



**Long-Term Care
Financing in New York:
How to Save Money
While Serving the Needy**

Stephen A. Moses

EXECUTIVE SUMMARY

New York's expensive Medicaid program provides generous long-term care benefits to a large number of recipients. Although Medicaid eligibility is means-tested, with limits on both income and assets, the program nevertheless pays for most professional long-term care services in the state.

Lenient and elastic eligibility criteria—partly mandated by the federal government and partly voluntary by the state—have placed most of the burden of long-term care financing on Medicaid. Ease of access to Medicaid after long-term care is needed has crowded out potential sources of private financing such as asset spend down, home equity conversion, estate recovery, and long-term care insurance.

Several of the Medicaid “redesign” proposals incorporated by Gov. Andrew Cuomo in his amended 2011-12 budget take important steps in the right direction, but much remains to be done to put long-term care policy in New York on an economically and financially sustainable footing. By targeting scarce Medicaid resources to New Yorkers in greatest need and by encouraging early and responsible long-term care planning by others, the state could save billions in county, state, and federal funds without sacrificing care, access, or quality.

ABOUT THE REPORT

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Stephen A. Moses, president of the Center for Long-Term Care Reform, did the research for this project (with the assistance of Tim Hoefer, the Empire Center's director) and wrote the report. Brian Blase of the Heritage Foundation participated in the field work and interviews offering valuable insights.

In the course of his research, the author interviewed 58 people directly involved in the long-term care field in New York, including senior state and local Medicaid administrators, social workers and policy analysts; insurance industry executives and consultants; and representatives of trade groups and associations representing practitioners and providers. Their assistance is greatly appreciated and acknowledged, without implying any endorsement on their part of the findings and recommendations of this report.

ABOUT THE AUTHOR

Stephen A. Moses is president of the Center for Long-Term Care Reform in Seattle, Washington (www.centerltc.com). The Center promotes universal access to top-quality long-term care by encouraging private financing as an alternative to Medicaid dependency for most Americans. Previously, Mr. Moses was president of the Center for Long-Term Care Financing (1998-2005), Director of Research for LTC, Inc., (1989-98), a senior analyst for the Inspector General of the U.S. Department of Health and Human Services (1987-89), a Medicaid state representative for the Health Care Financing Administration (1978-87), a HHS Departmental Management Intern (1975-78), and a Peace Corps Volunteer in Venezuela (1968-1970). He is widely recognized as an expert and innovator in the field of long-term care. Mr. Moses has directed numerous national and state-level studies on Medicaid nursing home eligibility, asset transfers, estate recoveries and long-term care financing. A graduate of the University of California, Davis, he earned his master's degree at the University of Maryland, College Park.

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OVERVIEW

The term long-term care (LTC) refers to the custodial and medical assistance required by elderly and disabled people who cannot fully care for themselves over an extended period of time.¹

In New York State, LTC is very expensive, whether provided in a nursing home (\$336 per day compared to the national average of \$205), in an assisted-living facility (\$3,701 per month vs. \$3,293 nationally), at an adult day-services facility (\$99 per day vs. \$67 nationally), or in one's own home (\$21 per hour for a home health aide; \$19 per hour for a homemaker, same as the national average).²

Sixty-nine percent of people turning age sixty-five in the United States will eventually need at least some LTC, and 20 percent require five years or more.³ New York's over-sixty-five population was 2.5 million or 13.2 percent in 2007, but it is expected to increase to 3.9 million or 20.1 percent in 2030. Even more alarming, New York's over-eighty-five population, the cohort most likely to require LTC, may increase from 385,000 or 2 percent in 2007 to 3.2 percent in 2030.⁴ A larger aging population will likely require more LTC.

Nevertheless, despite the likely need for and high cost of LTC, most people do not save, invest, or insure against it. Only 6.7 percent of New Yorkers fifty years of age or older own private LTC insurance.⁵ The proportion of LTC expenditures paid out of pocket by individuals and families has plummeted since 1970 while the share paid by public programs, mostly Medicaid and Medicare, has soared both nationally and in New York State.⁶ By 2007, 72 percent of nursing home residents in New York relied on Medicaid as their primary payer compared to the national average of 64 percent.⁷ Only 15 percent relied on "other" funding sources, including out-of-pocket payments.⁸

This increasing dependency on struggling public programs, coupled with the aging of the baby boom generation and the lagging economy, ensures that funding LTC will become a crippling burden on New York State's public finances. Nevertheless, New York continues to maximize Medicaid financing for a wide range of expensive LTC services. Consider:

- In 2008, the state spent about 43 percent of its \$48 billion Medicaid budget on LTC compared to an average of nearly 34 percent for the whole country.⁹
- Medicaid LTC expenditures for older people and adults with disabilities topped \$9.4 billion in 2007 or \$491 per person, ranking New York number one compared to the national average of \$213 per person.¹⁰
- New York also ranked number one in Medicaid home and community-based services expenditures for the elderly and disabled at \$19,551 per person served compared to \$9,459 on average in the United States.¹¹
- New York ranks number one in total nursing facility residents with 111,313 out of the country's 1,440,358 total and second in total nursing home stays.¹²

Today, like most states, New York relies heavily on temporary supplemental federal Medicaid funding from the stimulus provided by the American Recovery and Reinvestment Act (ARRA) of 2009. The ARRA increased New York's Federal Medical Assistance Percentage (FMAP),¹³ the share of Medicaid costs paid by the federal gov-

ernment, from 50 percent to 62 percent. According to New York's current budget: "In 2010-11, the expected contributions are \$14.2 billion from the State [27.0 percent], \$31.1 billion from the Federal government [59.1 percent] and \$7.3 billion from local governments [13.9 percent]."¹⁴ After June 30, 2011 when the supplemental matching funds expire and New York returns to its usual 50 percent FMAP, the State and local governments would have to put up an additional \$4.8 billion to receive enough federal matching funds to support the same total expenditure of \$52.6 billion.

Despite already high LTC expenditures, providers of all kinds insist they buckle under the weight of heavy Medicaid census and low reimbursement rates often at or below the cost of providing the care. That is the complaint we heard without exception in interviews with nursing home, assisted living and home health providers. One industry-sponsored study projected an average Medicaid nursing home reimbursement shortfall in New York State of \$47.95 per bed day in 2010.¹⁵

Several major factors make funding Medicaid LTC at the same or even higher levels in the future increasingly difficult. Most New Yorkers qualify easily for Medicaid-financed LTC due to lenient and elastic income and asset eligibility limits. New York further invites excessive utilization of Medicaid benefits for LTC through generous spousal impoverishment protections and by allowing spousal refusal. Medicaid planning or artificial impoverishment to qualify for Medicaid is rampant in New York State. This report explains Medicaid LTC eligibility and provides examples of Medicaid planning.

New York Medicaid invests heavily in home and community-based services (HCBS). The state ranks number one in HCBS personal care for older and disabled adults at \$24,268 per person compared to the national average of \$9,666. People prefer home care over nursing home care and HCBS saves money according to many academics and policy makers. But confidence that buying more HCBS and less nursing-home care will save money has eroded as HCBS costs have exploded and the number of recipients increased. Policy makers should consider the financial impact of providing more services people prefer while allowing generous eligibility.

We estimate that by (1) targeting Medicaid's scarce LTC resources to the neediest recipients by tightening eligibility criteria, (2) strongly enforcing federally mandated recovery of paid benefits from estates of deceased recipients, (3) requiring home equity conversion prior to Medicaid eligibility, and (4) encouraging the purchase of private LTC insurance, the New York Medicaid program could potentially achieve substantial savings from these four sources:

- Increased asset spend down: \$620 million (\$167.4 million state, \$86.2 million local, and \$366.4 million federal)¹⁶
- Stronger estate recovery: up to \$330 million (\$89.1 million state, \$45.9 million local, and \$195.0 million federal)
- Mandatory home equity conversion: \$1.3 billion (\$351.0 million state, \$180.7 million local, and \$768.3 million federal)
- LTC insurance: \$607 million (\$163.9 million state, \$84.4 million local, and \$358.7 million federal)

Note that the state/local/federal breakouts above are based on the current, highly subsidized FMAP. When New York's federal match drops to 50 percent after June

2011, the state and local cost of Medicaid will increase sharply, as will the savings from pursuing these recommended policies.

This report demonstrates that government financing of LTC in New York State has encouraged individuals and families to ignore its potentially ruinous cost. The public's denial of the financial risk associated with LTC is a rational response to a well-intentioned—but counterproductive—public policy. Most New Yorkers fail to plan adequately for their LTC expenses. Some are secure in the knowledge that, if such care becomes necessary, its costs can be successfully transferred to public programs such as Medicaid. Others simply do not worry about LTC risk and cost (because somebody or something else has always paid before). They may not know or ask who pays for LTC, but they do not feel personally at risk. New York should act before it is too late to wean aging citizens off Medicaid LTC dependency and to encourage responsible planning through private savings, investments, and insurance.

1. BACKGROUND

Families and friends provide upward of 80 percent of LTC in the United States. While usually provided for free, the estimated annual economic value of these voluntary services is \$375 billion (\$25 billion in New York State).¹⁷ In 2009, total national expenditure on formal LTC, provided either in a nursing home or at home, was \$205.3 billion, most of which came directly from government sources such as Medicaid and Medicare.¹⁸

The percentage of national nursing home costs paid by Medicaid and Medicare increased by 26.4 percent between 1970 and 2009, while out-of-pocket costs paid by families and individuals decreased by 20.4 percent. Of the \$68.3 billion spent on home health care in 2009, Medicare and Medicaid paid 79.2 percent and private insurance plans paid 7.3 percent. Only 8.8 percent of home-health-care costs were paid out-of-pocket by individuals and families in 2009.¹⁹

America's LTC system has serious problems. Despite the expenditure of increasingly significant sums of public money, current distribution methods create inadequate funding at all levels of care. Consequently, access and quality are doubtful wherever care is provided. Despite the public's preference for home care, the home- and community-based services infrastructure is underdeveloped, and the system perpetuates a bias toward nursing homes. Caregiver shortages are common. Tort liability and liability insurance rates are high, inflating overall service delivery costs. LTC insurance sales are low and declining in most places, which ensures ongoing high dependency on public funding. In short, the dominance of public funding reduces the personal financial risk of failing to prepare to pay for LTC.

