — home equity — to pay privately for care. Profitability for providers is low. Debt and equity capital to build, operate and maintain LTC facilities is scarce. Caregivers are in short supply. The system is notorious for quality problems. Tort liability for LTC facilities is huge. Liability insurance premiums have skyrocketed.[2]

These problems prevail already even though the oncoming demographic age wave has barely begun to crest, much less crash on us. Why? It depends upon whom you ask.

For example:

Ask the government (legislators and program administrators) and they'll tell you: Medicaid's LTC costs are staggering already and growing rapidly. It's impossible to raise enough money through taxes to meet the demand for care and pay adequately for it. We need to cut costs somehow before the boomers need care.

Ask the public and they'll say: What, me worry about LTC? I don't know who pays for it (Medicaid, Medicare, Santa Claus?), but somebody must. You don't see Alzheimer's patients dying in the gutter.

Ask LTC providers (nursing homes, assisted living facilities, and home health care agencies) and they'll say: Too few people are able to pay privately for LTC and the government usually pays less than the true cost of quality care. We need higher reimbursements.

Ask senior advocates and they'll say: The government doesn't do enough to provide LTC. We need bigger and better programs that are better-financed.

Ask LTC insurers and they'll say: What's wrong with consumers? Why don't they buy our product? Don't they know they'll have to spend into impoverishment before the government will help? We need tax credits and other incentives to get people to buy.

Ask reverse-mortgage lenders and they'll say: Seniors have $2 trillion worth of home equity that could help pay for their LTC or offset the cost of LTC insurance premiums, but they don't use it. We need government incentives to get them to do so.

Ask LTC financiers (the financial institutions that provide the debt and equity capital to build, operate and maintain LTC facilities) and too many of them will say: We can make a bigger return on investments in other areas of the economy than LTC. Who needs the LTC business?

Truly, as this overview suggests, LTC service delivery and financing is a very complicated subject. But boil it all down and it can also be very simple.

Plain(s) Talk: *Since 1965, government (mostly Medicaid) has paid for the vast majority of all professional long-term care (LTC) services (mostly nursing home care) without requiring significant spend-down of personal assets. The public thereby largely became anesthetized to the risk of LTC. Individuals rarely buy insurance, for instance, or use home equity to pay the expenses associated with care. Instead, they too often end up depending on public financing. The result is that the whole system is teetering on financial collapse, unable to fund care of consistently high quality either in nursing homes or in less institutional settings.*

The solution is also simple. Target Medicaid LTC benefits to people truly in need and use some of the savings to incentivize those who are medically and financially qualified to save, invest or insure for LTC or use their home equity.

This strategy relieves taxpayers, empowers Medicaid to provide a wider range of higher-quality LTC services to a smaller number of dependents, increases jobs and tax revenues in and from the LTC insurance and home equity conversion industries, makes LTC providers more financially viable by increasing their private-pay revenues, and attracts desperately needed investment capital to the LTC provider industry. The Center for LTC Reform (previously called the Center for LTC Financing) developed and documented this national level analysis in numerous publications.[3]

Has this simplified model of the problem and solution prevailed in public policy? Yes and no. Public policy regarding LTC financing has been schizophrenic, pushing in two opposite directions at once.

Over the past 20 years, several Congresses and Presidents have tightened eligibility for Medicaid-financed LTC. Simultaneously, however, federal and state policymakers have encouraged the expansion of home and community-based services as an alternative to nursing home care. These two trends work in opposite directions. Tighter eligibility makes Medicaid-financed LTC harder to get. More generous home and community-based services make Medicaid more desirable to obtain. Both trends are reconcilable, however.

II. The Deficit Reduction Act of 2005

The Deficit Reduction Act of 2005 (DRA) is a good example. On the one hand, the DRA tightens Medicaid LTC eligibility, making it harder for affluent people to qualify. It also encourages the expansion of LTC partnership programs intended to encourage the purchase of private insurance for LTC.

On the other hand, the DRA facilitates the expansion of Medicaid-financed home and community-based services (HCBS) by allowing states to provide such services under their regular Medicaid state plan instead of having to seek special complicated HCBS waivers. Because the public tends to prefer HCBS to nursing home institutionalization, this change tends to make Medicaid eligibility more attractive.

Whether a given state has a successful LTC service delivery and financing system as the pressure from the age wave mounts depends on which of these two aspects of the DRA that the state pushes first and most. States that tighten Medicaid eligibility and encourage private financing will be able to expand HCBS cost-effectively because they have fewer Medicaid dependents to serve. States that expand HCBS without controlling eligibility and encouraging private financing alternatives will find themselves sinking deeper and deeper into fiscal crisis.[4]

The remainder of this report explains what we found when we superimposed the foregoing analytical template over the LTC service delivery and financing system in Kansas. We begin with a demographic profile of the state followed by an analysis of the current LTC system in Kansas. We finish with conclusions and recommendations.

III. Demographic Profile

Kansas has 2.7 million residents, just a little under one percent of the U.S. population. That percentage is gradually decreasing. Kansas' population went up by 8.5 percent between 1990 and 2000, but the U.S. population increased 13.1 percent in the same period.

Economically, Kansans are on a par with other Americans. Per capita money income in 1999 was at $20,506 in Kansas, compared to $21,587 for the country as a whole. Similarly, median household income in 2003 was at $43,113 in Kansas, compared to $43,318 nationally. Better yet, people below the poverty level in Kansas are only 10.4 percent compared to 12.5 percent for the United States.

On the other hand, Kansans have less home equity than most other Americans. The median value of owner-occupied housing units in 2000 was only $83,500 compared to $119,600 nationwide. Real estate tends to have higher values in urban settings and Kansas is very rural. The population density in Kansas is only 32.9 persons per square mile, compared 79.6 for the U.S. as a whole.[5] These general statewide population characteristics set the stage for specific consideration of aging and LTC.

Although people of all ages may require LTC, the focus of this study is on LTC for the elderly. As of 2002, 13.0 percent of Kansas' population was over the age of 65 years compared to only 12.3 percent of the U.S. population. But by 2020, Kansas and the United States are expected to have equally elderly populations at 15.5 percent.[6]

To gauge a state's potential for funding LTC, its rates of elderly poverty and home ownership are very important. The more poverty and the less home ownership, the tougher the LTC financing challenge will be. Older Kansans are not much more or less poor than other elderly Americans. The state ranks 27th in those elderly below the poverty line and 25th in terms of elderly between 101 percent and 200 percent of poverty. The home ownership rate for people 65-plus in Kansas is 79.5 percent, compared to 78.6 for the U.S. This gives the state a ranking of 29th.

The incidence and cost of LTC is much lower for younger elderly. Age 85 is when LTC expenses begin to escalate rapidly. Kansas' population over that age was 1.9 percent in 2002 compared to 1.6 percent for the U.S. Both Kansas and the U.S. are expected to have populations exceeding 85 years of age of 2.0 percent in 2020. That is an increase of only 27.7 percent for Kansas compared to 60.0 percent for the United States. The vise of age will pinch Kansas a little less severely than the rest of the country over the next decade and a half.[7]

***Plain(s) Talk**: Demographically, Kansas is no worse off than most states and better off than many.*

IV. LTC Service Delivery and Financing

How does Kansas compare with the rest of the country in the delivery and financing of LTC? The percentage of Kansans over the age of 65 years who reside in nursing homes (6.0 percent) is half again as high as for the rest of the United States (4.0 percent) ranking Kansas 5th in the country for nursing home use. The state has 76 nursing facility beds per 1,000 residents over the age of 65 compared to an average of only 49 beds for the U.S., ranking Kansas 2nd in the country.

But Kansas relies much less heavily than most states on Medicaid to pay for nursing home care.[8] As of 2003, nursing facility residents in Kansas with Medicaid as their primary payer were only 53.8 percent, compared to 66.3 percent for the U.S., ranking Kansas 49th in the country. Medicare is the primary payer for only 6.2 percent of Kansans in nursing facilities, compared to 11.3 percent for the U.S. Kansas is 50th in that category. Other payers, such as private-pay or insurance, cover 40.1 percent of Kansans in nursing facilities. This is an extraordinarily high level for these payment sources when compared to only the U.S. average of 22.4 percent. Not surprisingly, then Kansas ranks 2nd in the country.[9]

Do Kansans pay enough for nursing home care to ensure quality? In 2002, 27.8 percent of nursing facilities in Kansas were cited with deficiencies for actual harm or jeopardy of residents compared to 18.0 percent in the U.S., ranking Kansas 6th in the country for such deficiencies.

Nursing home reimbursement in Kansas is very low compared to the rest of the country. Medicaid paid $95 per day in 2002 compared to $118 per day nationwide, ranking Kansas 40th. The private-pay nursing facility rate in 2003 was $115 in Kansas compared to $158 nationally, ranking the state 46th.[10] According to the national accounting and consulting firm BDO Seidman, Kansas Medicaid reimbursed nursing facilities $13.14 per bed day less than the cost of providing the care in 2003, $14.16 less than the cost in 2004 and is projected to provide $12.77 less than the cost in 2006.[11] The projected shortfall for 2006 occurs even though the Kansas

State Legislature increased the Medicaid nursing home reimbursement rate 9.5 percent this year.

According to Gilbert Cruz, Kansas' LTC Ombudsman, the most common complaints his office receives from consumers have to do with nursing home care and are related to inadequate staffing. Cruz is unusual as a State LTC Ombudsman in that he has personal experience as a commercial LTC provider.

In our interview, he said: "The fundamental problem is the funding source of the Medicaid system. Typically Medicaid reimbursement is 15 percent less than the true cost of providing the care. Private payers subsidize Medicaid recipients. With any Medicaid census over 50 percent, it is difficult for a nursing home to stay alive. If nursing homes were fully reimbursed, we could find a mechanism to mandate that they spend more money on CNAs [Certified Nursing Assistants] and nurses. It all boils down to the money; voluntary programs don't work if not funded."

Despite the heavy utilization of nursing facility care in Kansas, the state has moved aggressively away from using nursing homes and into the provision and financing of home and community-based care. The change shows up in statistics for both levels of care. For example, overall LTC spending per capita in Kansas is $285, roughly equal to the U.S. average of $288. But Kansas spends $129 per capita for nursing facility care compared to $154 nationally and $41 per capita for HCBS waivers for the Aged and Disabled, compared to only $15 for the U.S. Kansas ranks 30th for nursing facility spending and 5th for HCBS waiver spending for the aged and disabled.

Aged and disabled waiver participants per 1,000 population are 4.7 in Kansas and 1.8 in the U.S., ranking Kansas 3rd in the country. Among Medicaid recipients, people in the aged and disabled waiver programs as a percentage of persons in nursing homes as of 2001 were 108.5 percent in Kansas compared to only 49.5 percent in the US, ranking Kansas 7th.

Likewise, Medicaid spending on long-term services in Kansas for 2003 broke out to 46.5 percent for HCBS, 45.2 percent for nursing facility care, and 8.3 percent for ICF/MR services compared to 33.1 percent, 53.4 percent and 13.5 percent, respectively, for the U.S.[12] Kansas appears to be getting what it pays for in that the number of personal and home care aides per 1,000 people age 65+ as of 2003 in the state was 24 compared to 14 for the U.S., ranking Kansas 5th in the country. Their median hourly wage is relatively generous in Kansas at $8.45 compared to $7.91 for the U.S., giving the state a rank of 17.

Kansas' focus on HCBS is also reflected in the state's nursing facility statistics. Occupancy was only 78.0 percent as of 2003 compared to 82.6 percent in the U.S. giving Kansas a rank of 38. Nursing facility residents declined 8.8 percent in Kansas between 1998 and 2003 compared to a decline of only 4.0 percent nationwide. In the same time period, nursing facility beds went down 5.3 percent in Kansas compared to a drop of only 3.1 percent across the U.S. By comparison, Medicaid recipients in aged/disabled waiver programs increased 250.2 percent between 1996 and 2001 in Kansas compared to only 74.0 nationwide, ranking Kansas 9th.[13]

The following tabular array of Medicaid nursing home and home care expenditures in Kansas and in the United States is informative:[14]

	Kansas (Millions of Dollars)		United States (Millions of Dollars)	
Year	*Nursing Home*	*Home Care*	*Nursing Home*	*Home Care*
1980	$ 109	$ 1	$ 10,242	$ 277
1981	$ 116	$ 1	$ 11,516	$ 412
1982	$ 125	$ 1	$ 12,281	$ 488
1983	$ 137	$ 1	$ 13,292	$ 615
1984	$ 139	$ 1	$ 14,384	$ 774
1985	$ 147	$ 1	$ 15,439	$ 886
1986	$ 153	$ 2	$ 16,749	$ 1,019
1987	$ 165	$ 1	$ 18,229	$ 1,213
1988	$ 189	$ 2	$ 19,324	$ 1,358
1989	$ 202	$ 2	$ 21,036	$ 1,754
1990	$ 242	$ 3	$ 24,105	$ 2,144
1991	$ 274	$ 5	$ 28,127	$ 2,495
1992	$ 280	$ 7	$ 30,335	$ 2,939
1993	$ 290	$ 8	$ 32,184	$ 3,456
1994	$ 293	$ 9	$ 33,269	$ 3,841
1995	$ 283	$ 11	$ 34,084	$ 4,313
1996	$ 284	$ 12	$ 35,985	$ 4,676
1997	$ 273	$ 14	$ 36,882	$ 5,130
1998	$ 246	$ 16	$ 37,480	$ 5,585
1999	$ 236	$ 18	$ 38,923	$ 5,940
2000	$ 257	$ 23	$ 41,996	$ 6,755
2001	$ 242	$ 32	$ 45,752	$ 8,374
2002	$ 234	$ 37	$ 47,105	$ 10,045
2003	$ 258	$ 34	$ 49,614	$ 11,792
2004	$ 232	$ 38	$ 51,089	$ 13,698

Note that according to this table, total Medicaid nursing home and home care expenses in Kansas peaked in 1994 at $302 million and have since declined significantly. Nursing home expenditures fell precipitously from $293 million in 1994 to $232 million in 2004, a 21 percent decline. Home care expenditures, in contrast, increased very rapidly (although from a much smaller base) from $9 million to $38 million – a 322 percent increase.