LTC in New York

New York State faces all these challenges and more. People aged eighty-five and older—those most likely to need expensive LTC—made up 2 percent of the Empire State's population in 2007, compared to 1.8 percent nationally. By 2030, these "old-old" people will constitute 3.2 percent of New York's population, compared to 2.6 percent nationally, an increase of 62 percent in just twenty years.²⁰

Compared to the rest of the United States, a disproportionate share of older New Yorkers live in poverty²¹ and may need public assistance to fund their LTC. While families provide most of this care at no cost to the public,²² New Yorkers use a comparatively large amount of formal, paid, LTC services. The state ranks first in the nation in the number of its citizens living in nursing facilities, and second in home health aides (as a percentage of the over-sixty-five population).²³

Medicaid is the primary payer for 72 percent of nursing facility residents in New York State (compared with the national average of 64 percent). Medicare pays for another 13 percent. Only the remaining 15 percent of nursing facility residents in New York pay for their LTC from other sources including Veterans' Administration benefits, their own money, or private insurance.²⁴ Medicaid is also the dominant funder of home care in New York, paying \$356 per person—the highest nationally and nearly three times the national average of \$127 per person.²⁵

Statewide, Medicaid LTC expenditures increased 26.4 percent from \$9.8 billion in Calendar Year (CY) 2003 to \$12.4 billion in CY '09, a rate of 4.0 percent per year. But statewide data mask fundamental regional differences in spending. Between 2003 and 2009, Medicaid expenditures on LTC in New York City accounted for roughly two-thirds of the program's total spending statewide. During that same period, statewide Medicaid spending on LTC rose at an annual rate of 4 percent. Upstate, the rate of increase was just 2.1 percent annually. In the downstate region excluding New York City, it rose at 3.4 percent annually. But in New York City, annual Medicaid expenditures on LTC rose at 4.7 percent.²⁶

Aggregate data also mask vast differences in the amount and growth of Medicaid expenditures for specific kinds of LTC services. Nursing home expenditures in New York, for example, grew at a relatively mild 6.7 percent between 2003 and 2009 to \$6.3 billion. During that same period, however, personal care increased 22.4 percent to \$2.2 billion; home care services jumped 77.4 percent to \$1.3 billion; managed LTC rose 174.4 percent to \$1.2 billion; and, combined, Medicaid's other home and community-based services programs, such as adult day care, long-term home health care, and the assisted-living program grew 50.3 percent to \$1.2 billion.²⁷

New York State leads the country in spending on both Medicaid and LTC as a portion of its operating budget.²⁸ Even before the "age wave" spike in its elderly population that is expected over the next twenty years, the Empire State's Medicaid expenditures on LTC far exceed private-pay spending for nursing homes and home health care and have grown much faster than inflation. These funds are increasingly and disproportionately spent on home- and community-based services in the downstate region, especially in New York City.

These facts and trends, especially the heavy dependency on Medicaid—a financially challenged federal welfare program—bode ill for New York's fiscal future.

Medicaid's Dominant Role

The first step toward understanding New York's reliance on Medicaid funding of LTC is understanding how Medicaid became such a massive program in the first place. Medicaid dominates LTC financing everywhere in the United States, not just in New York. What follows is a brief history of LTC financing in the United States.

A means-tested welfare program funded partially by the federal government and partially by states, Medicaid began offering nursing home care in 1965. Medical and financial eligibility criteria were lenient. For example, there were no mandatory transfer of assets restrictions, which today penalize gifting to reach Medicaid asset limits. There was no recovery of exempt assets from recipients' estates as is mandatory under federal law today. Most frail or infirm people over age sixty-five could qualify easily. Cost plus reimbursements, which guaranteed profits, were very generous at the start in order to attract political support from LTC providers.

Several consequences followed rapidly from these conditions. Nursing homes became the setting for most LTC. Beds filled as fast as companies could build facilities, often with people who needed relatively minor care. The number of private payers shrank and the proportion of Medicaid recipients ballooned. A private market for home- and community-based services did not develop because Medicaid made nursing homes

free, or at least radically subsidized their cost. Private insurance for LTC didn't evolve for decades because Medicaid mitigated both its risk and its cost.

State and federal Medicaid expenditures on LTC skyrocketed immediately after the program's enactment in 1965. Government tried to control costs by capping bed supply with "Certificates of Need," which required official approval before a new nursing facility could be built. But capping supply only gave nursing homes an incentive to raise payment rates. So government capped rates, creating a differential between bare-bones Medicaid reimbursement levels and market rates.

By the 1980s, any nursing home willing to accept low Medicaid reimbursements could fill its beds almost without regard to the kind of care it provided. That led to high occupancy rates and serious quality problems. In response, the federal government mandated higher quality care in 1987,²⁹ but without offering higher reimbursement rates. State nursing home associations began suing for better rates under the Boren Amendment, a 1981 law that ensured at least minimal Medicaid nursing home reimbursement. The nursing homes won most of these suits. Repeal of the Boren Amendment in 1997 left no floor under Medicaid nursing home reimbursements and gave states greater flexibility to set rates.³⁰

While all this was going on during Medicaid's first three decades, two other trends developed. First, Medicaid eligibility bracket creep and Medicaid estate planning made publicly financed LTC easier to get.³¹ Second, believing that home-based care was much cheaper per capita than nursing-home care, policy makers and legislators, encouraged by academics, pushed for more Medicaid-financed home- and community-based services.

Presently, home- and community-based services are the fastest growing Medicaid LTC expense. This is how the nation came to have a welfare-financed, nursing-home-based, LTC system (struggling to retrofit more desirable home-care services) in the wealthiest country in the world.

Medicaid=More

New York State Medicaid experienced all these same incentives, trends, and pressures, on a grander scale. In Albany, people often joke that "Medicaid" is a verb. If the federal government allows something to be charged to Medicaid, then policy makers in New York tend to "Medicaid it." The Empire State did not just fund nursing-home care through Medicaid, it set its policies to take full advantage of federal matching funds.

Because New York is a relatively affluent state, its FMAP was set at the minimum allowable level of 50 percent for most of the program's history. Poorer states received higher matching rates so that they would be better able to provide comparable benefits to their needy citizens. But it didn't work out that way. Medicaid does not limit the amount of money states can invest to obtain federal matching funds, so richer states like New York can attract a disproportionate share of Medicaid money simply by putting up more state match monies. As a result, poorer states such as Alabama, Louisiana, and Mississippi receive lower payments per-capita than wealthier states such as New York.³²

The 2009 federal stimulus bill, formally known as the American Recovery and Reinvestment Act, only enhanced New York's ability to co-opt a disproportionate share of federal matching funds.³³ The state's budget is heavily dependent on a further extension of such largesse. Former Lt. Governor Richard Ravitch summarized the problem:

In State fiscal year 2009-2010, Medicaid spending—State, federal, and local—totaled over \$50 billion, the equivalent of more than one-third of the State's All Funds budget. Between 2009-10 and 2013-14, this total is expected to grow by 27 percent to \$63.5 billion, an average annual increase of nearly seven percent. During the same period, the State's share of Medicaid costs will increase much faster—by 71 percent, an average annual increase of nearly 18 percent—because of the expiration of federal stimulus aid.³⁴ In 2014, because of the recently enacted federal health care reform law, increased numbers of New Yorkers are projected to enroll in Medicaid, further increasing state costs.³⁵

Ravitch elaborated in a *Wall Street Journal* op-ed: "The net result is this: The federal stimulus has led states to increase overall spending in these core areas, which in effect has only raised the height of the cliff from which state spending will fall if stimulus funds evaporate."³⁶

Elected and appointed officials we interviewed for this study echoed the Lt. Governor's concerns. For example, former Assembly Aging Committee Chairman Steve Englebright said:

If we don't do long-term care insurance for essentially everybody who is entering working years and youthful enough to buy it inexpensively, we will have missed the only opportunity that I see for having an answer to the long-term care needs of the baby boomers. If we don't have an answer based on their paying their own way, then all our states will be bankrupt.³⁷

Deputy Commissioner for Long-Term Care Mark Kissinger said:

The Feds just gave us more FMAP. Otherwise we would have had to make real cuts. People are budgeting here like the extra federal funds are not going away. There is a sense that it will all work out. We have had a Medicaid crisis for twenty years, but the wrecking ball has not hit. Education and Medicaid are pillars of the state budget, but Medicaid is crowding out everything.³⁸

Nevertheless, despite all the budget pressures facing New York, the state took "positive policy actions" in provider payments, benefit expansions, eligibility expansions, and LTC expansions for fiscal years 2010-11 according to the Kaiser Commission on Medicaid and the Uninsured.³⁹ After the national midterm election in November 2010, it appears unlikely that Congress will authorize any further extension beyond June 30, 2011 of the massive supplemental matching funds that have propped up New York's Medicaid spending since October 2008.⁴⁰

Perverse Incentives

If Medicaid is a means-tested welfare program, and applicants must qualify based on low income and asset limits, how and why do so many New Yorkers qualify for its LTC benefits?

In fact, income almost never interferes with an individual's ability to qualify for Medicaid LTC benefits anywhere in the United States.⁴¹ This is particularly true in New York which operates a "medically needy" income eligibility system under which medical expenses, including the cost of private nursing-home care, are deducted from an applicant's income before eligibility is determined. It is not necessary to have an objectively low income to qualify for Medicaid LTC benefits in New York. It is only necessary to have a very low remaining income—\$787 per month—after medical and LTC expenses are deducted from total income.

In terms of assets, individuals with more than \$13,800 in cash or in resources convertible-to-cash are, at least in principle, ineligible to receive Medicaid benefits in New York State. Those seeking benefits, however, may spend down their assets to meet this requirement. Notably, Medicaid does not care how this spending down is done, so long as assets are not given away at less than fair market value for the purpose of qualifying for benefits. All manner of consumption is allowed, from taking a cruise vacation to remodeling the family home to buying home furnishings or purchasing a new car.

Medicaid LTC recipients can also retain a long list of assets that are exempt under federal law. These include:

- A home and all contiguous property up to an equity value of \$750,000⁴² as long as the Medicaid applicant/recipient (A/R) expresses a subjective "intent to return." No medical verification of ability to return to the home is required. Compare England's home equity exemption of only £23,500 or roughly \$37,000.⁴³
- A business including the capital and cash flow of unlimited value.⁴⁴
- Household goods and personal belongings are totally exempt.⁴⁵
- One automobile of unlimited value if used for transportation of the Medicaid recipient or someone in the same household. "Assume the automobile is used for transportation, absent evidence to the contrary."⁴⁶
- Prepaid burial plans for the Medicaid recipient and all immediate family members regardless of value.⁴⁷
- Unlimited term life insurance.⁴⁸ Why would an elderly person buy a large term life policy when the premium would nearly equal the benefit? Because assets transferred for value do not trigger an eligibility penalty, and there is no estate recovery because life insurance benefits pass outside an estate directly to the beneficiaries. This instantaneous "impoverishment" allows the elderly to qualify for Medicaid acute and LTC benefits.
- Individual retirement account assets and pensions in the applicant or recipient's name are uncounted as long as the A/R is receiving periodic interest and principal payments.⁴⁹

Because of spousal impoverishment protections, married recipients enjoy even more generous eligibility standards.⁵⁰ The community spouse of an institutionalized Medicaid recipient may retain half the couple's joint assets, not to exceed \$109,500. This is the Community Spouse Resource Allowance (CSRA). New York allows the community spouse to retain a minimum of \$74,820 even if the couple's joint assets are less than double that amount. This allowance is much more generous than the minimum permitted by federal law of \$21,912.

On the income side, if the community spouse's personal income is below \$2,739 per month, she or he can receive some of the Medicaid spouse's income to bring her or him up to that level. This is the Minimum Monthly Maintenance Needs Allowance or MMMNA. New York adopted the maximum MMMNA allowed under federal law as its minimum. Joint assets and income in excess of these limits are supposed to be "spent down" for care to offset Medicaid's costs.

Of course, neither the CSRA nor the MMMNA have any real meaning in New York because the state allows community spouses in most cases to refuse to support the Medicaid spouse at any level. (See the page 10 sidebar on "spousal refusal.")

A complicating factor in figuring Medicaid LTC eligibility is that federal law requires states to apply an eligibility penalty when a Medicaid applicant has transferred assets for less than fair market value for the purpose of qualifying for assistance within five years of applying. The eligibility penalty is computed by dividing the amount of the applicable transfer by the average private monthly rate for a nursing home in the state.

So, for example, a \$100,000 under-market transfer would trigger a ten-month eligibility penalty if the average cost of a nursing home were \$10,000 per month. There are additional complications such as certain transfers to some qualified individuals that are exempt, but this is the basic rule that needs to be understood in order to comprehend asset transfer references in this report.

The Need to Curb “Spousal Refusal”

The spouse and other relatives of a chronically ill elderly person in need of long-term care consult a Medicaid planning attorney, making it clear they prefer not to pay their fair share under the law. The lawyer advises them to transfer all assets from the ill spouse’s name to the well spouse’s name and apply for Medicaid for the now-impooverished ill spouse. (Medicaid allows asset transfers without triggering any eligibility penalty.)

When Medicaid asks for the well spouse’s share of the cost of care, the lawyer advises the family to refuse to pay. Under Title XIX of the federal Social Security Act, Medicaid cannot refuse to cover a sick spouse’s LTC bills if the well spouse refuses to pay. But Congress never intended this rule to be used to dodge Medicaid’s cost-sharing and spend down requirements. It was designed instead to protect infirm elders from losing their Medicaid eligibility because of expropriation by a criminally irresponsible spouse. That’s why Medicaid requires the ill spouse to assign to the state his or her rights to support from the well spouse when spousal refusal occurs.

The state then has the right to sue the well spouse to recover the stolen wealth. Unfortunately, some states don’t sue out of a desire to avoid the political sensitivity of chasing well spouses.

New York and Florida are the states most lax about spousal refusal. Nassau County briefly bucked the tide in 2006. The county sued nine wealthy spousal refusers, with a combined net worth of \$13 million, for the \$570,709 they had avoided paying to offset Medicaid expenses for their spouses.^a

As former Lt. Gov. Richard Ravitch pointed out, spousal refusal involves “abuses that divert resources from Medicaid’s legitimate purpose—serving as a safety net for the needy—and turn the program into an entitlement for the less needy”^b

Pursuing every spousal refuser for recovery until the practice halts could recover millions of dollars for New York and federal taxpayers in the short run and avoid their wasteful expenditure in the future.

Gov. Andrew Cuomo’s 2011-12 budget now proposes doing just that. Reflecting a proposal by his “Medicaid Redesign Team,” the budget would close the spousal refusal loophole, generating an estimated savings of \$56.6 million (half of it flowing to state taxpayers) in 2011-12, growing to \$113 million in later years.^c

- a. “Suozzi \$ocking it to Medicaid Millionaires,” *New York Post*, April 10, 2006.
- b. “Lieutenant Governor’s Report on Controlling Increases in the Cost of New York Medicaid,” letter to Governor David Patterson, September 20, 2010, p. 15; http://www.rockinst.org/pdf/budgetary_balance_ny/2010-09-20-LG_Medicaid.pdf.
- c. “Proposals Approved by the NYC Medicaid Redesign Team,” Feb. 24, 2011, Proposals 18, 102 and 132. http://www.health.state.ny.us/health_care/medicaid/redesign/

2. WHO IS LTC-ELIGIBLE IN NEW YORK?

To understand specifically how Medicaid LTC eligibility is determined in New York State, we interviewed eligibility-policy specialists in Albany as well as front line eligibility workers and supervisors in Suffolk and Rensselaer counties. The federal government establishes general requirements and guidelines for Medicaid eligibility which are interpreted and specified by the state, and then implemented by county workers.

Neither applicants for Medicaid LTC nor their representatives are required to come in for face-to-face eligibility interviews in New York. They can mail in their applications or have them filled out and submitted by a lawyer or some other private Medicaid application specialist. Although New York has implemented the federal maximum allowable home equity exemption of \$750,000, the state has never denied eligibility to anyone based on that limit.⁵¹

Our interviews with county eligibility workers provided many examples of how the federal/state system of Medicaid LTC eligibility determination works in practice at the county level.⁵² Suffolk and Rensselaer differ demographically; the Long Island county is considerably wealthier than the upstate county. Below is a synopsis of the differences.

Eligibility in Suffolk:

- Suffolk County workers said 75 percent of the nursing home applications they receive were completed by attorneys, paralegals, or agencies.
- Half of all new cases involve asset transfers most of which require calculation and application of an eligibility penalty as part of a reverse half-a-loaf strategy (see sidebar on next page).⁵³ Workers are seeing a lot more trusts than ever before, including “pooled trusts” used to disregard excess income and irrevocable trusts in 25 percent to 30 percent of nursing home cases. Because New York imposes no asset transfer penalty on home care cases, advisers recommend transferring assets immediately so that five years later, if nursing home care is needed, the transfers will be non-countable.
- Nearly every application in cases involving a community spouse comes in with spousal refusal. According to eligibility workers, approximately 35 percent of Suffolk County’s LTC applications—over 100 per month—involve a community spouse and 34 percent make use of spousal refusal.
- Around 75 percent of all LTC cases prepay burial expenses for the recipient and spouse in amounts averaging \$8,000 to \$10,000.
- Perhaps 35 percent of cases have transferred a home years before and retained the right to remain in the home until death (known as a “life estate”). This effectively eliminates the risk of estate recovery.
- Suffolk workers said they rarely see private LTC insurance and have seen “only one Long-Term Care Partnership policy.” There is “no reason for people to think about long-term care.”

Eligibility in Rensselaer:

- Upstate Rensselaer County has a less prosperous population than downstate Suffolk and eligibility workers’ responses reflected that difference.

- Only a quarter of applications, a third of the Suffolk rate, are done by lawyers or Medicaid application services that are sometimes run by former county workers.
- As in Suffolk, Rensselaer county LTC recipients transfer assets without penalty and get community Medicaid while the [five-year nursing home] look-back period is running out. Or they use the reverse half-a-loaf strategy with a promissory note as described in the sidebar. More people are planning five years in advance to transfer assets without penalty, but they are not the frail or infirm elderly.
- Spousal refusal isn't as common in Rensselaer as in Suffolk, but workers said it is standard in most attorney applications.
- Workers agreed that 90 percent of cases had prepaid burial accounts.
- Life estates are more common in Rensselaer than Suffolk. They're involved in 80 percent of LTC cases, workers explained.
- Asked how often they see private LTC insurance, Rensselaer workers said "maybe one per calendar quarter, a little under 1 percent."

Medicaid Planning

Medicaid-financed LTC in New York is relatively easy to obtain under the basic eligibility rules. Medicaid planning—the practice of intentionally impoverishing oneself through legal techniques of varying sophistication—only needs to be employed when relatively large sums are involved.

Medicaid planners who assist in this process are usually attorneys but may also be

The Reverse Half-a-Loaf

The single most common Medicaid planning strategy used to be the "half-a-loaf," born of the principle that half-a-loaf is better than none. Before the Deficit Reduction Act of 2005 (DRA '05), when the transfer of assets eligibility penalty began on the date of a transfer, applicants could give away half their assets, wait out the transfer penalty, and qualify for assistance without spending down any of their own wealth. But then the DRA '05 changed transfer-of-assets rules so that the eligibility penalty begins when the applicant is otherwise eligible and applies for Medicaid, instead of when the assets are transferred, as before.

In light of this change, Medicaid planners came up with the "reverse half-a-loaf strategy to achieve most of the same benefit. It works like this:

Medicaid applicants, nearly always on the advice of a Medicaid planning attorney, divest half their otherwise nonexempt assets, loan the remainder (usually to an adult child, taking a promissory note), or purchase an annuity, and apply for assistance.

During the penalty period thus created by the asset transfer, the Medicaid applicant uses the proceeds from the promissory note or annuity to pay privately for care.

The net effect is that the applicant becomes eligible for Medicaid in half the time with only half the penalty as otherwise and legally transfers half the assets to a selected beneficiary, usually an adult child.

CPAs, financial planners, or even former Medicaid eligibility workers. The National Academy of Elder Law Attorneys (NAELA) is the Medicaid planners' trade association. NAELA lists 311 members in New York State. As detailed in the Appendix, Medicaid planning advice is universally available throughout the state, but New York City and downstate counties are especially saturated with such practitioners.⁵⁴

New York's generous basic Medicaid eligibility rules, and the easy availability of Medicaid planning advice, ensure that virtually every New Yorker can qualify for Medicaid-financed LTC while preserving all or much of the family's assets.

Home- and Community-Based Services – The Answer?

New York's Medicaid program faces financial peril. Cutbacks have already strained LTC providers at all levels. This is due in part to lax eligibility requirements for Medicaid-financed home care and nursing-home care. But another factor is also important. Historically, Medicaid paid primarily for nursing-home care.