During the same time period, total Medicaid nursing home and home care expenditures nationwide increased from $37,110 million to $64,787 million, a 75 percent increase. This total subsumes an increase from $33,269 million to $51,089 for nursing homes, a 54 percent increase and a rise from $3,841 million to $13,698 million for home care, a 257 percent increase.

Thus, compared to the rest of the country, Kansas has done a better job of controlling – and even reducing – total LTC costs while changing its program's service delivery focus from nursing home to home care. The state's proclivity toward continuing with this policy was evident

from our interviews state officials. Each and all indicated the desirability of offering more home-based LTC under Medicaid and depending less on nursing facility or institution-based care. They complained about federal LTC policy which makes nursing home care an "entitlement" but places many more restrictions on the availability of HCBS, which they believe are less expensive and more desirable.

However, both LTC Ombudsman Gilbert Cruz and Medicaid Director Scott Brunner expressed concern that Medicaid-financed HCBS create their own demand and could end up in the long run costing as much or more than the traditional nursing-home based system.

Said Brunner: "One thing the waivers do is create demand. People can live at home with support from their family or go to nursing home as a Medicaid entitlement, but HCBS waivers create the option to get care and financial help from Medicaid at home. So, there is not enough money if everyone got HCBS. With the waiver you can cover more people but not the whole range of services for everyone. For example, we do nothing in Kansas for assisted living through Medicaid."

Said Cruz: "By pushing HCBS, are we discouraging people from getting LTC insurance? Are we prepared for that? Is that really solving the problem? The consumer wants to stay at home and I understand that. But will we stymie personal responsibility? I do not think expanding HCBS will save money. Savings can come from making eligibility more strict."

Plain(s) Talk: *Kansas has cost-effectively evolved its LTC service delivery and financing system toward less nursing home and more home care so far, but future prospects for continued success are questionable.*

V. Medicaid in Kansas is Both Expensive and Attractive

Clearly, Kansas' Medicaid program is expensive, growing rapidly in the cost of its home care component, and is becoming more and more attractive as a means for people to fund their health and long-term care. The focus of this report is LTC, but LTC must be seen in context with broader health care needs of the elderly. Seniors who qualify for Medicaid based on their need for LTC also receive the broader health care services and benefits provided by the program, including ones not covered by Medicare. For a good general overview of Medicaid's broader health care financing role, a number of other publications are available.[15]

Seniors have a disproportionate impact on Medicaid costs and services. For example:

> In Kansas, seniors and individuals with disabilities account for almost one-third of Medicaid enrollees but more than two-thirds of expenditures. Even though children and their parents account for more than two-thirds of enrollees, less than one-third of Medicaid spending is attributable to these populations. Children account for more than half of all Kansas Medicaid enrollees but less than one-quarter of the costs. The DHPF [Division of Health Policy and Finance in the Department of Administration] estimates that an average of 140,000 low-income children will be enrolled in Medicaid in FY 2006 — approximately 19 percent of all children in Kansas. Significantly more Medicaid dollars are used to provide services to seniors and individuals with disabilities than adults and children, largely due to the costs of

LTC, prescription drugs and specialty services. Most seniors and some Medicaid enrollees with disabilities also are enrolled in Medicare (commonly known as 'dual eligibles'), which pays for most of the cost of doctor visits, hospitalizations and other eligible services.[16]

In addition to diverting public funds from children to the elderly (a problem raised as a serious concern by the state legislators we interviewed for this project) Medicaid also consumes resources that might have gone toward other public goods, such as education, highways, or corrections.

Kansas Senate President Steve Morris offered this quote for our study: "The increases of recent years in Medicaid funding are unsustainable for the state. In the 1960s Medicare was created by the federal government as a safety net for seniors. Now state Medicaid programs, which were never designed as a safety net for seniors, are assuming a large part of the financial burden for vulnerable seniors. The Federal Government must step up and accept its responsibility."

According to Melvin Neufeld, Chairman of the Kansas House Appropriations Committee, "The feeling in the House is that we're going to have to get control of this."

Representative Bob Bethell – who is himself a LTC provider – agreed, but warned: "Many members agree it's a great idea to control Medicaid LTC eligibility . . . at least until it affects their own families, whether they agree philosophically or not."

Plain(s) Talk: *Medicaid's LTC and other medical services for the elderly place a heavy strain on state finances, divert resources from other priorities such as children, and pose a fiscal challenge for the future.*

VI. Medicaid LTC Eligibility

Given the huge and growing impact Medicaid has on the Kansas economy – and especially its LTC component – it is important to ask how easy eligibility for the program is to attain. Although Medicaid is a means-tested public assistance program (i.e. welfare) and has stringent income and asset limits for poor women and children, seniors in need of nursing home care qualify fairly easily for the program.

Income is rarely an obstacle to eligibility because the Kansas Medicaid program deducts medical expenses from an applicant's income before comparing any remaining income to the cost of nursing home care. The Wichita field office, for example, uses a standard nursing home cost of $3,600 per month for this purpose. If an applicant has less than $3,600 of monthly income after deducting other medical expenses, he or she is eligible based on income. Very few elderly Kansans have incomes above that level.

Assets are another matter. Ownership of cash or other negotiable resources of $2,000 or more will disqualify an applicant. But many kinds of assets do not count at all under federal law (a business, one automobile, prepaid burials for the applicant and his or her family, home furnishings, term life insurance) and others are allowed in limited amounts (a home up to $750,000, whole life insurance with a cash surrender value up to $1500, etc.).[17] Again, very few elderly Kansas have assets above those levels.

Married couples in which one spouse applies for Medicaid LTC get an even better deal. The healthy "community spouse" can retain half the couple's joint assets up to $99,540 and up to $1,650 of their monthly income (up to $2,488.50 if needed to maintain a home).[18]

A number of factors in Kansas facilitate Medicaid LTC eligibility. For example, the state permits people to apply for benefits by mail without a face-to-face interview. The state only verifies applicants' claims regarding income or assets if such are reported. Otherwise, unless the eligibility worker is suspicious claims of poverty are accepted at face value. Caseloads are huge – often 300 to 500 – making it difficult for workers to obtain documentation and verify claims.

Although eligibility workers are not supposed to provide "estate planning" advice, they are not discouraged from telling applicants how to deplete countable resources by purchasing exempt assets. "We've had a policy that workers telling applicants reasonable things is OK, such as, 'buy a TV or sweat pants but not a new car,'" said a headquarters policy specialist. Field staff in Wichita elaborated: "If they're a little over the limit, Mom and Dad can buy whatever they need, such as clothes, recliners, a TV. Go shopping. If you don't, all you're going to have is the protected limit [personal needs allowance] of only $50 dollars per month."[19]

VII. Medicaid Estate Planning

When applicants or their representatives persist either in person or by telephone in asking for advice about how to qualify for Medicaid LTC benefits, workers refer them to estate planning or elder law attorneys. Although we found no evidence of widespread egregious Medicaid planning (deliberate, attorney-assisted self-impoverishment of affluent citizens) in Kansas, we did note some evidence that Medicaid planning occurs and that it is sometimes encouraged both in seminars for seniors and in legal journal articles.

For example, Overland Park, Kansas, elder law attorney William Hammond, who kindly agreed to be interviewed for this study, provided the following advice on how to "spend down" to Medicaid eligibility limits in a 2003 personal communication:

> For someone who is pursuing Medicaid eligibility, following are the types of spend-down items, in no particular order, which should be considered:
>
> Purchase pre-paid funeral plans. The rules regarding funerals differ in Kansas and Missouri so you should only deal with a funeral home knowledgeable in this type of planning.
>
> Purchase a new car. It is perfectly acceptable to purchase a new car. The community spouse may even do this and have the entire purchase price come out of the nursing home spouse's spend-down.
>
> Payment of nursing home expenses. Of course, nursing home expenses and other healthcare costs can be made as part of a spend-down.
>
> Purchase of a new home. Since the home is an exempt asset, in some instances purchase of a new home makes sense from a Medicaid planning standpoint.

Make home improvements. Home improvements are often an excellent use of funds in a Medicaid spend-down. For instance, the community spouse might fix the roof, get a new air conditioning system, new carpeting, new furniture, etc. The intention here is to fix the house up so that, hopefully, no other home repairs will need to be done during the lifetime of either spouse. That is especially important since, in many cases, the community spouse will have to spend down one-half of his or her assets and may no longer have the resources necessary for large lump sum expenditures which may occur later.

Buy household goods or personal effects. Once again the intention is to have the community spouse get the types of things which are needed to keep the household running without major expenditures down the road.

Debt repayment. The key here is to make sure that the debts are repaid only after the Medicaid snapshot has been established. In other words, it would be disastrous to pay down a large amount of debt before there has been a snapshot. Once the snapshot is in force, then the entire debt repayment can count against the assets of the nursing home spouse. If done too soon, however, the debt repayment would only go one-half against the assets of the nursing home spouse and one-half against the assets of the community spouse.

Vacation. Can be a good idea for the community spouse at a time when there has been a long struggle to keep a loved one at home. The community spouse may be exhausted and a well-deserved vacation could be rejuvenating. Believe it or not, the entire cost of that vacation can come out of the nursing home spouse's spend-down.

These are, of course, not the only appropriate items for a spend-down. There are other expenses which would also qualify. The main rule to keep in mind is that whatever goods or services are purchased must be done at fair market value. In other words, giving the money away or paying outrageous amounts for less than the real value of the services can cause Medicaid disqualification.

Also, don't let anyone tell you that anything spent must be done solely for the benefit of the nursing home spouse. On the contrary, virtually anything that benefits the community spouse will also benefit the nursing home spouse.

Finally, keep in mind that while some of these spend-down strategies will not work as well for a single person qualifying for Medicaid, there are other strategies that can work equally well, no matter whether you are dealing with a single person or a married couple. Contact our offices to speak with an experienced elder law attorney for guidance.[20]

Although the foregoing techniques can protect a lot of assets from Medicaid spend-down rules, they are "chicken feed" compared to other methods of self-impoverishment employed in Kansas. For example, in the transcript of a "Financial Virtual Lunch" talk delivered by Mr. Hammond on May 24, 2006, he says:

As a financial advisor, you have probably been telling your clients for some time now that it's okay to make, for instance, the annual exclusion gift – amount is $12,000. That's true.

> And under the old laws, you didn't have to worry about that causing Medicaid issues because the $12,000 gift, for instance, only caused a four-month penalty period in Kansas. But under the new rules, the penalty won't start until the person is otherwise spent down or outside the five-year look back.

Translation: As of 2006, in order to avoid estate taxes on wealth above this year's exempt limit of $2,000,000, wealthy people can give away $12,000 per year to any single person without incurring a gift tax. A couple can give away $12,000 each, say to an adult child and his or her spouse. Previous to the DRA, such transfers were unlikely to interfere with Medicaid eligibility, because the transfer of assets penalty began at the date of the transfer and would have run out within a few months. After the DRA, the eligibility penalty begins when eligibility would otherwise have occurred in the absence of the change in the penalty date. Thus, the DRA makes it tougher for millionaires to qualify for Medicaid while avoiding estate taxes.

What planning techniques remain for the well-to-do? An internet search for "Medicaid planning in Kansas" reveals several websites referencing the practice.[21]

What sorts of people with what kind of wealth consult Medicaid planners in Kansas? How much of an elder law practice depends on Medicaid planning? One of the two elder law attorneys we interviewed for this study said Medicaid was half his practice, down considerably from past years. The other indicated 25 percent. Both said clients are "all over the board," but agreed that most have homes owned free and clear worth $80,000 to $150,000 and incomes, comprised mostly of Social Security, of $800 to $1,200 per month for a single person and $1,800 to $2.200 for couples, plus some investment income.

Asked to identify the upper and lower ends of their Medicaid planning clientele, one said: "I have three cases sitting on my desk right now with $70,000 to $100,000 houses and pensions around $2,000 per month. That's the lower end of scale. At the upper end, I have one with $450,000 in countable assets but no home equity." The other said: "My range is the same on the upper end. We've had people come in with a couple million dollars, but we discourage them from doing Medicaid planning. At the lower end of the range would be a married couple in the $30,000 area or just terrified to deal with the state."

Although Medicaid planning remains a niche practice of law in Kansas, it could grow rapidly as LTC becomes a bigger and bigger issue, unless discouraged by the courts and public policy. A recent *Washburn Law Journal* article, titled "Don't Plan on Aging: The Kansas Supreme Court Reaffirms its Hostility Toward Medicaid Planning," strongly recommended Medicaid planning and lamented a court decision delimiting the practice.[22]

Kansas Medicaid LTC eligibility policy expert Jeanine Schieferecke told us: "The general public is aware of Medicaid planning. Seniors do talk about it. They want to leave something for their kids. They are concerned about the government getting its hands on their money. The vast majority of seniors understand the bigger issue, but don't know the details. When my mom came to me and asked about Medicaid planning, I knew it was big."