Because most people prefer home care to nursing-home care, many otherwise eligible individuals deferred applying for assistance. For most of the past thirty years, however, New York Medicaid increased its payments for home- and community-based services. This was based on advice from academic researchers that home- and community-based services cost less than nursing-home care and that, therefore, the state could fund more of the services people prefer at less expense. For example, a recent AARP study of Medicaid financing for long-term services and supports (LTSS)⁵⁵ in New York made the argument:

Numerous AARP and other surveys have documented the fact that people needing LTSS want to receive those services and supports in their homes, whenever possible. Although the types of services they need may vary considerably, services provided at home, as opposed to costly institutional care, save money for individuals, their families and public programs. On average, three people can be served at home or in the community for the cost of serving one person in a nursing home.⁵⁶

AARP recommends that New York Medicaid take full advantage of new ways authorized by the Patient Protection and Affordable Care Act of 2010 to maximize supplemental FMAP for a range of new and improved home- and community-based service options.

Decades of maximizing federal matching funds, however, has left New York heavily dependent on unreliable federal generosity. Furthermore, the presumption that shifting toward home- and community-based services will save Medicaid money is proving increasingly dubious. Review of the literature on the cost-effectiveness of home- and community-based services suggests ever more expansion of Medicaid home-care coverage may have less than satisfactory results. For example:

When compared to an elderly population for whom traditionally available care is offered, recipients of expanded community-based services do not use significantly fewer days of nursing home care.⁵⁷

An increasingly large number of studies, including the results of a national channeling demonstration program, have shown that noninstitutional ser-

vices typically do not substitute for nursing home care, but, rather, represent additional services most often to new populations.⁵⁸

Although community-based LTC programs proved beneficial to both clients and informal caregivers in the LTC demonstrations, they did not prove budget neutral or cost effective.⁵⁹

The primary argument for the cost savings potential of home care rests on a comparison of the average per person Medicaid expenditures for people in the community and in nursing homes. The average annual Medicaid expenditures for home care for older people and adults with physical disabilities (\$8,355 in 2004) per person are dramatically less than average annual Medicaid expenditures (\$27,650 in 2004) per person for nursing home care. This comparison, however, is incomplete because it does not address differences in disability levels, use of acute care services, and the exclusion of housing and room and board costs from home care expenditures. Thus, it is not strictly an 'apples to apples' comparison.⁶⁰

Some recent research makes the case that perhaps someday funding more home- and community-based care through Medicaid will save money.⁶¹ As noted, however, most people prefer home care to institutionalization in a nursing home. So when Medicaid offers more home care and less nursing-facility care, it is reasonable to expect that more people will seek Medicaid eligibility than otherwise. In New York, with its exceptionally lenient Medicaid eligibility criteria, nothing prevents people from waiting until they need care, transferring assets without penalty to qualify for Medicaid home- and community-based services, and then five years later qualifying without penalty for skilled-nursing-facility care if it becomes necessary.

3. PROMOTING EQUITY AND AFFORDABILITY

Medicaid is already too expensive for New York's existing tax base. Alternative sources of LTC financing are desperately needed. There are four alternative sources of funding for LTC that could relieve a substantial portion of the budgetary pressure on the state's Medicaid program.

Asset Spend Down

As explained in the section on Medicaid LTC eligibility, New York does little to encourage people to spend their own money on LTC. The state has adopted Medicaid coverage and eligibility standards at the high end of what federal law allows. It covers most optional Medicaid services, making the welfare program as generous as many – and more generous than some – private sector health insurance programs. It exempts \$750,000 worth of home equity, \$250,000 more than the federal minimum. The state's minimum CSRA of \$74,820 is \$52,908 higher than the federal minimum. Unlike nearly every other state, New York allows spouses to refuse without penalty to provide mandatory support that would offset Medicaid's cost.

New York could send an important message to consumers about the importance of LTC planning by adopting the stricter eligibility and coverage limits allowable under federal law. But federal maintenance of effort requirements in the American Reinvestment and Recovery Act and the Patient Protection and Affordable Care Act penalize states for reducing eligibility and coverage. Furthermore, federal Medicaid rules do not allow states to target benefits to the truly needy. A large home equity protection and other resource exemptions are locked into federal law and regulations.

Thus, few choices exist for states to get out from under the federal thumb. In 2008, Rhode Island sought and received a "global waiver" to trade a cap on FMAP for wider discretion in controlling costs, but that waiver restricts changes in eligibility standards.⁶² A Kaiser Family Foundation publication recently suggested that some states are so "financially strapped" by mandatory Medicaid spending "[t]hey could even thumb their nose at the law and cut eligibility, which would force the Obama administration to decide whether to cut all federal Medicaid funding to those states."⁶³

New York State could discourage dependency on Medicaid for LTC by tightening income and asset eligibility limits. Even a 5 percent reduction in Medicaid LTC expenditures, achieved by diverting people from Medicaid to more and longer private payment for LTC, would save the program \$620 million per year, with the savings divided according to the federal, state and local shares.

Estate Recovery

Since 1993, federal law has required states to recover Medicaid expenditures from the estates of deceased recipients.⁶⁴ The requirement serves a dual purpose: to relieve tax payers by generating non-tax revenue to support Medicaid and to encourage consumers to insure against the cost of LTC in order to avoid Medicaid dependency and future estate recovery. Unfortunately, most states, including New York, have neither enforced the estate recovery mandate aggressively nor publicized the requirement to the public. Consequently, consumer behavior has changed little and few people plan early enough to be able to pay privately for LTC.

As of 2004, a federal report found New York's Medicaid estate recoveries came to only \$30 million, or 0.5 percent of nursing home expenditures, which was much less than the national average of 0.8 percent.⁶⁵ For comparison, nearby states had recovery ratios varying from 0.1 percent in Pennsylvania to 2.0 percent in Massachusetts, with Vermont (0.4 percent), New Jersey (0.6 percent) and Connecticut (0.8 percent) in between.⁶⁶ More recent results for New York are not much better than 2004's \$30 million: \$33 million for 2005, \$38 million for 2006, and \$35 million for 2007.⁶⁷

But what if New York recovered from estates at the average national rate of 0.8 percent? Or even at the rate achieved by the country's most successful state, Oregon, which recovered 5.8 percent of the cost of its Medicaid nursing home program in 2004? Merely by attaining the average national estate recovery rate, New York would generate an additional \$15 million, based on the latest collection data. If New York could equal the recovery rate of Oregon, the most successful state in this regard, it would generate \$330 million in total recoveries. While the total recovery would include local, state and federal shares, the local and state shares can be leveraged back up to the total by reinvesting it in Medicaid and receiving the federal share again.

Based on the recommendations of his Medicaid Redesign Team, Governor Cuomo's amended 2011-12 budget seeks to authorize the Health Department's Office of Medicaid Inspector General (OMIG) to assume statewide responsibility for pursuing estate recoveries.⁶⁸ The Redesign Team said OMIG was better staffed and more capable of handling this task than county administrators, who "have little, if any, financial incentive to pursue estate recoveries, and thus have not done so aggressively."⁶⁹ The Redesign Team estimated that this change would generate total savings of \$78 million in 2011-12, increasing to \$104 million in later years, with half the annual savings flowing to the state. However, this may be conservative at barely one-third of the savings that could result from replicating Oregon's recover rate, as noted.

Home Equity Conversion

If New Yorkers were required to use home equity to fund LTC before getting help from the government, Medicaid expenditures in the state would decline considerably. While New York State's home ownership rate (53 percent) is much lower than the national average (66.2 percent),⁷⁰ the median home value in the state (\$258,500) is much higher than for the USA (\$179,900).⁷¹ Furthermore, in the New York City metro area, which consumes a disproportionate share of Medicaid LTC expenditures, home values are much higher still, with a median value of \$362,000, although the home ownership rate is much lower, only 30 percent in New York City proper.⁷²

People sixty-two or older can access their home equity through reverse mortgages without having to leave their homes or make monthly payments.⁷³ Supplemental income from reverse mortgages could enable many New Yorkers to pay privately for services now routinely covered by Medicaid. By purchasing home care or household modifications such as wheelchair ramps with the proceeds of a reverse mortgage, many New Yorkers could offset the cost of LTC expenses.⁷⁴

New York Medicaid exempts up to \$750,000 worth of home equity, nearly three times the median home value in the state and more than double the median value of homes

in New York City. Yet, even this generous exemption is not routinely enforced by all New York counties.⁷⁵

New York's meager efforts at estate recovery ensure that most home equity retained by Medicaid recipients disappears into inheritances instead of helping to fund the program. Furthermore, most home equity held by seniors is gone by the time they apply for Medicaid. Eligibility workers told us families often execute a transfer of assets—including the home—from the older to the younger generation as a matter of course, regardless of whether it is consciously done to escape Medicaid's five year look back. Nationally, over 80 percent of seniors own their homes and more than 70 percent of these are free of mortgage debt.⁷⁶ Yet, only 14 percent of Medicaid recipients owned homes according to a 1989 GAO study, the most recent data available on this point.⁷⁷

Measures Medicaid could take to encourage the use of home equity funding of LTC include lowering the home-equity exemption to the federal minimum of \$500,000, seeking waivers to permit a much lower home-equity exemption and a longer transfer of assets look back period for real estate. With stronger measures like these in place, more New Yorkers would have an incentive to retain ownership of their homes; to use reverse mortgages to purchase home care in the private market or to supplement their incomes to afford private LTC insurance; and to become less dependent on Medicaid.

By bringing home equity conversion, a huge new source of private funding for LTC, into the system, such measures as these could also reduce the number of New Yorkers who are entitled to both Medicaid and Medicare benefits, the so-called dual eligibles. By using their home equity to purchase LTC, many could avoid or at least delay dependency on Medicaid.

If home equity were at risk, recipients would also have a much larger incentive to purchase private LTC insurance when they are still young enough, healthy enough, and affluent enough to afford it. While constituting just 15 percent of Medicaid enrollees, the dual eligibles account for 40 percent of Medicaid spending.⁷⁸ Reducing duals even by 1 percent by ensuring that all aging New Yorkers utilize home equity before relying on Medicaid could save nearly \$1.3 billion per year.

LTC Insurance

A fourth source of private financing that could relieve the financial pressure on Medicaid is private LTC insurance. New York was an early adopter of the Long-Term Care Partnership program, a plan to promote the purchase of LTC insurance by forgiving Medicaid spend-down entirely (the original total asset approach) or more recently, by a dollar-for-dollar approach that reduces spend-down by an amount equal to the value of insurance purchased and actually used. New York also offers a 20 percent state income tax credit for the purchase of private LTC insurance, which is tantamount to a one-fifth discount on LTC insurance premiums for people with high enough incomes to qualify.