Even when Medicaid planning is not intentionally practiced, eligibility for Medicaid LTC benefits is often the outcome of general estate planning. We found in Nebraska – and have reason to believe the practice also occurs in Kansas – that aging owners of farms and farm land often

transfer ownership to the younger generation for tax or estate planning reasons unrelated to qualifying for Medicaid.[23] The effect of such transfers, however, is to ensure relatively easy Medicaid eligibility ten or fifteen years later when LTC becomes necessary. With a transfer of assets look back period of only five years, such transfers totally avoid eligibility penalties and such assets are not even considered for purposes of determining Medicaid qualification.

Thus, for many reasons – most of which are grounded in federal laws and regulations that the state cannot change – Medicaid LTC eligibility is relatively easy to achieve. The more surprising fact in Kansas is that relatively few elderly residents of the state take advantage of the program to pay for their LTC. Perhaps traditional values of personal responsibility are stronger in the Heartland than on the coasts and in the more urban areas of America.

The bottom line, however, is that because relatively few Kansans rely on Medicaid for LTC, the state's marginal vulnerability to increasing LTC costs is relatively greater than for states that have already saturated their Medicaid LTC rolls. Imagine the extra cost to Medicaid and state taxpayers if the Medicaid nursing home census in Kansas increased from its current 53.8 percent to the national average of 66.3 percent. This is a realistic possibility if Kansans' "pioneer spirit" of independence and self-sufficiency is further eroded by the "entitlement mentality" that has grown to be dominant elsewhere.[24]

Plain(s) Talk: *Generous and elastic Medicaid LTC eligibility criteria bode ill for Kansas' ability to fund HCBS and nursing home care in the future.*

VIII. Liens and Estate Recoveries

One way for a state that has easy eligibility for generous Medicaid-financed benefits to offset the cost, disincentivize welfare dependency, and encourage personal responsibility is to recover the cost of their care from recipients' estates after they die. Congress and President Clinton made Medicaid estate recovery mandatory in the Omnibus Budget Reconciliation Act of 1993 (OBRA '93). Kansas has had an estate recovery program since 1992. The state also added a Tax Equity and Fiscal Responsibility (TEFRA) lien program in 2004. This allows Kansas to encumber real property under certain circumstances in order to discourage and track its transfer until it can become part of a recoverable estate.

In many ways, Kansas' lien and estate recovery program is exemplary. Attorney Administrator of the Estate Recovery Unit Brian M. Vazquez and his former colleague Roger Van Etten wrote a four-volume "Kansas Estate Recovery Primer" published in 2005 by The Flint Hills Center for Public Policy that covers much of the program's efforts and goals.[25]

Under their management, the Kansas program adopted several best practices. For example, the state has had a system since 1992 to collect automatically the "personal needs accounts" of Medicaid nursing home residents, each of which can be up to $2,000, upon the death of the recipient. On July 1, 2004, Kansas adopted a broadened definition of "estate" as authorized in OBRA '93 so that recoveries could be pursued from assets that pass in joint tenancy with right of survivorship, from life insurance proceeds, from trusts, or life estates, not just from traditional "probate" estates. Kansas is also one of a small number of states that recover from "spousal"

estates and currently tracks 600 spouses to ensure eventual recovery from their estates of Medicaid benefits previously paid to their husbands or wives.

In the six state fiscal years between 2001 and 2006, Kansas recovered over $30 million from the estates of deceased recipients or their spouses. Based on the cost of recovery, including salaries, benefits and other prorated office expenses, the Unit estimates it recovers $13 or $14 dollars for every dollar invested – a very respectable estate recovery ratio of seven or eight percent. According to a recent national study of Medicaid estate recovery programs conducted by AARP, Kansas' 2003 estate recovery total of $5.8 million was equal to .75 percent of the state's total LTC expenditures of $775.7 million.[26]

Nevertheless, one cannot help but wonder whether Kansas could achieve a higher return from its lien and estate recovery program. For example, the state's total recoveries dropped 25 percent from $6.0 million in fiscal year 2005 to $4.5 million in fiscal year 2006. In fiscal 2003, if Kansas had recovered at the same rate as the top state in the AARP study – Arizona at 5.78 percent of total LTC expenditures – Kansas recoveries would have been $44.8 million instead of the actual $5.8 million, an increase of $39.0 million. Even at the lower rate achieved by Oregon of 2.22 percent, Kansas' 2003 recoveries would have been $17.2 million, an increase of $11.4 million.

Would a private firm do a better job of estate recovery? Several states have opted to outsource the task to the private sector. Kansas passed legislation calling for a pilot project to explore the feasibility and effectiveness of using a private contractor for estate recoveries. So far, the state has not proceeded with this experiment.

The current Estate Recovery Unit supervisor questions the advisability of doing so. He expressed concern that a private contractor might bring in more money initially, but increase expensive litigation over time by interfering with the sensitive rapport he has established between the Estate Recovery Unit and the elder law bar. He also questioned whether eligibility staff would work as well with non-state recovery staff. A devil's advocate might ask whether state staff are at risk of becoming too cozy with the Medicaid planning bar.

Plain(s) Talk: Although operating a reasonably successful Medicaid estate recovery program, Kansas is clearly not maximizing potential recoveries. To the extent recoverable wealth remains unrecovered, Kansas Medicaid is operating as "inheritance insurance" for heirs instead of as a LTC safety net for people in need.

IX. Alternatives to Medicaid Financing of LTC

Long-term care is already a heavy fiscal burden on state and federal coffers. The challenge of financing LTC will likely increase as the demographic age wave passes through American society and history over the next thirty years. If Medicaid and Medicare are nearly stretched to their limits, where will the money come from to fund LTC cost increases in the future?

Obviously, there is a limit to how much expensive LTC people can finance out of their own pockets. Even if Medicaid's currently generous income and asset limits were severely reduced, there would still remain an absolute limit beyond which Americans could not pay as they go

without facing destitution. So, what other sources of LTC financing are there, how much do they currently contribute to LTC costs, and what would need to be done to increase their potential?

X. Home Equity Conversion

By far the biggest repository of wealth owned by seniors in the United States resides in their homes. According to the National Council on the Aging report "Use Your Home to Stay at Home: Expanding the Use of Reverse Mortgages for LTC: A Blue Print for Action":

> One of the paradoxes of our current LTC system is that impaired, older Americans are struggling to live at home at a time when they own more than $2 trillion in untapped housing wealth. The majority of older Americans are homeowners. Many have accumulated substantial amounts of home equity, including families whose other retirement resources may be very modest. Over half the net worth of seniors is currently illiquid in their homes and other real estate. With so much wealth tied up in the home, the decisions that today's older homeowners make about this financial asset can significantly impact our nation's ability to better balance public and private funding for LTC and to respond more rapidly to consumer preferences for "aging in place."
>
> Reverse mortgages are specialized loans that enable seniors to tap their home equity while they continue to live in the home. With an estimated amount of over $72,000 available on average to older households from these loans, reverse mortgages can help impaired elders pay for several years of daily home care visits, over a decade of out-of-pocket expenses and respite for family caregivers, or substantial home modifications. Despite the promise of this financing option, older Americans have not been encouraged to tap into their substantial housing assets.[27]

Is it really a "paradox" that most homeowners don't use their home equity to fund their LTC? Do older Americans have to be "encouraged to tap into their substantial housing assets"? Actually, there should be no mystery why home equity is rarely used to fund LTC in the United States. Medicaid exempts the home and all contiguous property up to at least half-a-million dollars in home equity. Until the DRA '05, there was no limit on home equity.

Although federal law requires states to recover from deceased recipients' estates, including the value of real property remaining in estates, the reality is that the total percentage of elderly homeowners (approximately 83 percent) plummets by the time people end up on Medicaid (14 percent).[28] If Medicaid did not exempt the home, people would be much more likely to tap their home equity to pay for LTC with or without additional "encouragement."

What is the potential for home equity conversion as an alternative funding source for LTC in Kansas? State level data on home equity of the elderly is difficult to obtain. Just for the sake of discussion, let us assume that the amount available to older households in Kansas from reverse mortgages bears the same relationship to the national average of $72,000 documented in the AARP report cited above as the median value of owner-occupied housing units in Kansas as of 2000 ($83,500) bears to the national average ($119,600) or 70 percent. Seventy percent of $72,000 is $50,400. Since we know the home-ownership rate for people 65 plus in Kansas is 79.5 percent and the elderly are 13.0 percent of Kansas' total population of 2,733,968 or 355,416, it is a simple mathematical computation to arrive at an estimate.[29]

If 79.5 percent of 355,416 elderly Kansans or 282,556 own an average of $50,400 worth of home equity that could be tapped by a reverse mortgage, the total available would be $14,240,808,288, over $14 billion. That is a substantial sum that could be used, but isn't, to help fund quality LTC for older Kansans and to relieve the financial burden of Medicaid LTC on Kansas taxpayers.

To learn more about reverse mortgages and their potential to fund LTC in Kansas, we interviewed a reverse mortgage lender by the name of Todd Drew, who is the Branch Manager for Urban Financial Group, Inc., in Wichita. He explained that reverse mortgages allow people 62 years of age or older to withdraw otherwise illiquid equity from their homes in the form of a lump sum, a monthly payment, or a line of credit. Such loans are highly regulated to protect consumers and do not require repayment until the recipient of the loan dies, permanently leaves the home, or sells the property.

Reverse mortgages carry substantial fees and are not advisable for short-term loans, but for people who seek permanent supplemental income or extra funds for a special need and do not mind using home equity, these loans can be a godsend. As a rule of thumb, Todd Drew says reverse mortgages are not feasible unless the borrower's equity in the home is at least half the home's market value. Because of steady increases in home values in the past, many reverse mortgage borrowers have been able to take money out of their homes in this way and still see their total equity grow. But, of course, past performance is no guarantee of future results. A full description and explanation of reverse mortgages is beyond the scope of this report. For that, see the AARP report cited above.

We asked Mr. Drew why people in his coverage area around Wichita, Kansas take out reverse mortgages. He explained that the most common reason is for lower to middle-income people to supplement their monthly incomes by paying off any underlying mortgages thus eliminating monthly payments and adding a little extra income from the reverse mortgage. Some middle income people use reverse mortgages to pay for special projects such as remodeling a kitchen. So far in Kansas, he says, very few more affluent people have made use of reverse mortgages for any purpose.

Asked to describe a typical case, Mr. Drew indicated a home worth $82,000 owned by a 72-year-old person with an underlying mortgage of $20,000. The reverse mortgage would allow this person to pay off the mortgage, thus freeing up extra income that previously went toward mortgage payments. The borrower might add an additional $100 to $150 per month of income. The single most common reason for seniors to seek this additional income from reverse mortgages is to help pay for their prescription drugs. Unlike going back to work to supplement their income, which may cause a reduction in Social Security benefits, the proceeds of a reverse mortgage are not treated as income and therefore do not have that negative effect on public benefit eligibility.

We asked about the market for reverse mortgages in Kansas. He said: "We're probably one of the last states to get really involved." We asked whether people ever took out reverse mortgages to help with LTC costs. He said: "At this point in my experience it has come up only a couple times." Asked why he thought that was, Mr. Drew said: "Medicaid is a given so people don't worry about LTC."

Mr. Drew expressed serious concerns about potential abuse of reverse mortgages by "dragons with briefcases" who might use the loans to fund the purchase of other products they market, such as used cars, aluminum siding, or annuities. State representative Bob Bethell raised a related concern observing that television advertisements for reverse mortgages seem to urge people to use them even for frivolous reasons such as vacations or recreational vehicles that the homeowners cannot really afford. Mr. Drew recommends additional regulation, but he believes reverse mortgages are starting to come into their own in Kansas and that used properly they can be an enormous benefit to older Kansans.

Hard data on the actual number of home equity conversion mortgages (HECM), the most common type of reverse mortgage, is difficult to find. A National Governor's Association publication reported that HECM loans originated by October 1999 were highest in Utah (1,083), lowest in Texas (0) and low in Kansas (215).[30] More recent data patched together from several sources by the author indicate that as of 2004, Kansans had taken out only 3.1 HECMs per 1,000 elderly homeowners, ranking the state 36th in the country.

Plain(s) Talk: *Home equity conversion is an enormous but largely untapped potential funding source for LTC in Kansas that could substantially relieve fiscal pressure on Medicaid and state taxpayers except that Medicaid exempts the home and all contiguous property up to as much as $750,000.*

XI. LTC Insurance

The other major potential source of private financing for LTC that could relieve the burden on Medicaid is LTC insurance (LTCI). In the opinion of both the Insurance Commission staff and LTC salespeople we interviewed, Kansas regulates LTC insurance effectively.

The state adopted guidelines published in 2000 by the National Association of Insurance Commissioners. The Kansas Insurance Commission publishes both an informational booklet and a "shopper's guide" for LTC insurance. It makes available to consumers a list of LTC insurance carriers that have raised premium rates on in-place business either in Kansas or elsewhere. Staff of the Commission report that although consumer complaints about LTC insurance are not excessive, they do tend to be primarily about rate increases on older policies, with delays on first time claims a distant second.

Kansas also implemented some public policies to encourage the purchase of LTCI. For example, the state permits an above-the-line state income tax deduction of $500 for tax years beginning after December 31, 2004. This deduction increases by $100 per year until it levels off at $1,000 in 2010. Kansas also exempts an amount from Medicaid estate recovery liability equal dollar-for-dollar to the amount of LTC insurance purchased and used to pay privately for care. The state is certainly more congenial to private LTC insurance than most others. This is reflected in Kansas' LTCI market penetration, which America's Health Insurance Plans, a major insurance trade association, reports as 10 to 14 percent as of 2002.[31] Only five states have a higher LTC insurance market penetration than Kansas.[32]

Nevertheless, the LTC insurance market in Kansas and nationally is struggling. Very few insurance agents in the state specialize in marketing LTC insurance, probably no more than

fifteen in the Kansas City area according to our interviewees.

We were fortunate to have Claude Thau, the primary author of the Tillinghast *Broker World* LTC insurance surveys in 2004 and 2005, as an interviewee for this study. He said "Kansas' market share in terms of annualized LTC insurance premium sold dropped from 1.48 percent of the national individual LTCI policy annualized premium in 2004 to 1.20 percent in 2005, an 11 percent drop in market share after some adjustments. I think it is reasonable to say Kansas was among the 10 states with the largest drop. Pennsylvania dropped 33 percent; West Virginia dropped 20 percent; Montana dropped 17 percent; Oregon dropped 15 percent; Nebraska dropped 14 percent; Louisiana and Texas dropped 13 percent; and Maryland dropped 12 percent." Ominously, we learned that a LTC insurance plan for state employees was cancelled by the carrier for lack of participation.

Why are LTCI sales flagging even as the future need for LTC is increasing with population aging? It is true that the product is expensive compared to other kinds of insurance. But this makes sense actuarially. Fire insurance would not be cheap if every tenth house burned down. In fact, after age 65, people have a nine percent probability of needing five years or more of expensive LTC.[33]

It is also true that LTC insurance has had its challenges in the marketplace. Early underpricing of the product, lower lapse rates than anticipated, and interest rates on reserves well below what insurance carriers anticipated have all led to pricing pressures on new business and to rate increases on in-place business in many instances. But despite all these problems, both the insurance agents we interviewed and the Kansas Insurance Commission staff we interviewed – including Commissioner Praeger herself – expressed the opinion that high quality, reasonably affordable LTC insurance policies are readily available in Kansas if people would buy them.

Demand for any product or service is directly proportional to perceived need. With regard to LTC insurance, perceived need is very low. LTC insurance salespeople we interviewed indicated that Kansans are in "denial" about LTC. They assume that if expensive LTC is a fifty-fifty proposition, all that means is that the other guy should worry about it. "Won't happen to me. Never go to one of those places. Shoot myself first."

Yet, the statistics on incidence and cost of LTC are objective facts that trump those subjective, self-deceiving opinions. The more important question to ask is: What enables the public's denial about LTC? The answer is clear. Most people can ignore the risk of LTC, avoid the premiums for private LTC insurance, wait to see if they every need expensive LTC, and if they do, when they do, easily transfer the cost to Medicaid without spending down their own assets significantly.

As explained above, most elderly Kansans in need of nursing home level care qualify for Medicaid LTC benefits based on their income and assets without fancy legal machinations. Others with greater wealth can see "Medicaid planners" for help self-impoverishing down to Medicaid's already generous income and asset limits. The LTC insurance agents we interviewed said Medicaid planners are "very strong here in Kansas. Potent competition. They run lots of commercials on the radio: Do you have an Alzheimer's diagnosis? Then see an elder law attorney. Come see us quick before you lose everything. This absolutely impairs the market for our product."

Whatever the problems with private LTC insurance, including affordability and complexity, it is clear that the product would penetrate a wider market if Medicaid LTC coverage were not so easy for middle-class and even more affluent people to obtain. In a paper for the National Bureau of Economic Research, Brown and Finkelstein concluded: "We . . . estimate that *Medicaid can explain the lack of private insurance purchases for at least two-thirds and as much as 90 percent of the wealth distribution*, even if comprehensive, actuarially fair private policies were available."[34]

For the record, William Hammond, the elder law attorney quoted above, strongly disagreed. He believes that even in the absence of any public financing for LTC, most people would fail to buy LTC insurance just as less than half of Americans do appropriate estate planning and roughly half die intestate, i.e. without a will. On the other hand, if even half of all Americans purchased private LTC insurance, the problem would be solved.

Plain(s) Talk: *Although quality affordable LTC insurance is available in Kansas, too few people buy it, partially because of the cost and complexity, but mostly because consumers do not perceive that LTC is a big financial risk for them, and in fact they are right because of the generous availability of Medicaid-financed care after the insurable even occurs.*

XII. Conclusion

Upon a close – albeit brief – review, we would describe Kansas LTC in simplest terms this way: Kansas has made a strong commitment to provide quality LTC to its residents. The state has made significant strides toward giving Kansans more of the kind of home and community-based LTC they prefer with less of the traditional nursing-home-based institutional care most people would rather avoid if possible. Although offering LTC to large numbers of old and frail people is very expensive, Kansas has so far managed the task in a way that has restrained the kind of explosive, unrestrained growth in expenditures experienced by other states and the United States as a whole. It is highly questionable, however, whether LTC costs can continue to be restrained as Kansas faces the oncoming demographic age wave.

Medicaid, a means-tested public assistance program co-funded by the federal government and the state of Kansas, is the main although certainly not the only source of financing for the Kansas' LTC commitment. Because of its generous income and asset eligibility limits and elastic eligibility rules, Medicaid is routinely available to pay for Kansans' LTC without their having to spend down personal savings significantly for privately financed care.

The facts that people in Kansas are more likely than consumers in most other states to pay privately for LTC and to purchase LTC insurance are anomalies which do not follow logically from the incentives in Kansas' LTC public policy. The fact that Medicaid-financed LTC is easily available after an insurable LTC event occurs tends to numb consumers to the risk and cost of LTC and discourages responsible early planning to save, invest or insure for LTC. Educational campaigns and small tax incentives intended to awaken citizens to the risk of LTC and the need for planning can hardly compete permanently with a reality that government pays for most LTC. A growing sense of entitlement to publicly financed LTC could tip the balance even more heavily toward Medicaid dependency and away from personal responsibility in Kansas.

Fortunately, the federal government recently provided state Medicaid programs with some stronger tools to restrain the growth of public dependency on government-financed LTC and to encourage more personal responsibility and private LTC funding alternatives. The Deficit Reduction Act of 2005 addresses these issues on three fronts:

- First, it tightens Medicaid LTC eligibility rules and discourages Medicaid estate planning.
- Second, it authorizes expansion of the "LTC partnership programs," which incentivize the purchase of private LTC insurance.
- Third, it makes the provision of Medicaid-financed home and community-based services easier for states by allowing them to offer HCBS under the normal Medicaid state plan instead of requiring a complicated waiver. The Appendix of this report includes a detailed description of the provisions of the Deficit Reduction Act that are germane to LTC financing policy.

XIII. Recommendations

It should be obvious by now that the DRA is a double-edged sword. Although it gives states important new tools to restrain Medicaid dependency and encourage private LTC financing alternatives, it also invites further expansion of home and community-based LTC services which make Medicaid-financed care more desirable than ever for the public, thus encouraging Medicaid dependency and discouraging private financing.

The primary recommendation of this report, then, is that Kansas implements the new Deficit Reduction Act rules fully and aggressively, but that the state first emphasizes measures to control Medicaid LTC eligibility and encourage private financing alternatives before focusing further on the expansion of HCBS. By diverting most Kansans early to privately financed LTC, whether from personal spend down, private insurance, or home equity conversion, the state will be able to continue to improve the kind and quality of services it provides to people most in need of public assistance.

Note that on July 27, 2006, the Centers for Medicare and Medicaid Services (CMS) published detailed guidance for state Medicaid programs on how to interpret and implement the DRA's changes regarding "Medicaid Transfer of Assets" and "LTC Partnerships." Copies of the state Medicaid directors' letters and attachments outlining the new policies implementing the DRA are available from the CMS website.[35] CMS's press release announcing these issuances included the following statement fully in keeping with the analysis and recommendations of this report:

> "One of the greatest challenges facing our nation is providing high-quality care for older Americans when their health declines," said Mark McClellan, MD PhD, administrator of CMS. . . .
>
> "Partnerships between consumers, the private insurance industry and Medicaid will help people better plan for LTC needs they may have in the future," said Dr. McClellan. "The Partnership program, we believe, will encourage people to accept personal responsibility for their future LTC needs by purchasing insurance, and will reduce the incentive to transfer or hide assets that can be protected legally," Dr. McClellan said. . . .

"Medicaid is truly not equipped to pay the LTC expenses of every American," said Dr. McClellan. "We must preserve the program for the future and for those who are its intended beneficiaries."

"Medicaid cannot afford to pay for LTC services for those who truly need it, if it is used to protect inheritances for those with the assets to pay for the care they need," said Dr. McClellan. "We are taking steps to make sure that Medicaid benefits do not go to those who are trying to protect inheritances, but only to those without alternative ways to pay. At the same time we will also work with states to make sure that people who did not deliberately shield assets are not penalized."

Following are specific recommendations which follow the order of the explanation of DRA provisions in the Appendix. Many of these recommendations are mandatory under the DRA. But mandatory changes required by the Omnibus Budget Reconciliation Act of 1993 were often ignored by states, including California's failure to implement new transfer of asset rules and the failure of Texas, Michigan, and Georgia to implement estate recovery programs for many years after that legislation required them. Moreover, mandatory changes can be implemented quickly or slowly, half-heartedly or aggressively, behind the scenes or widely publicized.

1. Implement the new five-year look-back period (expanded from three years by the DRA) for assets transferred for the purpose of qualifying for Medicaid as quickly and fully as possible. Publicize the change and explain why it is necessary. Explain to the public that this new restriction on divestment of assets to qualify for Medicaid is only the latest in a long series of such increasingly restrictive constraints. Warn that as the baby boom ages, federal controls on Medicaid spending for LTC will likely become more and more severe, thus delimiting the state's ability to fund LTC through Medicaid. Encourage early forward planning for the public to prepare to pay privately for LTC.

2. Change the date of the imposition of transfer of assets (TOA) eligibility penalties as required by the DRA, but even more importantly, make sure the public and seniors' financial advisers understand the significance of that change.

   Medicaid imposes an eligibility penalty when assets are transferred for less than fair market value for the purpose of qualifying for Medicaid. The TOA penalty equals in months the amount of assets so transferred divided by the average cost of a private nursing home in the state. So, an $80,000 transfer in a state with $4,000-per-month nursing home costs incurs a 20-month penalty. When previously the asset transfer penalty began at the date of the transfer, however, most penalties had expired before people applied for Medicaid. In fact, people routinely gave away half their assets to qualify for Medicaid in half the time. This "half-a-loaf" strategy was the single most common Medicaid planning technique throughout the United States. It will no longer work because the DRA requires that the TOA penalty begin at the date that an applicant would otherwise have become eligible without the change. In other words, the TOA penalty will now begin when the person needs nursing home care and applies for Medicaid.

   That means someone who transfers assets to qualify for Medicaid could end up in need of care with no remaining funds but ineligible for assistance from Medicaid. Because of this possibility, it is critical for Kansas to publicize this change and warn the public and its

financial advisors against asset transfers to qualify for Medicaid. Implemented effectively and fully publicized, the new rule will drastically reduce abusive asset transfers and encourage responsible LTC planning. But if consumers do not know about this change, their behavior will not alter. This is why LTC providers are worried they may end up with more charity cases because of the new rule. Nursing home, assisted living, and home care providers should assist the state to publicize the new controls on asset transfers, to discourage Medicaid planning abuses and to encourage private financing alternatives such as insurance and home equity conversion.

3. Implement the DRA's stronger "undue hardship waiver" rules – including the provisions that allow LTC facilities to request such waivers on behalf of applicants and to receive payments while eligibility is pending – in order to prevent any Kansan from suffering the loss of needed LTC because of the new restrictions on asset transfers to qualify for Medicaid.

4. Kansas has already ended the practice of "rounding down" asset transfers to reduce the eligibility penalty, anticipating the prohibition of that method in the DRA. "Rounding down" had the effect of allowing people to give away one dollar less than double the monthly cost of a nursing home without incurring a TOA penalty of more than the month of the transfer. Kansas should now take the next step and implement the new DRA authorization for states to treat multiple asset transfers as a single transfer and to begin the penalty period on the earliest date that would apply to such transfers. This practice more effectively discourages asset transfers for the purpose of qualifying for Medicaid.

5. Implement the new $500,000 limit on Medicaid's home equity exemption. Do not adopt the more generous $750,000 home equity limit authorized in the DRA legislation. As importantly, publicize this new limit, explain to the public that it is an historic and qualitative change from past public policy that exempted unlimited home equity, and disclose the possibility, more likely the probability, that the home equity exemption may be reduced even further in the future. People who care about preserving home equity as a legacy for their heirs should not plan for the future based on current public policy. They need to anticipate what the future will bring. For example, if they plan to prepare for future LTC needs by purchasing insurance, they must buy the coverage before they need the benefits, possibly decades earlier. Given the current discouraging prognosis for social insurance and public welfare safety nets, consumers would be wise not to plan on public assistance continuing to provide LTC while protecting half a million dollars worth of real estate wealth for heirs. Kansas should begin immediately to encourage people to utilize home equity through reverse mortgages to fund LTC now instead of becoming dependent on Medicaid and to supplement their income to increase the affordability of LTCI. Although this may be a difficult case to make as long as Medicaid exempts such large amounts of home equity, the state should consider positive incentives such as tax deductions or credits to encourage home equity conversion similar to the ones used to encourage the purchase of private LTC insurance.

6. Implement the DRA's new requirements to discourage the use of annuities for Medicaid estate planning, especially the requirement to disclose all annuities at eligibility determination and to name the state as remainder beneficiary. Annuities are frequently used for Medicaid planning in Kansas both as devices to shelter non-exempt assets by converting them to income and as a method of prepaying funeral costs. It is important to remember that

most Kansans who have a nursing home level of medical need qualify for Medicaid LTC benefits without employing legal self-impoverishment techniques. People who use annuities for that purpose are generally much more affluent than the average Medicaid recipient. By restricting the use of annuities for Medicaid planning and publicizing the new constraints, Kansas can send an important message that people should plan for LTC much earlier, before a crisis occurs that invites the use of creative techniques to qualify for public assistance. The same points apply to the need to implement and publicize the DRA constraints on other Medicaid planning techniques such as the sheltering of Continuing Care Retirement Community (CCRC) accounts, self-canceling installment notes (SCINs), and life estates.