Despite this, LTC insurance coverage has not expanded significantly. The number of "insured lives" receiving LTC in New York rose from 408,167 in 2007 to 422,758 in 2008, an increase of 3.6 percent.⁷⁹ The product's market penetration is only 6.7 per-

cent.⁸⁰ LTC insurance agents we interviewed for this study on November 11, 2010 said their market is basically flat. Less than ten companies sell LTC products in New York State, and the number of agents who specialize in them has declined. Agents also worry that mandates to improve LTC Partnership products, such as requiring 5 percent annual benefit increases, make the product less affordable.

The state Legislature has considered an LTC Compact proposal under which citizens could pledge a portion of their savings in exchange for Medicaid LTC eligibility without further spend down.⁸¹ A limited LTC Compact pilot project with 5,000 slots was recently passed into law and is pending implementation.⁸²

But the single biggest reason for the poor performance of the LTC insurance market in New York State is articulated clearly in the state's consumer booklet on the LTC Partnership program:

For many people, the Medicaid program has become their long-term care "safety net" and the primary source of funding for these expenses. In fact, more than 80 percent of nursing home days in New York State are paid by Medicaid...As the population continues to age and older New Yorkers require more care, funding of Medicaid becomes an urgent matter. The assumption of personal responsibility, mainly through the use of long-term care insurance, will help maintain Medicaid benefits for those in greatest need.⁸³

Between two-thirds and 90 percent of the private LTC insurance market is crowded out by the availability of Medicaid financed LTC.⁸⁴ As long as New York Medicaid makes home care and nursing-home care readily available to most people without significant financial risk, LTC insurance is bound to remain a niche product. The problem, however, is not simply that most New Yorkers know that Medicaid will pay and therefore do not bother to save or insure for LTC, but that most people don't think about LTC until it is too late for them to buy a medically underwritten insurance product. An AARP study of people aged fifty and over found that, when specifically asked, 67 percent doubted they could pay for LTC themselves and 88 percent supported increased state spending for HCBS.⁸⁵

If New York removes the perverse incentives that discourage responsible LTC planning, it is reasonable to expect that between 5 percent (\$607 million) and 10 percent (\$1.24 billion) of New York's annual Medicaid LTC expenditures could be picked up over time by private insurance.

Among the Medicaid Redesign team proposals embraced by Governor Cuomo is a series of steps for expanding the Partnership for Long Term Care Insurance Program and other LTC insurance products. Changes would include a doubling, from 20 percent to 40 percent, of the income tax credit for the purchase of tax-qualified LTC insurance policies, a plan option allowing for lower minimum benefits more closely tailored to actual experience, and more options for financing LTC insurance through, for example, allowing proceeds of reverse mortgages to be used for purchasing Partnership products.⁸⁶

4. FINDINGS AND RECOMMENDATIONS

Our recommendations are divided into two categories: (1) measures New York Medicaid could take immediately under existing federal law to reduce the impact of impending budget shortfalls; and (2) measures the state could take over time to solve the problem of LTC financing by seeking a “global waiver.”

Immediate Reforms

Under existing federal law, New York could (1) tighten eligibility, (2) maximize non-tax revenue from estate recovery, (3) encourage the use of home equity as an LTC funding source, and (4) increase the purchase and use of private LTC insurance. Taken together these measures would encourage responsible LTC planning, and reduce the number of people who ultimately become dependent on Medicaid.

Eligibility

Although any reduction in eligibility standards since July 1, 2008 would violate “maintenance of effort” requirements in the soon-to-expire federal stimulus package and the Affordable Care Act, New York should consider them anyway. California has refused to implement critical mandatory provisions in prior federal laws without negative enforcement action by the federal government.⁸⁷ New York should similarly challenge the federal government to block its cost-control efforts. For example:

- Drop the home equity exemption to the federal minimum of \$500,000 from the current level of \$750,000.
- Apply transfer of assets restrictions and penalties to home- and community-based services as well as nursing home eligibility.
- Reduce the Community Spouse Resource Allowance to the federal minimum of \$21,912 from the current level of \$74,820.
- Reduce the Minimum Monthly Maintenance Needs Allowance to the federal minimum of \$1,891 per month from the current level of \$2,739.
- Pursue spouses who expropriate their husbands’ or wives’ resources through spousal refusal and use the authority in the “assignment of rights” required by federal law to recover the stolen property, as embodied in Governor Cuomo’s proposal to eliminate the spousal refusal option.⁸⁸
- Systematically study the income rules and resource exemptions guaranteed by federal law and regulations and ensure they are not allowed beyond minimum levels.

Estate Recovery

- Take over the estate-recovery program from the counties and either administer it aggressively with state employees or hire a private firm to do recoveries in exchange for a percentage of amounts collected, as proposed by Gov. Cuomo on the recommendation of his Medicaid Redesign Team.⁸⁹
- Conduct a study of successful estate-recovery practices in other states, especially Oregon, and implement proven methods and techniques.
- Disabuse the public of the notion that Medicaid LTC is free. Recipients who own exempt assets, including a home, must either pay for LTC out of pocket in advance or pay after the fact.

Home Equity Conversion

- Explain the benefits of paying privately for LTC to the public, including independence, control, access, and quality.

- Encourage the use of reverse mortgages to fund LTC in lieu of Medicaid by means of tax incentives or offsets on closing fees.
- Explain that home equity must be captured from recipients' estates to repay Medicaid expenditures so that using the real property asset to avoid welfare and enjoy the benefits of being a private payer is advantageous.

LTC Insurance

- Publicize the fact that, as proposed in Governor Cuomo's 2011-12 budget, New York Medicaid will enforce stricter eligibility- and estate-recovery rules in the future so that everyone who qualifies medically and can afford private LTC insurance should buy it.
- Explain to the public that Medicaid LTC benefits in the future are highly unlikely to be as generous in the past due to future demographic and financial pressures.

Permanent Solutions

The measures described above—which are allowable under federal law (except as restricted by the maintenance-of-effort rules)—will not solve New York's LTC financing problem. They will help on the margin only if they are combined with a shift in the public's understanding that individuals and families—not Medicaid—must be responsible for most LTC financing.

To solve New York's LTC problem, the state will have to go much further than federal Medicaid rules currently allow. Public financial support for LTC must be limited to only the neediest. But to do that New York would have to drop out of Medicaid altogether or seek a "global waiver," trading an FMAP cap for fuller authority to design and operate a LTC program for the truly needy. Without the traditional strings attached to Medicaid participation, New York could fund better LTC for fewer citizens who need the help the most by implementing the following guidelines.

Measures that could be taken to target public assistance for LTC to people who need it most and incentivize others to save, invest or insure for LTC:

- **Transfer of Assets:** Implement a ten year "look back period" for most assets⁹⁰ and a twenty-year look-back for real property transferred for less than fair market value.⁹¹ Eliminate the incentive to divest assets to qualify for public assistance.
- **Public Relations:** Impress upon aging New Yorkers that they cannot give their wealth away and then expect to receive publicly financed LTC.
- **Home Equity:** Radically reduce or eliminate the home equity exemption for receipt of public LTC benefits. Require the use of a reverse mortgage or sale of the real estate to fund LTC, thus reducing all property to a minimal level before receipt of public benefits.
- **Home Equity Conversion:** Once homeowners can no longer give away their home equity by transfers, with or without retaining life estates, the market for reverse mortgages to fund LTC will expand rapidly, creating jobs, generating tax revenue, and pouring much needed private financing into the service-delivery system.
- **LTC Insurance:** When aging New Yorkers can no longer ignore LTC risk and cost, avoid premiums for private insurance, wait to see if they ever need expensive LTC, and if they do, transfer the expense to taxpayers while retaining

substantial wealth, they will finally begin to purchase private LTC insurance. This too will create jobs, generate tax revenue, and pump private financial oxygen into the revenue-starved service delivery system.

- **Income Treatment:** Once assets, particularly home equity, must be spent for care instead of transferred or sheltered, people will have more savings and reverse-mortgage income to fund their LTC privately. The state could then provide vouchers for care to close gaps between available income and costs of care for people genuinely needy.
- **Family Responsibility:** Once Medicaid stops incentivizing families to take early inheritances and place their loved ones on Medicaid, grown sons and daughters will pull together to support their parents and preserve their estates instead of fighting over the heritable wealth. Adult children's self-interest would presumably impel them to help parents purchase LTC insurance in order to protect their inheritances and ensure access to quality care.

Taken together, these measures or similar initiatives would (1) encourage early and responsible LTC planning; (2) expand private investment to build a better and stronger home and community-based services infrastructure; (3) reduce institutional bias because people spending their own money will avoid entering nursing homes until it is medically necessary; (4) grow the reverse mortgage and LTC insurance markets thus creating jobs and tax revenue; (5) relieve taxpayers of the burden to fund most LTC through Medicaid; (6) ensure that scarce public resources go to people who need them most; (7) shut down the expensive practice of Medicaid planning; and (8) restore personal responsibility as the keystone for LTC planning.

CONCLUSION

Access to Medicaid funding for LTC in New York State has been too easy for too long. The combination of an aging population with greater care needs, a flagging economy, and dwindling federal support will soon bring Medicaid LTC spending up short. Instead of trying to provide a full range of LTC services to nearly everyone in the state, New York Medicaid will have to prioritize.

Cutting provider reimbursements further is not feasible while maintaining access and quality. Reducing services to all recipients is undesirable because it disproportionately hurts the poor. The preferable course is to funnel scarce Medicaid resources to the neediest people and encourage wealthier individuals to plan early and save, invest, or insure against the risks and costs of LTC.

Unfortunately, federal Medicaid maintenance-of-effort rules discourage limiting eligibility even for the well-to-do. When federal stimulus money runs out, New York will face "an immediate 20 percent reduction in funds . . . while Medicaid inflation and the rising number of recipients are increasing costs 8 percent a year."⁹² Dramatic action over time is necessary to solve the problem, but certain urgent measures could mitigate the damage. Both should begin immediately.

Most of the problems discussed in this report spring from perversely counterproductive federal law and regulations. New York Medicaid staff have little choice but to implement and enforce those rules as written and interpreted by federal officials. That remains true as long as New York participates in the Medicaid program.