7. Implement a LTC insurance partnership program. Several government agencies in Kansas, including the Insurance Commission, the Department of Aging, and the Social and Rehabilitation Service, have already begun to confer about the design and implementation of a LTC partnership program for the state. This work should be done in close coordination with implementation and enforcement of the DRA rules tightening eligibility limits and constraining Medicaid estate planning. Both efforts should be publicized widely and often. The reason is that unless the public understands that Medicaid will not be as easy solution to the problem of paying for LTC as it has been in the past, the incentives in the LTC partnership, i.e. forgiving Medicaid spend down and estate recovery up to the amount of LTC insurance purchased and used, will not have their full intended effect. No one buys insurance against a risk they do not perceive exists. This is what has prevented LTC partnerships in the four or five states that have had them since the late 1980s from having more than marginal success incentivizing the purchase of LTC insurance. Combining imposition of the new DRA eligibility rules with implementation of the partnership program and an aggressive public information campaign could magnify the beneficial impact of these measures manyfold.

8. Resist the temptation to adopt home and community-based care as a new, optional Medicaid state plan service unless and until the DRA's eligibility and LTC partnership provisions are fully implemented and publicized. Kansas has already gone a long way down the path of making Medicaid-financed LTC attractive and popular. The state should continue in the same direction but realize that the more desirable it makes Medicaid LTC while allowing most people to qualify easily without spending down, the fewer people are likely to save, invest or insure for LTC and the more people will end up in crisis with nowhere else to turn but to their own resources or Medicaid. Over time, Medicaid dependency may increase and private-payers could decline. Kansas may be able to sustain that tendency when economic times are good as now, with tax revenues up and welfare rolls down. But the real risk is what will happen as the boomers retire, start removing benefits from Social Security and Medicare instead of paying in, and finally become a burden on Medicaid for their LTC. That eventuality may seem decades off still, but now is when reserves must be set aside against those future costs. Medicaid is not doing so. Insurance carriers are required by law to do so. Kansas should seek a better balance between these funding sources.

Plain(s) Talk: *Kansas should implement, enforce, and publicize new federal rules and guidelines from the Deficit Reduction Act of 2005 in order to restrict Medicaid LTC eligibility, discourage Medicaid estate planning, and encourage private financing alternatives like home equity conversion and LTC insurance.*

Finally, following are some recommendations unrelated to the Deficit Reduction Act that Kansas should consider.

9. Conduct a study to find out why so few people are sufficiently concerned about LTC to save, invest or insure against the risk. Is the public aware of the risk and cost? Do people know that Medicaid pays for LTC or are they simply in denial? Do Kansans consider LTC a right to which they are entitled? Do they think about the subject at all? How do they respond when informed about the potential problem of paying for LTC with public funds in the future? Would more people purchase LTC insurance or use their home equity to pay for LTC if Medicaid were not available at all or if help from Medicaid were only available under much more restrictive terms? Answers to these questions could help inform and design a public information campaign to awaken the public to the need for personal responsibility and LTC planning.

10. Undertake a study of private LTC insurance and home equity conversion. Identify objective standards of quality and suitability for these products and give the state's seal of approval in some formal way when these defined standards are met.

11. Increase staffing for the Kansas Medicaid lien and estate recovery a little at a time until achieving the marginal rate of return. As long as adding another staff member to the unit increases recoveries, keep adding. Proceed with the planned experiment to use a private sector contractor to conduct some or all of the collections. Let the two approaches compete and choose permanently the one that contributes the most non-tax revenue at the least cost to offset Medicaid expenditures. Publicize the lien and estate recovery liability and encourage the public to insure privately in order to avoid it.

12. Research and design a system to encourage farm and business owners to plan for LTC either through the early purchase of private insurance or with an arrangement whereby families can pledge to refund the cost of Medicaid-financed LTC. Because Medicaid rules exempt a business, including the capital and cash flow of unlimited value, and because many older people transfer ownership of such assets to the younger generation many years before they need LTC, closely held farms or businesses will not usually obstruct eligibility for Medicaid. Therefore, any system designed by the state to encourage prepayment of LTC or repayment of Medicaid LTC expenditures will probably have to be voluntary but it could be incentivized in various ways already discussed in other contexts above.

XIV. The Heartland Manifesto

This report closes with the same "Heartland Manifesto" we've published previously in similar reports for the states of South Dakota and Nebraska. The reference to home equity conversion is a new addition to the manifesto reflecting the growing feasibility of reverse mortgages as a source of LTC financing.

- Kansas 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 LTC to the extent they are able without suffering financial devastation.
- Home owners who need LTC should pay privately for it by using their home equity with the help of reverse mortgages.

- Prosperous people who rely on public assistance for LTC 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 LTC insurance, and pay privately for the care of their choice when the time comes.

About the Author

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Appendix I: Testimony on The Deficit Reduction Act of 2005

Congressional testimony presented to the House of Representatives Small Business Committee Roundtable on The Future of Long-Term Care and Medicaid on July 10, 2006 before Chairman Donald Manzullo (R,IL) and Vice Chairman Roscoe Bartlett (R, MD) by Stephen A. Moses, president, Center for Long-Term Care Reform, www.centerltc.com.

Mr. Chairman Manzullo and Vice Chairman Bartlett, thank you for the opportunity to testify before you today about Medicaid, long-term care financing, and the impact of the Deficit Reduction Act of 2005 on those two critical issues.

On February 8, 2006, President Bush signed into law the Deficit Reduction Act of 2005 (DRA). Although the DRA does not address all the problems nor implement all the solutions proposed by the Center for Long-Term Care Reform, it does go a long way in the right direction. Following is a summary of the provisions of the DRA related to long-term care, an explanation of how and why they advance the cause of rational long-term care financing policy, and comments about what more needs to be done.[36]

It must be noted first that the Deficit Reduction Act faces a legal challenge. Several lawsuits have been brought in federal court challenging the constitutionality of the DRA. A Medicaid planning attorney in Alabama filed one of the suits; Public Citizen, founded by Ralph Nader, filed another; a third was brought by members of Congress. All of the suits challenge the DRA on the grounds that, due to a clerical error, it was not passed in identical form in both Houses of Congress. Until this matter plays out in the courts, the DRA is presumed to be the law of the land.

The DRA has three major sets of provisions germane to long-term care. The first set of provisions addresses Medicaid long-term care eligibility. The second involves the long-term care insurance partnership program. And the third applies to the provision of home and community-based services under the Medicaid program.

THE DRA AND MEDICAID LTC ELIGIBILITY

The Look Back Period

The DRA, most of the provisions of which were effective upon enactment February 8, 2006, extends the look back period for asset transfers from the previous three years to five years. The Social Security Act imposes a Medicaid eligibility penalty when assets are transferred for less than fair market value for the purpose of qualifying for Medicaid. What has changed is that the period of time state Medicaid programs are required to "look back" and consider whether transfers qualify for the penalty has been extended from three years to five years.

Note that this change is the latest in a series of laws making Medicaid's transfer of assets restriction longer and stronger. The process began with the Tax Equity and Financial Responsibility Act of 1982 which allowed states at their option to impose a transfer of assets penalty of up to two years for assets improperly transferred within the previous two years. The Medicare Catastrophic Coverage Act of 1988 made the transfer of assets penalty mandatory for state Medicaid programs to impose, extended the look back period to 30 months, and increased

the upside limit of the potential penalty to 30 months. Finally, the Omnibus Budget Reconciliation Act of 1993 extended the look back period to a full three years for general transfers and to five years for transfers into a trust. Thus, the DRA merely extends the look back period for general transfers to equal the same period used since 1993 for transfers to trusts.

As always, the purpose of the look back and transfer of assets eligibility penalty is to discourage inappropriate use of Medicaid's scarce resource to fund long-term care for people who could have paid their own way. The further ahead people have to plan to give away their wealth to qualify for Medicaid benefits, the less likely they will be to do so. A five-year look back period is more likely to discourage intentional self-impoverishment than a three-year period, but it probably is not enough to prevent the practice altogether.

The average period of time from onset to death in Alzheimer's Disease is eight years. When it becomes obvious that an aging person is declining in physical or mental capacity, future long-term care is easy to anticipate. Thousands of Medicaid planners throughout the country advise people to plan for this eventuality by divesting or sheltering their assets early. The Congress should consider extending the transfer of assets look back period to at least eight years. Few people are willing to give up control of their wealth in anticipation of needing long-term care in the future as long as they remain physically and mentally healthy. At that earlier stage, they are far more likely to consider and to qualify medically and financially for private long-term care insurance.

The look back period for asset transfers done to qualify for public assistance in Germany is ten years. Ironically, the United States, with its supposedly market-based health care system, is more lenient in this regard than Germany's social insurance system for funding long-term care.

The Transfer of Assets Eligibility Penalty and the Half-a-Loaf Strategy

The Medicaid eligibility penalty for transferring assets applies only to assets transferred for less than fair market value and for the purpose of qualifying for the program. The penalty period in months is equal to the amount of assets improperly transferred divided by the average cost of a private nursing home in the state. For example, $100,000 divested without compensation for the purpose of becoming eligible for Medicaid would incur a 20-month penalty if the average cost of a nursing home in the state is $5,000 per month.

But this full penalty as intended by Congress was rarely imposed. The reason is that under previous law, the penalty period began at the date the assets were transferred. This fact gave rise to the widely recommended "half-a-loaf" Medicaid planning strategy. In other words, don't give away the whole $100,000 at once and incur the full 20-month penalty. Rather, give away $50,000, incur a ten-month penalty, spend the other $50,000 as you choose or convert it to an exempt asset, bide your time and apply for Medicaid ten months later without having spent any of your own money for long-term care.

The Deficit Reduction Act eliminated this "half-a-loaf" strategy by changing the date of imposition of the transfer of assets penalty from the date of the transfer to the date at which the transferor would have otherwise been eligible if the law hadn't changed, usually the date of nursing home admission or Medicaid application. Thus, in the example above, the individual who transferred $50,000 and waited ten months would find himself or herself vulnerable under

the new law to a ten-month penalty at the very time that the penalty under the previous law would have ended. This change was also effective upon enactment.

The new rule regarding the start of the penalty period has senior advocates up in arms. They worry that thousands (they've even said millions) of Americans will be denied critical long-term care because of gifts they made unwittingly to grandkids or charities. Long-term care providers are also concerned they'll end up providing charity care for hapless residents who transferred assets without realizing the consequences. Neither problem will occur.

Assets transferred for any other reason than to qualify for Medicaid are not penalizable. Gifts to families or charities for other reasons have been and remain exempt under federal law. Furthermore, asset transfers that would incur a penalty are much less likely to occur now than before because the "half-a-loaf" divestment strategy no longer works. Medicaid planning attorneys who recommend it will be vulnerable to malpractice lawsuits.

The far more likely scenario is that instead of transferring their assets to qualify for Medicaid as before, people will preserve their wealth and use it to pay privately for long-term care. That's good for seniors because private payers have more choices among a wider range of better long-term care services than Medicaid recipients do. It's good for long-term care providers because they desperately need more private patients paying market rates for their services to make up for Medicaid's dismally low reimbursement rates.

Undue Hardship Waivers

"But what if?," insist the senior advocates and long-term care providers. Could it actually happen that some people would intentionally or unwittingly transfer assets for less than fair market value for the purpose of qualifying for Medicaid and incur an eligibility penalty at the very time they need long-term care? It's not likely now that the incentive to divest assets has been removed, but of course it is possible. If that happens, however, the DRA has also strengthened provisions in the law which provide for "undue hardship waivers" in such cases.

If a transfer of assets eligibility penalty would deny medical care or food, clothing, shelter, or other necessities of life to a Medicaid applicant, then the applicant, the applicant's representative, and even the long-term care facility itself may request a hardship waiver allowing the applicant to receive Medicaid benefits in spite of the improper, penalizable asset transfer. The law even permits payments to long-term care facilities while Medicaid eligibility is pending for up to 30 days. State Medicaid programs are required to notify recipients of the hardship waiver option. Finally, members of Congress and the American Health Care Association have appealed to the Centers for Medicare and Medicaid Services to build strong protections into the regulations that will be published to implement the Deficit Reduction Act's stricter eligibility provisions.[37] The devastating consequences predicted by opponents of the Deficit Reduction Act before and after its passage are thus highly unlikely to occur.

Rounding Down and Combining Asset Transfers

The Deficit Reduction Act made two additional changes to the rules bearing on asset transfers that warrant explanation. State Medicaid programs are now barred from "rounding down" fractional periods of ineligibility to determine asset transfer ineligibility periods. Before the DRA,

the transfer of assets penalty began at the date of the transfer. This meant that someone could give away an amount equal to the average cost of a nursing home in the state at the beginning of each month and only incur an eligibility penalty equal to the duration of that current month.

Some states rounded down the amount of assets transferred to qualify for Medicaid to the next lowest whole amount equal to the average cost of a nursing home. Thus, in such states, a person could give away one dollar less than double the nursing home cost and only be penalized for the single, current month of eligibility. Federal law no longer allows states to round down in this way. Therefore, this provision eliminates the loophole that allowed states to ignore otherwise penalizable asset transfers up to double the average monthly price of a private nursing home minus one dollar. Why would states have allowed that? Who knows, but some did. Not anymore.

In a related provision, the DRA permits states to treat multiple asset transfers as a single transfer and to begin the penalty period on the earliest date that would apply to such transfers. States may thus combine multiple fractional asset transfers to make one cumulative uncompensated value for the purpose of determining the transfer of assets penalty. This prevents penalties for fractional transfers from running concurrently thus reducing the effective penalty. As explained above, stronger undue hardship waivers and, one might add, good public service business practices, protect Medicaid applicants and recipients from possible but unlikely negative consequences that could occur as a result of these changes.

The Home Equity Exemption

The other major change to Medicaid long-term care eligibility enacted by the Deficit Reduction Act is a reduction in the program's home equity exemption. Previously, Medicaid recipients could retain a home and all contiguous property of unlimited value while receiving long-term care benefits from the welfare program. The DRA places a limit of $500,000 on home equity, although it allows states at their option to increase that limit to $750,000. Critical to note is that this new limit does not apply if a spouse or a minor or disabled child remain living in the home. Starting in 2011, the new home equity exemption limit will increase annually with the Consumer Price Index. Reverse mortgages may be used to reduce home equity down to a level at which the homeowner can qualify for Medicaid. The new home equity limit applies for Medicaid applications filed on or after January 1, 2006.

One might reasonably ask why a $500,000 limit on home equity for Medicaid eligibility matters much. After all, the median home equity of elderly Americans is only $85,516.[38] Unfortunately, a common Medicaid estate planning strategy is to "hide money in the home." In other words, people can convert a countable resource like cash into an exempt resource simply by investing the money in home improvements or even buying a more expensive house. For the first time since its enactment in 1965, Medicaid now limits that method of qualifying for Medicaid. Although the median home value for seniors is low, the prime candidates for Medicaid planning have homes worth $250,000 to $400,000 which they mostly own free and clear of mortgage debt.

Obviously, to have full effect, the home equity exemption needs to be lowered much further to discourage dependency on Medicaid by people of substantial wealth and to encourage the use of home equity conversion to pay for long-term care in lieu of going on welfare. Ironically, the

United Kingdom--another European socialized health care system--only allows a home exemption of around $36,000 for people who receive publicly financed long-term care. Over time, as Medicaid-driven budget pressures at the state and federal levels increase, the program's home equity exemption will undoubtedly drop considerably, ultimately to $50,000--the level recommended already last year by the National Governors Association--or even lower.

Until such a low limit on home equity is applied, it is unlikely that the markets for reverse mortgages and long-term care insurance will reach their full potentials. Why encumber your home equity if it is not at risk for long-term care? Why purchase insurance against the risk of expenses for which the government will pay while protecting your biggest asset? One similar eligibility loophole that the DRA left untouched is the exemption of a business including the capital and cash flow in unlimited amounts. One can expect the practice of sheltering of assets in a business to increase now that the sheltering of assets in a home has been limited, however slightly.

Annuities for Self-Impoverishment

In addition to the big changes in Medicaid eligibility rules bearing on asset transfers and the home equity exemption, the DRA plugged a number of other "loopholes" previously used to qualify for the program by means of artificial self-impoverishment. Medicaid's treatment of "annuities and other large transactions" is one such area. Medicaid planners and some annuity salespeople have long recommended "Medicaid-friendly annuities." The idea is that people who need long-term care but don't want to pay for it themselves may convert a large countable asset (for example, $100,000 cash) into an annuitized income stream and qualify for Medicaid.

Such a conversion of wealth from an asset to income is not a penalizable "transfer of assets for less than fair market value for the purpose of qualifying for Medicaid" because the cash flow from the annuity is equal in economic value to the cash in exchange for which it was obtained. It is a value for value exchange. The new income from the annuity must be considered in determining Medicaid eligibility, but income is rarely an obstacle to eligibility because most states have "medically needy" eligibility systems in which medical expenses including private nursing home costs are deducted from income before determining eligibility. The remainder of the states have "income cap" systems in which "Miller income trusts" can be used to the same effect. The annuity can also be in a community spouse's name which makes it even more attractive.

The Deficit Reduction Act put a number of obstacles in the way of using annuities as a Medicaid planning technique, although it didn't eliminate the practice altogether. The DRA requires Medicaid recipients and community spouses to disclose annuities at the time of eligibility determination and at every periodic recertification of eligibility, which usually occurs annually or semi-annually. Beginning with the date of enactment of the new law, the state must be named as remainder beneficiary for annuities held by Medicaid recipients or their spouses. State Medicaid programs must notify the issuer of the annuity of the state's status as remainder beneficiary. At their option, states may require annuity issuers to report income or principal withdrawals from the annuity. States may then deny Medicaid eligibility based on such withdrawals if they exceed allowable limits.

Hence forward, purchase of an annuity is a penalizable transfer of assets unless the state is listed as remainder beneficiary in first position for at least the total amount of Medicaid payments made on behalf of the recipient or in second position to a community spouse or minor or disabled child for the same amount. Spousal annuities remain an option under certain circumstances. But the message about annuities in the Deficit Reduction Act is clear: the door is closing on the abuse of annuities as a means to divert responsibility for long-term care financing from affluent individuals to taxpayers at the expense of Medicaid's long-term care safety net for the poor.

Transfer of Assets Before Income

The Deficit Reduction Act eliminates the "transfer assets before income" technique of Medicaid planning and imposes a mandatory "income first rule." This topic is complicated and requires some historical background and explanation to understand fully. But in a nutshell, state Medicaid programs must henceforth apply the "income-first" rule and not the "assets-first" option to community spouses who appeal for an increased resource allowance to maximize assets invested to meet their minimum income requirements.

In more detail, community spouses of institutionalized Medicaid recipients are allowed to retain half the couple's joint assets not to exceed $99,540. This is called the Community Spouse Resource Allowance or CSRA. Community spouses may also retain a Minimum Monthly Maintenance Needs Allowance (MMMNA) which has an upper limit of $2,488.50. These figures for the CSRA and MMMNA are current as of 2006 and increase annually with the Consumer Price Index. The CSRA and MMMNA were introduced in the Medicare Catastrophic Coverage Act of 1988 (MCCA '88) in order to put an end to the problem of "spousal impoverishment." Originally, the CSRA was limited to $60,000 and the MMMNA, $1,500.

People in nursing homes on Medicaid must contribute most of their income, excluding a small personal needs allowance, toward the cost of their care. Before MCCA '88, community spouses of institutionalized Medicaid recipients were only allowed to retain their own income (in any amount) or a portion of their spouse's income not to exceed the Supplemental Security Income (SSI) monthly allowance. The SSI allowance is $603 as of 2006, but it was only approximately $350 in 1988. Because community spouses are predominantly women and because women of the older generation tend to have less income than men, spousal impoverishment most often occurred when a husband was institutionalized on Medicaid and his wife was only allowed to retain the SSI monthly allowance of roughly $350 per month, hardly enough to survive. MCCA '88 ended spousal impoverishment by increasing the community spouse's asset and income limits as described above.

Here's how the Deficit Reduction Act changes that arrangement. Prior to the DRA, state Medicaid programs could allow community spouses to increase their income up to the MMMNA in either of two ways. The "income first" rule required them to take income from the institutionalized spouse first before taking assets. This approach resulted in Medicaid receiving less of the recipient's income to offset his cost of care but it left excess assets vulnerable to resource limits. The other "asset first" approach allowed the community spouse to receive extra assets from the institutionalized spouse in addition to the CSRA up to a total amount the interest on which would bring her up to the MMMNA.

Medicaid planners sought out opportunities to utilize this "asset first" approach. They routinely advised their clients to find the lowest possible interest rate returns in order to maximize the amount of assets transferable from the institutionalized to the community spouse to bring the latter up to her MMMNA. It was reportedly commonplace for families to be able to shelter up to several hundreds of thousands of dollars from Medicaid asset eligibility limits in this way. The Deficit Reduction Act prohibits this practice and mandates the "income first" rule. Unless Medicaid applicants find other ways to shelter or divest excess assets, this change should encourage more people to spend their money for long-term care in the private marketplace instead of gaming Medicaid to preserve large amounts.

CCRCs, SCINs, and Life Estates

Finally, the Deficit Reduction Act curtailed three additional Medicaid planning techniques. The new law allows state Medicaid programs to count Continuing Care Retirement Community (CCRC) and Life Care Community (LCC) admission contracts as countable resources. CCRCs and LCCs usually charge entrance fees which are sometimes refundable if the resident never needs the high-cost nursing home care for which the fees are intended to provide. Medicaid planners had found a way to shelter such fees thus allowing residents to get the money back AND get Medicaid to pay for their nursing home care. This was a serious problem for the retirement communities because of Medicaid's low reimbursement rates, which are often less than the cost of providing the care. The DRA permits states to eliminate this eligibility loophole which Medicaid planners employed to evade spend-down requirements at long-term care facilities' expense.

The DRA changes Medicaid eligibility rules to include certain funds used to purchase a promissory note, loan or mortgage among countable assets unless repayment terms are actuarially sound, provide for equal payments and prohibit the cancellation of the balance upon the death of the lender. This provision makes funds used to purchase certain promissory notes, loans or mortgages vulnerable to the transfer of assets penalty.

It stops the ever-popular Medicaid planning device known as SCINs (self-canceling installment notes) and other similar loopholes previously used to qualify for Medicaid. Last but not least, the DRA treats the purchase of a "life estate" as a penalizable asset transfer unless the purchaser resides in the home for at least one year after the date of purchase. So ends the hit list of Medicaid planning gambits successfully targeted by the Deficit Reduction Act.

Effective Dates

Now, a word about effective dates. The provisions of the DRA are effective as indicated in the law except if state legislation is required to implement them. If so, then the new rules take effect "the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act." Medicaid planners are touting this potential delay of implementing these new rules as one last opportunity to plan for Medicaid, a Medicaid planning fire sale as it were.

Here's how one Medicaid planning publication put it: "The bottom line is if you have been hesitating about seeing an attorney about long-term care planning, hesitate no longer. If you have considered protecting some assets for your loved ones in case you later require long-term

care, you should contact a qualified elder law attorney now."[39] This is precisely the sort of abuse--lucrative for lawyers, but devastating for taxpayers, Medicaid, and poor people legitimately dependent on public assistance--that the Deficit Reduction Act attempted, evidently with some considerable success, to curtail.

The DRA and the Long-Term Care Partnership Program

The second major set of provisions of interest to us in the Deficit Reduction Act authorizes expansion of the Long-Term Care Partnership Program. The LTC Partnership Program began as an experimental project funded by the Robert Woods Johnson Foundation in the late 1980s. It was the brainchild of Dr. Mark Meiners, an economist who did the early research that established long-term care as an insurable risk and helped to launch the product and the market as viable economic enterprises.

Dr. Meiners recognized that Medicaid crowded out most demand for long-term care insurance. He reckoned that a positive incentive to buy the protection might prevail where Medicaid's toothless spend-down rules had little effect. He designed the partnership program to provide just such an incentive by forgiving the Medicaid spend-down requirement in an amount equal to the amount of insurance protection purchased and used. The program differed in New York somewhat, but conceptually that was the idea and the way the program was implemented in Connecticut, Indiana and California. For example, buy $100,000 worth of long-term care insurance, use it up, and qualify for Medicaid while keeping $102,000 of your own money instead of having to "spend down" to the ostensible limit of $2,000 otherwise required.

All went well at first. More and more states were gearing up to implement the LTC partnership program as the decade of the 1990s began. But then came a devastating blow. When Congress mandated Medicaid estate recoveries in the Omnibus Budget Reconciliation Act of 1993 (OBRA '93), Congressman Henry Waxman (D, CA) who was then Chairman of the House Energy and Commerce Committee (the germane committee for Medicaid in the U.S. House of Representatives) refused to exempt any future LTC partnership states from the new requirement.

Thus, while new partnerships states might exempt assets for purposes of eligibility, they could not exempt the same assets from estate recovery. Figuring that this change eliminated the LTC partnership's incentive to buy insurance, states stopped implementing new partnerships and the program languished until now. The Deficit Reduction Act repealed the "Waxman amendment" and authorized new state LTC partnership programs to exempt protected assets from estate recovery as well as from eligibility limits. Everyone expects the popular LTC partnership programs to expand rapidly nationwide with that obstacle removed.

While the DRA removes the major obstacle to new partnership programs, it also imposes some new requirements. To qualify for the partnership program, long-term care insurance policies must be "tax qualified," meaning they need to qualify for the limited tax deduction authorized by the Health Insurance Portability and Accountability Act of 1996. They must meet the National Association of Insurance Commissioners' model regulations and Act as of October 2000. They must provide for benefit increases or options especially for younger insureds.

The DRA mandates reporting for insurers and training for agents who market partnership policies. There are minimum data set reporting requirements to ensure proper evaluation of the programs. By January 1, 2007, the Secretary of the Department of Health and Human Services is supposed to publish "standards for uniform reciprocal recognition," that is to say portability guidelines that will help to make partnership benefits available in one state equally available in others. The Secretary is also required to report annually to the Congress on the LTC partnership programs' progress. Finally, the DRA establishes a National Clearinghouse for Long-Term Care Information, with funding of $3 million per year from 2006 to 2010, to help educate consumers about the risk and cost of long-term care and the importance of buying private insurance protection.

Likely Impact of LTC Partnerships Enhanced by Medicaid Eligibility Changes

The long-term care insurance industry is clearly thrilled by this expansion of the LTC partnership program. It will enhance the market for their product. Long-term care providers are also enthusiastic, although less so, inasmuch as the benefits of having more insured private payers someday in the future won't benefit providers as soon as it will help insurers. Ironically, however, LTC insurers seem to have hardly noticed the changes in Medicaid eligibility and LTC providers actually opposed one of the most important modifications, e.g. the change in the date of the asset transfer penalty.