APPENDIX: New York's Medicaid Planning Industry

An internet search for "Medicaid planning in New York" returns over 300,000 hits, many of which are advertisements for firms that provide Medicaid planning services. Following are examples of Medicaid planners' Internet ads:

From New York City planners:

"Medicaid will cover the cost of in-home LTC expenses as well as the cost of assisted living or nursing home facilities. Many people who need home care or nursing home care have the mistaken belief that if they have assets they can not qualify for Medicaid benefits. With proper legal advice from a [sic] Elder Law attorney and comprehensive Medicaid planning, even if you have assets, those *assets can be preserved and protected and you can legally qualify for Medicaid benefits.*"⁹³ (Emphasis added.)

"Is it possible to protect your assets and income, and still be eligible for Medicaid benefits? YES! [Emphasis in the original] With proper legal advice and comprehensive Medicaid Planning from a qualified Elder Law attorney, *you or your family member or friend may be able to conserve your life's savings and your income, and your home, for yourself and your Estate.*"⁹⁴ (Emphasis added.)

"There are simple legal ways to limit exposure to nursing home bills and protect the assets you have worked so hard to obtain. To avoid or limit exposure to nursing home bills, it is important to be proactive. A five-year look-back period may be in place at the time you enter a nursing home, so *waiting too long to transfer assets to your family or loved ones may make it impossible to protect your assets in the best manner possible.*"⁹⁵ (Emphasis added.)

From Medicaid planners in other counties:

Orange County: "Protecting Assets and Ensuring Medicaid Eligibility: *Our elder law attorneys are AARP-approved to help clients become eligible for Medicaid benefits.*" (Emphasis added.)

Nassau County: "Medicaid Planning Techniques for 2010 . . . A gift and promissory note program is designed to procure as much of the assets as possible of a senior about to go into a nursing home or already in a nursing home. . . The result of this type of planning will *safeguard approximately fifty percent of the senior's assets instead of all the senior's assets being utilized to pay the nursing home expenses.*"⁹⁷ (Emphasis added.)

The Ettinger Law Firm with offices in Albany County, Dutchess County, Saratoga County, Orange County, Richmond County, Rockland County, Westchester County: "With over 2,500 Medicaid applications filed, Ettinger Law Firm has the experience to help your family. For a *free consultation at any of our eight New York locations*, please contact us by telephone or email."⁹⁸ (Emphasis added.)

The Ettinger Law Firm also publishes the "New York Elder Law Attorney Blog" at which readers can find articles on "Protecting Assets With Caregivers Agreements," "Protecting Assets on the Nursing Home Doorstep: 'Half-a-Loaf' Planning or the 'Gift and Loan' Strategy," "Using Medicaid Annuities to Protect Assets," "The Medicaid

Asset Protection Trust (MAPT) - Do's and Don'ts," "Spousal Refusal in New York - 'Just Say No,'" and other Medicaid planning strategies.⁹⁹

Onondaga County and Monroe Counties: "Many counties have improperly created their own policies that vary from county to county. As a result, Medicaid applicants may be deprived of their legal rights and lose assets unnecessarily. . . . If you or a loved one is facing a catastrophic illness, please contact our Medicaid planning attorneys to schedule a free initial consultation. *Our firm is available for home and hospital visits. You should never assume that it is too late. There is something you can do.*"¹⁰⁰ (Emphasis added.)

ENDNOTES

¹ Care is generally considered to be long-term when it exceeds 90 days.

² These cost figures are statewide New York averages. Regional variations range from \$207 to \$500 per day for a semi-private nursing home room; from \$1,600 to \$8,205 per month for an assisted living facility; from \$25 to \$220 per day for adult day services; and from \$17 to \$31 per hour for a home health aide or \$15 to \$25 per hour for a homemaker. Source: MetLife Mature Market Institute, "The 2010 MetLife Market Survey of Nursing Home, Assisted Living, Adult Day Services, and Home Care Costs," October 2010, <http://www.metlife.com/assets/cao/mmi/publications/studies/2010/mmi-2010-market-survey-long-term-care-costs.pdf>.

³ Peter Kemper, Harriet L. Komisar, and Lisa Alecxih, "Long-Term Care Over an Uncertain Future: What Can Current Retirees Expect?," *Inquiry*, Vol. 42, Winter 2005/2006, pps. 341-342, <http://www.inquiryjournal.org/>.

⁴ Ari Houser, Wendy Fox-Grage, Mary Jo Gibson, "Across the States: Profiles of Long-Term Care and Independent Living," eighth edition, 2009, AARP, Washington, DC, p. 228; http://assets.aarp.org/rgcenter/il/d19105_2008_atc.pdf.

⁵ New York had 422,758 long-term care insured lives in 2008 according to Jesse Slome, "The 2010 Sourcebook for Long-Term Care Insurance Information," American Association for Long-Term Care Insurance, Westlake Village, California, 2010, p. 14; <http://www.aaltci.org/ltc-marketing/sourcebook/2009.php>. The state had 6,313,521 people over the age of 50, the prime market for LTC insurance, according to Department of Health, "Vital Statistics of New York State 2008," Table 1 - Estimated Population by Sex, Age and Region, New York State 2008, http://www.health.state.ny.us/nysdoh/vital_statistics/2008/table01.htm. The product's market penetration is therefore only 6.7% percent.

⁶ Stephen A. Moses, "So What If the Government Pays for Most Long-Term Care, 2009 Data Update," Center for Long-Term Care Reform, Seattle, Washington, January 26, 2011, <http://www.centerltc.com/bullets/latest/903.htm>.

⁷ Ari Houser, Wendy Fox-Grage, Mary Jo Gibson, "Across the States: Profiles of Long-Term Care and Independent Living," eighth edition, 2009, AARP, Washington, DC, p. 231; http://assets.aarp.org/rgcenter/il/d19105_2008_atc.pdf.

⁸ *Ibid.*

⁹ Kaiser Family Foundation, *StateHealthFacts.org*, extracted January 27, 2011, <http://www.statehealthfacts.org/profileind.jsp?cmprgn=1&cat=4&rgn=34&ind=178&sub=47>.

¹⁰ Ari Houser, Wendy Fox-Grage, Mary Jo Gibson, "Across the States: Profiles of Long-Term Care and Independent Living," eighth edition, 2009, AARP, Washington, DC, p.230; http://assets.aarp.org/rgcenter/il/d19105_2008_atc.pdf.

¹¹ *Ibid.*

¹² *Ibid.*, p. 231.

¹³ FMAP is the share of Medicaid expenses reimbursed by the federal government. With an FMAP of 50 percent, New York gets one dollar from the federal government for every dollar it puts up. With an FMAP of 62 percent, the state needs to put up only \$.38 to get \$1.00 from the federal Medicaid program.

¹⁴ *New York State 2010-11 Enacted Budget Financial Plan*, August 20, 2010, p. 66; <http://publications.budget.state.ny.us/budgetFP/2010-11FinancialPlanReport.pdf>. The respective federal, state and local shares for 2010-11 to not reflect the 62/38 FMAP precisely, because the federal supplement was reduced somewhat for the January 1 to June 30, 2011 period.

¹⁵ ELJAY, LLC, "A Report on Shortfalls in Medicaid Funding for Nursing Home Care," for the American Health Care Association, December 2010; http://www.ahcancal.org/research_data/funding/Documents/2010%20Medicaid%20Shortfall%20Report.pdf.

¹⁶ This break out of state, local and federal shares is based on current FMAP as reported in *New York State 2010-11 Enacted Budget Financial Plan*, August 20, 2010, p. 66; <http://publications.budget.state.ny.us/budgetFP/2010-11FinancialPlanReport.pdf>.

¹⁷ New York State Family Caregiver Council, "Supporting and Strengthening Caregivers in New York State," November 2009, p. i; <http://www.aging.ny.gov/Caregiving/Reports/InformalCaregivers/FamilyCaregiverCouncilReport.pdf>.

¹⁸ Source: Centers for Medicare and Medicaid Services, <http://www.cms.hhs.gov/NationalHealthExpendData/downloads/tables.pdf>, Tables 9 and 11.

¹⁹ Stephen A. Moses, "LTC Bullet: So What If the Government Pays for Most LTC?, 2009 Data Update," January 26, 2011, <http://www.centerltc.com/bullets/latest/903.htm>.

²⁰ Ari Houser, Wendy Fox-Grage, Mary Jo Gibson, "Across the States: Profiles of Long-Term Care and Independent Living," eighth edition, 2009, AARP, Washington, DC, p. 228; http://assets.aarp.org/rgcenter/il/d19105_2008_atc.pdf.

²¹ *Ibid.*

²² New York State Office for the Aging, "Executive Summary: Sustaining Informal Caregivers," funded by the Administration on Aging Performance Outcomes Measures Project, 2009;

<http://www.aging.ny.gov/Caregiving/Reports/InformalCaregivers/SustainingInformalCaregiversPOMPSurveyReport.pdf>.

²³ Ari Houser, Wendy Fox-Grage, Mary Jo Gibson, "Across the States: Profiles of Long-Term Care and Independent Living," eighth edition, 2009, AARP, Washington, DC, pps. 231, 232;

http://assets.aarp.org/rgcenter/il/d19105_2008_atc.pdf.

²⁴ The "private insurance" referred to here "includes premiums paid to traditional managed care, self-insured health plans and indemnity plans" and not long-term care insurance. See "Quick Definitions for National Health Expenditure Accounts (NHEA) Categories,"

<http://www.cms.gov/NationalHealthExpendData/downloads/quickref.pdf>.

²⁵ *Ibid.*

²⁶ New York Medicaid Director Donna Frescatore and her staff provided the data in this and the following paragraph.

²⁷ *Ibid.*

²⁸ Paul H. Keckley and Barbara Frink, "Medicaid Long-Term Care: The Ticking Time Bomb," Deloitte Center for Health Solutions, Washington, DC, 2010, pps. 12-13; <http://www.thefiscaltimes.com/Issues/Life-and-Money/2010/09/18/~media/CB85A5D7ABD2426CA27C72195EFD3C76.ashx>.

²⁹ The Omnibus Budget Reconciliation Act of 1987 (OBRA '87).

³⁰ Joshua M. Wiener and David G. Stevenson, "Repeal of the Boren Amendment: Implications for Quality of Care in Nursing Homes," Number A-30 in Series, "New Federalism: Issues and Options for States," Urban Institute, December 1, 1998, <http://www.urban.org/url.cfm?ID=308020>.