Why ironic? Without the provisions of the DRA that tightened Medicaid long-term care eligibility, it is unlikely that expansion of the long-term care partnership program would have had much effect. Studies conducted of the partnerships programs in the four original states indicate that they helped expand the long-term care insurance market on the margin, but they hardly made a qualitative difference as compared to the market for the product in other, non-partnership states.[40] Think about it. Why would someone buy private long-term care insurance many years in advance of needing long-term care, an eventuality about which most consumers are in denial anyway, simply to avoid a Medicaid spend-down liability that didn't really exist in the first place? The answer is: they wouldn't and for the most part they didn't. That's why the original partnership programs were only marginally successful.

The big news now is that Medicaid does finally have, thanks to the DRA, much stronger limits on long-term care eligibility. Therefore, the long-term care partnership's asset forgiveness benefit, both on the front end for eligibility and on the back end from estate recovery, is far greater than it used to be. We have every reason to believe that the partnership program will be far more successful now that it has been in the past. Of course, that expectation depends entirely on whether or not the Medicaid eligibility provisions of the DRA are aggressively implemented, enforced and publicized.

The DRA and Home and Community-Based Services Under Medicaid

The third and final major set of provisions in the Deficit Reduction Act bearing on long-term care relates to the expansion of home and community-based services (HCBS) funded by Medicaid. The DRA makes HCBS an option coverable under the Medicaid state plan without a special waiver as previously required. States may limit enrollment in the program to control expenditures. They can also elect not to comply with "statewideness," the requirement

governing most services offered by Medicaid which says they must be made available at substantially the same level and in the same form everywhere in the state.

Receipt of home and community-based services will no longer require that the Medicaid recipient have a medical need for nursing home level of care in order to qualify for HCBS, an ironical contradiction seemingly inimical to recipients' best interests, that was mandated under the waiver programs. At their option, states may allow recipients to purchase and control their own care thus extending the idea of consumer-driven health care into the arena of welfare-financed long-term care. States must provide for quality control of HCBS. These provisions are effective January 1, 2007.

This is a good thing, right? Absolutely. One of the biggest problems with Medicaid-financed long-term care in the past has been its "institutional bias." Medicaid paid mostly for nursing home care and much less for home care over the years. That imbalance has been changing for a decade or more but still exists. But now, on the other hand, consider this.

Won't Medicaid be more attractive when it provides home care, assisted living and other community-based services, not just nursing home care? Won't people be more likely to search for ways to qualify for Medicaid by means of artificial self-impoverishment and consulting Medicaid planners? Won't they be less likely to buy long-term care insurance, which requires big premiums to qualify for benefit payments covering HCBS that Medicaid will now be offering for free? Yes, expansion of Medicaid to cover HCBS more liberally than in the past could have caused all those negative consequences, except for the fact that the DRA also tightened Medicaid's eligibility limits.

Therefore, once again, just as the new constraints on Medicaid long-term care eligibility promise to enhance the effectiveness of the long-term care partnership program, they will also mitigate any damage that might have been done by expanding the program's coverage of HCBS and making Medicaid therefore more attractive as a long-term care payor. Medicaid will be a better, more attractive program for a smaller number of recipients who genuinely need its help.

Conclusion

The Deficit Reduction Act is an important step forward toward improving America's long-term care service delivery and financing system. It eliminates some of the perverse incentives in Medicaid that crowded out long-term care insurance and home equity conversion as long-term care payors. It adds positive incentives for people to plan early, and save, invest or insure for long-term care. It makes Medicaid a better program for people genuinely in need by enhancing the availability of home and community-based services which most people prefer.

The job is not finished, however. Medicaid needs to be further reformed to lengthen the transfer of assets look back period, to lower the home equity exemption, to place a limit on the wide-open business exemption, to eliminate the shameful "spousal refusal" gambit which encourages people to abandon their spouses in order to obtain welfare benefits for them, and to close the dozens of other loopholes that continue to trap people on public assistance unnecessarily. The DRA is a vital beginning, although only a start.

Let me close with a warning. If the Deficit Reduction Act is not implemented by the states, enforced by the federal government, publicized by the media, and sold by LTC insurance agents and reverse mortgage lenders, it may fail to achieve its full potential for improving long-term care service delivery and financing. The Center for Long-Term Care Reform is dedicated to ensuring that the DRA does achieve its full potential in that regard. We invite everyone of good will to join with us to make the most of this wonderful victory in the fight for rational long-term care policy.

Appendix II: Interviewees

Bob Bethell, State Representative, Alden, KS

Scott Brunner, Director, Kansas Medical Assistance Programs, Kansas Health Policy Authority, Topeka, KS

Tim Carmody, Lawyer, Berger and Carmody, Overland Park, KS

Jim Cates, Talk Show Host, Cumulus Broadcasting, Inc., Topeka, KS interviewed Stephen Moses and Greg Schneider on the air, Wednesday, July 19, 2006

Barbara Schoof Conant, Director of Public Affairs, Department of Aging, Topeka, KS

Kim Conlee, Public Relations Consultant, Wichita Independent Business Association, Wichita, KS

Steffani M. Crawley, Regional Sales Vice President, MetLife Long-Term Care, Louisburg, KS

Jennifer Crow, Legislative Liaison for Governor Sebelius, Office of the Governor, Topeka, KS

Gilbert Cruz, State Long-Term Care Ombudsman, Topeka, KS

Mary Dempsey, Long Term Care Insurance Sales, Target Insurance Services, Inc., Overland Park, KS

Joe E. Dobson, Regional Long-Term Care Ombudsman, Kansas City, KS

Todd Drew, Branch Manager, Urban Financial Group, Inc., Wichita, KS

Karen Fillenworth, Manager, Insurance Services, Wichita Independent Business Association, Wichita

Kathy Greenlee, Acting Secretary, Department of Aging, Topeka, KS

William G. Hammond, President, The Elder and Disability Law Firm, Overland Park, KS

Jean A. Hogan, Regional Director, Department of Social and Rehabilitation Services, Wichita, KS

Susan Joski, Long Term Care Specialist, Partners for Life LTC Planning, Overland Park, KS

K. Bruce Kallmeyer, President, Kallmeyer Associates, Inc., Overland Park, KS

Susan W. Kannarr, Senior Fiscal Analyst, The Legislative Research Department, Topeka, KS
Kyle Kessler, Deputy Secretary for Public and Governmental Services, Department of Social and Rehabilitation Services, Topeka, KS

Glenna Kleinkauf, Human Service Supervisor, Department of Social and Rehabilitation Services, Wichita

Sue Krische, Chief of Staff to the Senate President, Topeka, KS

Cindy Luxem, President/CEO, Kansas Health Care Association, Topeka, KS

Mark McClaflin, Accident and Health Policy Examiner, Kansas Insurance Department, Topeka, KS

Kevin D. McFarland, Executive Vice President, Kansas Association of Homes and Services for the Aging, Topeka, KS

Karen S. Miller, Insurance Consultant, MetLife AARP Long-Term Care Insurance Plan

Melvin Neufeld, Chairman, House Appropriations Committee, Ingalls, KS

Lori Nord, Manager, Membership Services, Wichita Independent Business Association, Wichita

Sandy Praeger, Commissioner of Insurance, Kansas Insurance Department, Topeka, KS

Jay Rogers, Accident and Health Division, Kansas Insurance Department, Topeka, KS

Jeanine Schieferecke, Eligibility Manager, Kansas Health Policy Authority, Topeka, KS

Ellen Schlagel, Human Services Specialist 1, Wichita, KS

Pete Schrepferman, Johnstone Supply of Wichita, Wichita, KS

Ed Schulte, Ph.D., Executive Director, Caregivers Home Health, Topeka, KS

David A. Snower, Sales Manager, Benefit Designs, Inc., Overland Park, KS

Cliff Sones, President, Wichita Independent Business Association, Wichita, KS

Stuart Speer, Overland Park, KS

Robert Sudbury, CEO, Sudbury Transportation, Inc., Wichita, KS

Claude Thau, President, Thau, Inc., Overland Park, KS

Brian M. Vazquez, Attorney Administrator, Estate Recovery Unit, Kansas Health Policy Authority, Topeka, KS

Theresia M. Weber, Principal Analyst, The Legislative Research Department, Topeka, KS

Karren Weichert, President/CEO, Midland Hospice Care, Topeka, KS

Michael J. Weinrich, Representative, Allianz and Asset Protection Solutions, LLC, Kansas City, MO

James Weldon, Wichita, KS

Debra Harmon Zehr, RN, MA, President, Kansas Association of Homes and Services for the Aging, Topeka, KS

Notes:

[1] This work was funded by a grant to The Flint Hills Center for Public Policy from the Milbank Foundation for Rehabilitation. Stephen Moses, president of the Center for Long-Term Care Reform, conducted the research on which the report is based with the collaboration and assistance of Dr. Greg Schneider, Senior Fellow at The Flint Hills Center for Public Policy. George Pearson, president of The Flint Hills Center, provided guidance and oversight for the project.

Field work consisted of a single week of interviews in Topeka, Wichita, and Overland Park, Kansas from July 17 to July 21, 2006. A list of individuals interviewed for this study is included as an appendix. We thank everyone who participated for their time and expertise. Each interviewee will receive a copy of this report.

[2] See Stephen Moses, "Nursing home system in need of reform," *The Pittsburg Morning Sun*, 22 May 2005. Available at: http://www.flinthills.org/component/option,com_docman/task,doc_view/gid,24/.

[3] For example:

> "Aging America's Achilles" Heel: Medicaid Long-Term Care" (Washington, D.C.: The Cato Institute, 1 September 2005). Available at: http://www.cato.org/pubs/pas/pa549.pdf.
> "The Realist's Guide to Medicaid and Long-Term Care" (Seattle, WA: The Center for Long-Term Care Financing, 2004). Available at: http://www.centerltc.org/realistsguide.pdf.
>
> "LTC Choice: A Simple, Cost-Free Solution to the Long-Term Care Financing Puzzle" (The Center for Long-Term Care Financing, 1998). Available at: http://www.centerltc.com/pubs/CLTCFReport.pdf.
>
> The Center has also applied these principles in several state-level studies, including:
>
> "What We Don't Know About Medicaid and Long-Term Care is Hurting Washington State" (The Center for Long-Term Care Financing, 7 December 2004). Available at: http://www.centerltc.com/pubs/washington.pdf.
>
> "The Heartland Model for Long-Term Care Reform: A Case Study in Nebraska" (The Center for Long-Term Care Financing, 1 December 2003). Available at: http://www.centerltc.com/pubs/Nebraska.pdf.
>
> "The Magic Bullet: How to Pay for Universal Long-Term Care: A Case Study in Illinois" (The Center for Long-Term Care Financing, 1995). Available at: http://www.centerltc.com/pubs/MAGIC_Bullet.pdf.
> "The Florida Fulcrum: A Cost-Saving Strategy to Pay for Long-Term Care" (The Center for Long-Term Care Financing, 1994). Available at: http://www.centerltc.com/pubs/FLORIDAREP.pdf.

[4] For more on this subject, see Matthew Hisrich, "First Things First: Kansas Medicaid Must Get Its House In Order Before Expanding Home-based Care," The Flint Hills Center, 20 August 2004. Available at: http://www.flinthills.org/component/option,com_docman/task,doc_view/gid,12/.

[5] U.S. Census Bureau, State & County QuickFacts on Kansas at http://quickfacts.census.gov/qfd/states/20000.html.

[6] For alternate views on future demographics in Kansas, see Matthew Hisrich, "Medicaid could swamp state budget," *The Wichita Eagle*, 26 July 2005. Available at: http://www.flinthills.org/component/option,com_docman/task,doc_view/gid,27/. Also, Rosemary Kennedy Chapin, Ph.D., et al., "Planning for Long-Term Care Services in Kansas Before the Boom," The University of Kansas School of Social Welfare Office of Aging and Long-Term Care, May 2006. Available at: http://www.oaltc.ku.edu/Reports/Before%20the%20Boom%20Final%20Report.pdf.

[7] Source of statistics in this section is Mary Jo Gibson, Steven R. Gregory, Ari N. Houser and Wendy Fox-Grage, "Across the States: Profiles of Long-Term Care 2004: Kansas," (Washington, DC: AARP Public Policy Institute, 2004). Available at: http://assets.aarp.org/rgcenter/post-import/d18202_2004_ats_ks.pdf. Again, see note 6 for a contrasting view.

[8] In the following table, CMS stands for the "Centers for Medicare and Medicaid Services" and OSCAR stands for "Online Survey, Certification and Reporting." OSCAR is a data network maintained by the CMS in cooperation with the state long-term care surveying agencies. OSCAR is a compilation of all the data elements collected by surveyors during the inspection survey conducted at nursing facilities for the purpose of certification for participation in the Medicare and Medicaid programs.

Payor Mix and Census by Ownership Control, State of Kansas, data as of June 2006

Obs	Ownership Control	Medicare Census	Medicare Percent	Medicare Census	Medicaid Percent	Other Census	Other Percent	Total Census
1	Total	1,661	8.29%	10,669	53.25%	7,706	38.46%	20,036
2	For-Profit	1,081	10.03%	6,307	58.53%	3,388	31.44%	10,776
3	Government	37	2.54%	689	47.26%	732	50.21%	1,458
4	Non-Profit	543	6.96%	3,673	47.08%	3,586	45.96%	7,802

Source: CMS OSCAR data arrayed by Cowles Research Group

This data is more recent than those that follow in the text, but we do not have state rankings yet for the more current data.