³¹ "Eligibility bracket creep" is the gradual expansion of Medicaid LTC eligibility to include more and more people. According to a Hoover Institution report: "But over the years, Medicaid LTC has become more readily available to middle-income citizens due to policy mechanisms that allow applicants to 'spend down' their income and assets. Under this approach, certain assets, such as homes and cars, are not counted towards eligibility. People who could have otherwise paid for their long-term care have used estate planning, asset sheltering, and trusts to get Medicaid to foot the bill for them. It is fantasy to believe that Medicaid can continue to pick up all these tabs." (Henry Olsen and Jon Flugstad, "The Forgotten Entitlements," Hoover Institution, Policy Review No. 153, January 27, 2009; <http://www.hoover.org/publications/policy-review/article/5519>.)

³² Robert B. Helms, "The Medicaid Commission Report: A Dissent," American Enterprise Institute for Public Policy Research, Washington, D.C., No. 2, January 2007,

http://www.aei.org/publications/filter.all,pubID.25434/pub_detail.asp.

³³ *New York State 2010-11 Enacted Budget Financial Plan*, August 20, 2010, p. 66;

<http://publications.budget.state.ny.us/budgetFP/2010-11FinancialPlanReport.pdf>.

³⁴ Ravitch explains in a footnote that "These figures do not reflect the recent extension of the temporary FMAP increase through June 2011."

³⁵ Richard Ravitch, "Lieutenant Governor's Report on Controlling Increases in the Cost of New York Medicaid," letter to Governor David Patterson, September 20, 2010, pps. 1-2;

http://www.rockinst.org/pdf/budgetary_balance_ny/2010-09-20-LG_Medicaid.pdf.

³⁶ Richard Ravitch, "Washington and the Fiscal Crisis of the States," *Wall Street Journal*, January 7, 2010;

<http://online.wsj.com/article/SB10001424052748704130904574644131951994574.html>.

³⁷ Interview on November 8, 2010 with Assemblyman Steve Englebright, Chair, Committee on Tourism, Arts and Sports Development, former chair of the Committee on Aging.

³⁸ Interview with Deputy Commissioner for Long-Term Care Mark Kissinger on November 8, 2010.

³⁹ Vernon K. Smith, *et al.*, "Hoping for Economic Recovery, Preparing for Health Reform: A Look at Medicaid Spending, Coverage and Policy Trends, Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2010 and 2011," Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation, September 2010, p. 75; <http://www.kff.org/medicaid/upload/8105.pdf>.

⁴⁰ "A Republican-controlled House is unlikely to extend the enhanced Medicaid funding for states in last year's Recovery Act, the head of a nursing home trade association said Monday. A return to the initial federal share (known as FMAP) would be particularly painful for nursing homes and assisted living facilities, who rely on Medicaid to pay about two-thirds of their patients' bills." (Julian Pecquet, "Nursing home industry fears pending Medicaid cuts," *The Hill*, November 8, 2010, <http://thehill.com/blogs/healthwatch/medicaid/128161-nursing-home-industry-fears-pending-medicaid-cuts>.)

⁴¹ In roughly 15 states that have income caps, people can get around the income limit by setting up "Miller income trusts," which were authorized by the Omnibus Budget Reconciliation Act of 1993 and which permit Medicaid applicants to divert income into the trust until they fall below the income cap and then draw income out of the trust to offset Medicaid's cost for their care.

⁴² Federal law (the Deficit Reduction Act of 2005) guarantees exempt home equity of at least \$500,000, but New York opted for the maximum allowable exemption of \$750,000 instead.

⁴³ "[T]hose with assets - which in most cases will include the value of their home - of more than £23,500 are given no help at all with care costs." (No author cited, "Long-term care: get the best deal now: A new commission is to investigate the best way of funding care for our ageing population. But what steps can families take now?," *Telegraph.co.uk*, July 21, 2010; <http://www.telegraph.co.uk/finance/personalfinance/7902277/Long-term-care-get-the-best-deal-now.html>.)

⁴⁴ “Property essential to self-support used in a trade or business is excluded from resources regardless of value or rate of return effective May 1, 1990.” (Social Security Administration, *Program Operations Manual System* (POMS), <http://policy.ssa.gov/poms.nsf/lnx/0501130501>.)

⁴⁵ “Based on a change in the regulations effective March 9, 2005, the resource exclusion for household goods and personal effects was changed to eliminate the dollar limit of the exclusion.” (Social Security Administration, *Program Operations Manual System*, POMS, “SI 01130.430: Household Goods, Personal Effects and Other Personal Property,” <http://policy.ssa.gov/poms.nsf/lnx/0501130430>.)

⁴⁶ “One automobile per household is excluded regardless of the value if it is used for transportation of the eligible individual/couple or a member of the eligible individual’s/couple’s household. ASSUMPTION: Assume the automobile is used for transportation, absent evidence to the contrary.” (Social Security Administration, *Program Operations Manual System* (POMS), “SI 01130.200: Automobiles and Other Vehicles Used for Transportation,” <http://policy.ssa.gov/poms.nsf/lnx/0501130200>. Emphasis in original.)

⁴⁷ “A burial space or agreement which represents the purchase of a burial space held for the burial of the individual, his or her spouse, or any other member of his or her immediate family is an excluded resource, regardless of value.” (Social Security Administration, *Program Operations Manual System* (POMS), “SI 01130.400: Burial Spaces,” <http://policy.ssa.gov/poms.nsf/lnx/0501130400>.)

⁴⁸ “[T]he FV [face value] of the following are not taken into account: burial insurance policies; and term insurance policies that do not generate a CSV [cash surrender value].” (Social Security Administration, *Program Operations Manual System* (POMS), “SI 01130.300: Life Insurance,” <http://policy.ssa.gov/poms.nsf/lnx/0501130300>.)

⁴⁹ “If an individual is eligible for periodic retirement benefits, he/she must apply for those benefits to be eligible for SSI. If he/she has a choice between periodic benefits and a lump sum, he/she must choose the periodic benefits.” (Social Security Administration, *Program Operations Manual System* (POMS), “SI 01120.210 Retirement Funds,” <https://secure.ssa.gov/apps10/poms.nsf/lnx/0501120210>.)

⁵⁰ Before the Medicare Catastrophic Coverage Act of 1988 (MCCA ‘88) created spousal impoverishment protections, wives or husbands of institutionalized Medicaid recipients were often left with incomes as low as the Supplemental Security Income monthly allowance, around \$350 per month at the time. MCCA ‘88 ensured that community spouses could retain up to half the couple’s joint assets not to exceed \$60,000 and up to \$1,500 per month of income. These amounts were subject to state-specified minimums and set to increase with inflation so that the amounts in the following paragraph are currently in effect for New York.

⁵¹ Interview November 8, 2010 with Wendy Butz, Director, Bureau of Medicaid/FHPlus Enrollment, Department of Health and Eileen Brennan, Chronic Care Specialist, CDHS, Department of Health, Albany, NY.

⁵² Based on interviews by phone with Nicholas Settiani, a chronic care eligibility unit supervisor, on October 29, 2010 and in person with Suffolk County eligibility staff on November 9, 2010 in Ronkonkoma, NY and with Rensselaer County eligibility staff on November 10, 2010 in Troy, NY.

⁵³ A study prepared by the “New York Health Policy Research Center” and published in March 2009 found fewer “transfer of assets” cases were denied eligibility (in the 5 percent to 10 percent range) than were reported to us. This is probably because most of their review period (1998 to 2008) was before the DRA ‘05 became law in early 2006 and became fully effective in New York still later. DRA ‘05 closed off the “half-a-loaf” strategy and gave rise to the “reverse half-a-loaf” strategy which has radically increased the number of penalizable asset transfers. (See The New York Health Policy Research Center, “Assessing Asset Transfer for Medicaid Eligibility in New York State,” March 2009, Albany, New York; http://www.rockinst.org/pdf/health_care/2009-04-09-asset_transfer.pdf.)

⁵⁴ Typical of Medicaid planning advice published frequently in local newspapers throughout the state is Bonnie Kraham, “Protecting Your Future: Medicaid strategies to protect assets,” *Times Herald-Record*, November 28, 2010; <http://www.recordonline.com/apps/pbcs.dll/article?AID=/20101128/BIZ/11280315>.

⁵⁵ The expression “long-term services and supports” is being used more often and “long-term care” less often by many writers. LTSS emphasizes the importance of home and community-based services, whereas some believe the LTC term is associated with a nursing home bias.

⁵⁶ AARP, “Long Term Services and Supports in New York: a Blueprint for Action, A Policy Report by AARP,” October 25, 2010, Washington, DC, p. 2.

⁵⁷ General Accounting Office, “The Elderly Should Benefit From Expanded Home Health Care But Increasing Those Services Will Not Insure Cost Reductions” (Dec. 7, 1982) p. 43, <http://archive.gao.gov/f0102/120074.pdf>.

⁵⁸ John F. Holahan and Joel W. Cohen, *Medicaid: The Trade-off between Cost Containment and Access to Care*, The Urban Institute Press, Washington, D.C., 1986, p. 106.

⁵⁹ Kenneth G. Manton, “The Dynamics of Population Aging: Demography and Policy Analysis,” *The Milbank Quarterly*, Vol. 69, No. 2, 1991, p. 322.

⁶⁰ Joshua M. Wiener and Wayne L. Anderson, “Follow the Money: Financing Home and Community-Based Services,” Pennsylvania Medicaid Policy Center, Pittsburgh, Pennsylvania, 2009, p. 10, footnote omitted; http://www.pamedicaid.pitt.edu/documents/Homecare_rp_09.pdf.

⁶¹ H. Stephen Kaye, Mitchell P. LaPlante, and Charlene Harrington, “Do Noninstitutional Long-Term Care Services Reduce Medicaid Spending?,” *Health Affairs*, Vol. 28, No. 1 (2009), p. 262, <http://content.healthaffairs.org/cgi/reprint/28/1/262>, gated.