[9] Mary Jo Gibson, Steven R. Gregory, Ari N. Houser and Wendy Fox-Grage, "Across the States: Profiles of Long-Term Care 2004: Kansas" (Washington, D.C.: AARP Public Policy Institute, 2004). Available at: http://assets.aarp.org/rgcenter/post-import/d18202_2004_ats_ks.pdf.

[10] *Ibid*.

[11] BDO Seidman, LLP, "A Report on Shortfalls in Medicaid Funding for Nursing Home Care," prepared for the American Health Care Association, June 2006, Table I: State-by-State Comparison of Rates and Costs, 4-5. Available at: http://www.ahca.org/brief/seidmanstudy0606.pdf.

[12] ICF/MR stands for Intermediate Care Facility for the Mentally Retarded.

[13] Gibson, et al., "Across the States."

[14] Office of the Actuary, Centers for Medicare and Medicaid Services, May, 2006. Tables for 2004 State Estimates - Medicaid - Home Health Care (Millions of Dollars) and 2004 State Estimates - Medicaid - Nursing Home Care (Millions of Dollars). Available at: http://www.cms.hhs.gov/NationalHealthExpendData/downloads/nhestatesummarymcaid2004.pdf.

[15] See, for instance, "Kansas Medicaid Primer," (Topeka, KS: The Kansas Health Institute, 2005) 5. Available at: http://www.khi.org/Medicaid/MedicaidPrimer.pdf. Here's what the primer says about Medicaid coverage in Kansas:

"Medicaid covers a broad and comprehensive range of health, mental health and long-term care services. Those required by federal law include:

- Inpatient and outpatient hospital services.
- Rural health clinic and federally qualified health center (FQHC) services.
- Laboratory and X-ray services.
- Physicians' services and pediatric and family nurse practitioners' services.
- Nursing home and home health services.
- Early and periodic screening, diagnosis and treatment (EPSDT) for children younger than age 21, including immunizations and well-child care.
- All 'medically necessary' care for children. Examples of services that must be covered include organ transplants, comprehensive dental care and individualized education plans (IEPs) in public schools.
- Family planning services and supplies.
- Nurse midwife services.
- Nursing facility services for individuals ages 21 and older.
- Home health care services for individuals eligible for nursing facility care.

". . . Kansas covers the following optional services:

- Prescription drugs. [Medicare Part D provides prescription drug coverage now]
- Clinic services (including diagnostic, screening and preventive).
- Services from podiatrists, optometrists and psychologists.
- Physical, occupational and speech therapy.
- Limited, emergency adult dental services.
- Prosthetic devices.
- Eyeglasses when necessary after surgery.
- Rehabilitative services, including mental health counseling.
- Inpatient psychiatric services for children younger than age 21 and for those 65 and older.
- Intermediate care facilities for the mentally retarded.
- Alcohol and drug addiction counseling and treatment for pregnant women.
- Case management services.
- Program for all-inclusive care for the elderly (PACE).
- Hospice care.
- Home and community-based services (HCBS) for qualified populations."

Additional Medicaid information can be found in Matthew Hisrich, "A Backgrounder on Kansas Medicaid," The Flint Hills Center for Public Policy, 19 July 2004. Available at: http://www.flinthills.org/component/option,com_docman/task,doc_view/gid,13/. Also, Michael Bond, "What's wrong with Medicaid in Kansas?," The Flint Hills Center, 26 December 2005. Available at: http://www.flinthills.org/component/option,com_docman/task,doc_view/gid,270/.

[16] *Ibid.*, 3.

[17] The Deficit Reduction Act of 2005 places a limit on exempt home equity of $500,000 with an option for the state to increase the exemption to $750,000. We do not know yet for sure which limit Kansas will choose but received some indication the state will keep the lower $500,000 limit.

[18] For a detailed explanation of Medicaid long-term care eligibility rules, including hyperlinks to the applicable federal laws and regulations, see Stephen A. Moses, "Aging America's Achilles' Heel: Medicaid Long-Term Care."

[19] The personal needs allowance was only recently raised from the long-standing limit of $30 per month.

[20] Source: E-mail correspondence from Attorney Hammond to Richard A. Schafer of Minnesota, subsequently forwarded to the author on October 19, 2006. According to the e-mail, "*Elder Law Today* is written by William G. Hammond, Attorney at Law." For more information, visit: http://www.kcelderlaw.com/index.html.

[21] Here are some examples:

> Law Offices of Hubbart & Kurtz, LLP, Kansas City, MO: Extracted June 27, 2006 from http://www.mokanlaw.com/CM/PracticeAreaDescriptions/Elder-Law.asp: "The cost of nursing home care can be daunting. It is important to plan ahead in order to take advantage of the help that is available. We help clients with issues related to eligibility for Medicaid assistance, administrative hearings, nursing home expense matters, legitimate transfers for eligibility, and issues related to the five year look back. We help craft life estate deeds, special needs trusts, and handle litigation of claims for Medicaid reimbursement. Along with our wills and trusts practice, we assist clients in crafting a plan for the future. . . . From our offices in Kansas City, we help clients from throughout the region, including St. Joseph, Independence, Lees Summit, Columbia, Warrensburg, Overland Park, Olathe, Atchison, Lawrence, Topeka, and many more Kansas and Missouri communities."
>
> Tamara L. Davis, Attorney at Law, Dodge City, KS: Extracted June 27, 2006 from http://www.tldavispa.com/MedicaidPlanning.shtml: "Medicaid Planning: Southwest Kansas Medicaid Planning Attorney. No one plans to get ill, but as we live longer, many of us will face the reality of expensive long term care. How can you afford it? Medicaid is the obvious solution for some, but what about the assets you've worked for all your life? Contact the law firm of Tamara L. Davis, P.A. in Dodge City, Kansas, for a consultation. You can save your assets. . . . Worried about liquidating your assets to pay for long term care? Medicaid may require some recipients to 'spend down' assets in order to qualify for benefits, leaving many unprepared families with the added stress and heartache of losing family homes, farms, or businesses. Don't let this happen to your family. Leave your family with a legacy by planning for long term care expenses. Contact the Medicaid planning attorney at the southwest Kansas law firm of Tamara L. Davis, P.A. for a consultation. . . . Don't let long term care eat away at the security net you and your spouse have worked so hard for. Medicaid planning lawyer Tamara L. Davis has helped clients in the southwest Kansas area protect assets while planning for the future."

Law Office of Stacey J. Gunya, Olathe, Kansas: Extracted June 27, 2006 from http://www.staceygunyalaw.com/PracticeAreas.shtml: "Long-Term Care Services - Life expectancies increase every year with advances in medicine and elder care. When preparing for your golden years, you need to consider all the possibilities, including guardianships, conservatorships, Medicaid planning, and Medicare. We also represent you in matters of resident's rights and advocacy if you reside in a long term care facility." (Emphasis added)

Parman & Easterday, LLP, Overland Park and Hays, KS: Extracted June 27, 2006 from http://www.parmanelderlaw.com/: "Helping Your Loved One Get the Nursing Home Care They Deserve While Legally Protecting Your Family's Assets." "Please choose a FREE report that you would like to receive in the mail: . . . Consumer's Guide to Medicaid Planning."

McDowell Chartered, Wichita, KS: Extracted June 27, 2006 from http://www.adoption-wichita.com/estateplanning.shtml: "Our lawyers also understand the complexities of Medicaid planning when a family member will need nursing home care. We will help you preserve at least some assets for the other spouse or family members."

[22] Bryn A. Poland, "Don't Plan on Aging: The Kansas Supreme Court Reaffirms its Hostility Toward Medicaid Planning," *Washburn Law Journal*, Vol. 45, April 19, 2006, 491-523. Available at: http://washburnlaw.edu/wlj/45-2/articles/poland-bryn.pdf.

[23] This practice is discussed in more detail on page 7 of Stephen A. Moses, "The Heartland Model for Long-Term Care Reform: A Case Study in Nebraska."

[24] See Stephen Moses, "Its time to end welfare for the well-to-do," *The Kansas City Kansan*, 26 April 2006. Available at: http://www.flinthills.org/component/option,com_docman/task,doc_view/gid,287/.

[25] Roger Van Etten and Brian Vazquez, "Kansas Estate Recovery Primer," The Flint Hills Center, 22 September 2006. Available at: http://www.flinthills.org/component/option,com_docman/task,cat_view/gid,12/Itemid,52/.

[26] Naomi Karp, Charles P. Sabatino and Erica F. Wood, "Medicaid Estate Recovery: A 2004 Survey of State Programs and Practices," #2005-06 (Washington, D.C.: AARP Public Policy Institute, June 2005) Table 3: Revenue as Percentage of Medicaid Long-Term Care Expenses, 51. Available at: http://www.aarp.org/research/assistance/medicaid/2005_06_recovery.html.

[27] Barbara Stucki, "Use Your Home to Stay at Home: Expanding the Use of Reverse Mortgages for Long-Term Care: A Blueprint for Action," (Washington, D.C.: National Council on the Aging, 2005) iv. Available at: http://www.ncoa.org/attachments/ReverseMortgageReport3%2Epdf.

[28] General Accounting Office, "Recoveries from Nursing Home Residents' Estates Could Offset Program Costs," GAO/HRD-89-56, March 1989, 3. Available at: http://archive.gao.gov/d15t6/138099.pdf.

[29] Gibson, et al., "Across the States."

[30] Laura Summer, Robert Friedland and Susan Mathieu, "Measuring the Years: State Aging Trends and Indicators," (Washington, D.C.: National Governors Association, 2004) Table: Penetration of

Home Equity Conversion Mortgage Loans by State, 1999. Available at: http://www.nga.org/portal/site/nga/menuitem.9123e83a1f6786440ddcbeeb501010a0/?vgnextoid=83601d8692cc2010VgnVCM1000001a01010aRCRD&vgnextchannel=4b18f074f0d9ff00VgnVCM1000001a01010aRCRD.

[31] Susan Coronel, *Research Findings: Long-Term Care Insurance in 2002*, (Washington, D.C.: America's Health Insurance Plans, 2004) 29. Available at: http://www.ahip.org/content/default.aspx?bc=39|341|328|454.

[32] One further public policy option to consider is assistance in connecting buyers to sellers, something the state of New York is currently pursuing. For more information, see "Help with long-term care insurance offered online," *The Dunkirk Observer*, 8 August 2006. Available at: http://www.observertoday.com/articles.asp?articleID=3587. The state website is: www.ins.state.ny.us.

[33] "We project that almost one third of all persons who reached 65 years of age in 1990 will spend at least three months in a nursing home during their lifetimes; 24 percent, at least a year; and 9 percent, at least five years." Peter Kemper and Christopher M. Murtaugh, "Lifetime Use of Nursing Home Care," *New England Journal of Medicine*, Vol. 324, No. 9, February 28, 1991, 597. Brenda C. Spillman and James Lubitz reconfirmed similar estimates in "New Estimates of Lifetime Nursing Home Use: Have Patterns of Use Changed?," *Medical Care*, Vol. 40, No. 10, October 2002, 965: "As a result, by 2020, 46% of those turning age 65 will enter a nursing home before they die, a quarter will spend at least a year, and 9% will spend five years or longer."

[34] Jeffrey R. Brown and Amy Finkelstein, "Supply or Demand: Why is the Market for Long-Term Care Insurance So Small?," NBER Working Paper No. 10782 (Cambridge, MA: National Bureau of Economic Research, Inc., September 2004) Available at: http://www.nber.org/papers/w10782. Emphasis added.

[35] See http://www.cms.hhs.gov/smdl/smd/list.asp. Appendix I available at www.flinthills.org.

[36] The report of the Conference Committee of the House of Representatives and the Senate for the Deficit Reduction Act of 2005 is available at http://thomas.loc.gov/cgi-bin/cpquery/?sel=DOC&&item=&r_n=hr362.109&&&sid=cp109lxkwK&&refer=&&&db_id=cp109&&hd_count=&. The Conference Report describes the provisions of the original bills passed by the House and Senate and the provisions of the compromise reached in the Conference Committee and ultimately passed by both Houses in identical form with the exception of the clerical error mentioned above.

[37] AHCA Press Release, "Long Term Care Associations Backing U.S. Rep. Peter King's Effort to Ensure Nation's Most Vulnerable Seniors Protected During DRA Implementation Period, March 28, 2006. Available at: http://www.ahca.org/news/nr060328a.htm.

[38] Wan He, Manisha Sengupta, Victoria A. Velkoff, and Kimberly A. DeBarros, "65+ in the United States: 2005," Current Population Reports, P23-209, U.S. Census Bureau, (U.S. Government Printing Office: Washington, D.C., 2005) Table 4-10: Median Net Worth and Median Net Worth Excluding Home Equity for Households by Age of Householder and Monthly Household Income Quintile: 2000, 108. Available at: http://www.census.gov/prod/2006pubs/p23-209.pdf.

[39] *ElderLaw Answers*, "Congress Passes Bill Containing Punitive New Medicaid Transfer Rules" at: http://www.elderlawanswers.com/resources/article.asp?id=5221&section=4.

[40] Nelda McCall, editor, *Who Will Pay for Long Term Care?: Insights from the Partnership Programs* (Chicago, IL: Health Administration Press, 2001).

More About The Flint Hills Center For Public Policy

The Flint Hills Center for Public Policy is a Kansas think tank created as an independent voice to help political decision makers make informed choices. The Flint Hills Center for Public Policy is a non-profit, nonpartisan policy think tank. While not involved in the implementation or administration of government policy, our goal is to inform and raise public awareness of policy issues. For more information, visit our website at *www.flinthills.org*.

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