- ⁶² For details on Rhode Island's "global waiver," see Stephen A. Moses, "Doing LTC Right," Ocean State Policy Research Institute, Providence, Rhode Island, January 2010; http://www.centerltc.com/pubs/Doing_LTC_Right.pdf.
- ⁶³ Marilyn Werber Serafini and Julie Appleby, "States May Face Showdown With Feds Over Cutting Medicaid Rolls," *Kaiser Health News*, January 20, 2011; <http://www.kaiserhealthnews.org/Stories/2011/January/28/medicaid-maintenance-of-effort.aspx>.
- ⁶⁴ Omnibus Budget Reconciliation Act of 1993.
- ⁶⁵ U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, Office of Disability, Aging and Long-Term Care Policy, "Medicaid Estate Recovery Collections," Policy Brief No. 6, September 2005, pps. 1-2; <http://aspe.hhs.gov/daltcp/Reports/estreccol.pdf>.
- ⁶⁶ Why is New York's recovery rate so low? In New York, counties are responsible for Medicaid estate recoveries. In conversation, county employees reported that they have no incentive to pursue collections aggressively, because they do not share in the recoveries. A New York City elder law attorney we interviewed said "I have not had any estate recovery cases in a long time. I haven't heard others talking about recovery either. It looks like the [Medicaid] agency has made a decision not to do it." Centralizing the estate recovery function, learning and applying best practices in other states including Oregon, and publicizing the inevitability of paying for LTC either on the front end with more asset spend down or on the back end with higher estate recoveries, could generate significant new non-tax revenue and encourage future generations to prepare to avoid dependency on Medicaid.
- ⁶⁷ Data on Medicaid estate recoveries for 2005-2007 were provided by the state Health Department office of Medicaid Director..
- ⁶⁸ Medicaid Rdesign Team, "Proposals Approved by the NYC Medicaid Redesign Team," Feb. 24, 2011, Proposal 102, http://www.health.state.ny.us/health_care/medicaid/redesign/
- ⁶⁹ Medicaid Redesign Team, "Descriptions of Recommendations," p. 118, http://www.health.state.ny.us/health_care/medicaid/redesign/
- ⁷⁰ U.S. Census, "State and County QuickFacts," New York, <http://quickfacts.census.gov/qfd/states/36000.html>.
- ⁷¹ New York Home Prices and Home Values, Zillow Home Value Index, November 5, 2010, http://www.zillow.com/local-info/NY-home-value/r_43/.
- ⁷² New York City Department of Housing Preservation & Development, "A Message from Mayor Bloomberg," retrieved January 31, 2011 from <http://www.nyc.gov/html/hpd/html/buyers/guide.shtml>.
- ⁷³ For more information about reverse mortgages, see www.reversemortgage.org, the National Reverse Mortgage Lenders Association's (NRMLA's) website and Donald L. Redfoot, "In Brief: Reverse Mortgages: Niche Product or Mainstream Solution?," AARP Public Policy Institute Paper #2007-22, Washington, DC, December 2007, http://assets.aarp.org/rgcenter/consume/inb999_revmortgage.pdf.
- ⁷⁴ Barbara R. Stucki, "Use Your Home to Stay at Home: Expanding the Use of Reverse Mortgages for Long-Term Care: A Blueprint for Action," The National Council on the Aging, January 2005, <http://www.reversemortgagetimes.org/guides/reverselongterm.pdf>.
- ⁷⁵ State eligibility policy staff, eligibility workers in Suffolk and Rensselaer Counties, and a Medicaid planning attorney all told us that New York does not enforce the \$750,000 limit on home equity.
- ⁷⁶ "The vast majority of Americans age 65 and older in 2004 (82 percent) are homeowners (Callis and Cavanaugh 2004). Over half the net worth of seniors is currently illiquid in their homes and other real estate (Orzechowski and Sepielli 2003). [p. 1]
- "Based on the Health and Retirement Study, in 2000 there were 27.5 million elder households with at least one resident age 62 or older. A high proportion (21.1 million) of these households (78 percent) were homeowners (Figure 3.2). About 74 percent owned their homes free and clear of any mortgages. In aggregate, elder households have accumulated over \$2 trillion in home equity. [p. 26]
- (Barbara R. Stucki, "Use Your Home to Stay at Home: Expanding the Use of Reverse Mortgages for Long-Term Care: A Blueprint for Action," The National Council on the Aging, January 2005, <http://www.reversemortgagetimes.org/guides/reverselongterm.pdf>.)
- ⁷⁷ General Accounting Office, "Medicaid: Recoveries from Nursing Home Residents' Estates Could Offset Program Costs," GAO/HRD-89-56, March 1989, p. 4; <http://archive.gao.gov/d15t6/138099.pdf>.
- ⁷⁸ Richard Ravitch, "Lieutenant Governor's Report on Controlling Increases in the Cost of New York Medicaid," letter to Governor David Patterson, September 20, 2010, p. 8; http://www.rockinst.org/pdf/budgetary_balance_ny/2010-09-20-LG_Medicaid.pdf.
- ⁷⁹ Jesse Slome, "The 2010 Sourcebook for Long-Term Care Insurance Information," American Association for Long-Term Care Insurance, Westlake Village, California, 2010, p. 14; <http://www.aaltci.org/ltc-marketing/sourcebook/2009.php>.
- ⁸⁰ New York State has 6,313,521 people over the age of fifty, the prime market for LTC insurance.
- ⁸¹ The Long-Term Care Compact proposal was developed and promoted primarily by New York's elder law bar, including leading Medicaid planners. A full discussion of the LTC Compact idea is beyond the scope of this report but is available in Stephen A. Moses, "The New York Long-Term Care Compact Proposal: Update, Analysis and Recommendations," Center for Long-Term Care Reform, Seattle, Washington, July 27, 2007; http://www.centerltc.com/pubs/NY_Compact.pdf.

⁸² Chapter 58, Laws of 2010, Part C, "Reform Medicaid reimbursement for Long Term Care (LTC)," S. 6608--B, A9708--C, 6/30/2010; <http://www.osc.state.ny.us/reports/budget/2011/2010-11enactedbudgetreport.pdf>, p. 59.

⁸³ New York State Department of Health, NYS Partnership for Long-Term Care, "Affordable Financing for Long-Term Care: Consumer Booklet," February 2006, Albany, New York, p. 5, footnotes omitted; <http://www.nyspltc.org/docs/ltcnewbooklet.pdf>.

⁸⁴ Low market penetration for private long-term care insurance in a state with generous access to Medicaid-funded LTC benefits comports with research findings that confirm the impact of Medicaid "crowd out." For example: "We examine the interaction of the public Medicaid program with the private market for long-term care insurance and estimate that Medicaid can explain the lack of private insurance purchases for at least two-thirds and as much as 90 percent of the wealth distribution, even if comprehensive, actuarially fair private policies were available." (Jeffrey R. Brown and Amy Finkelstein, "The Interaction of Public and Private Insurance: Medicaid and the Long-Term Care Insurance Market," National Bureau of Economic Research, December 2004, cited from the paper's "Abstract," http://www.nber.org/~afinkels/papers/Brown_Finkelstein_Medicaid_Dec_04.pdf), emphasis added.

⁸⁵ Cassandra Burton and Katherine Bridges, "Long-Term Care: An AARP Survey of New York Residents Age 50+," AARP Knowledge Management, Washington, DC, March 2007, p. 2; http://assets.aarp.org/rgcenter/il/ny_ltc_2007.pdf.

⁸⁶ Medicaid Redesign Team, "Proposals Approved by the NYC Medicaid Redesign Team," Feb. 24, 2011, Proposal 1462, http://www.health.state.ny.us/health_care/medicaid/redesign/

⁸⁷ For examples, see Stephen A. Moses, "Medi-Cal Long-Term Care: Safety Net or Hammock?" forthcoming from the Pacific Research Institute.

⁸⁸ Medicaid Redesign Team, "Proposals Approved by the NYC Medicaid Redesign Team," Feb. 24, 2011, Proposal 18, http://www.health.state.ny.us/health_care/medicaid/redesign/

⁸⁹ Medicaid Redesign Team, "Proposals Approved by the NYC Medicaid Redesign Team," Feb. 24, 2011, Proposal 102, http://www.health.state.ny.us/health_care/medicaid/redesign/

⁹⁰ Germany currently imposes a ten-year look back period for asset transfers and seeks recovery from the donees to offset welfare-based long-term care expenses.

⁹¹ Transfers of real property are relatively easy to track because they are recorded in public records.

⁹² Michael Gormley, "NY governor candidates seek Medicaid spending trim," *Buffalo News.com*, October 25, 2010, <http://www.buffalonews.com/wire-feeds/24-hour-world-news/article230961.ece>.

⁹³ New York Elder Law Attorneys, contact Robbins & Associates, P.C., One Grand Central Place, 60 East 42nd Street, 46th Floor, New York, NY, 10165, phone: (212) 808-0444; <http://www.jarpc.net/Practice-Areas/Health-Care-Issues.aspx#Healthcare2>, retrieved October 22, 2010.

⁹⁴ Lamson & Cutner, P.C., 9 East 40th Street, New York, NY, 10016, <http://www.elder-law-cutner.com/Medicaid-Benefits-Planning.html>, retrieved October 22, 2010.

⁹⁵ Connors and Sullivan Attorneys at Law, PLLC represents clients throughout the five boroughs of New York City, including Brooklyn, Queens, Manhattan, The Bronx and Staten Island, including such neighborhoods as Bay Ridge, Park Slope, Astoria, Middle Village and Bayside. Retrieved October 22, 2010 from <http://www.connorsandsullivan.com/PracticeAreas/Medicaid-Planning-Avoiding.asp>.

⁹⁶ Jacobowitz & Gubits, LLP, 158 Orange Avenue, Walden, NY, 12586-2029, phone: 845-764-4285, retrieved October 22, 2010 from <http://www.jacobowitz.com/Practice-Areas/Medicaid-Guardianships.shtml>.

⁹⁷ Law Offices of Elliot S. Schlissel, Wills, Trust & Estate Attorneys, 479 Merrick Road, Lynbrook, NY 11563, in the five boroughs: 718.350.2802, in Nassau County: 516.561.6645. Retrieved October 22, 2010 from <http://www.nywillsandtrustslawyer.com/medicaid-planning-techniques.php>.

⁹⁸ Ettinger Law Firm, retrieved October 22, 2010 from <http://www.trustlaw.com/>.

⁹⁹ Retrieved October 22, 2010 from <http://www.newyorkelderlawattorneyblog.com/medicaid-planning/>.

¹⁰⁰ Syracuse Office, Koldin Law Center, P.C., 6661 Kirkville Road, P.O. Box 279, East Syracuse, NY 13057, Tel: 315-463-4032 and Rochester Office Koldin Law Center, P.C., 120 Corporate Woods, Suite 130 Rochester, NY 14623, Tel: 585-292-0090. Retrieved November 24, 2010 from http://koldin.com/estate_planning_medicaid/medicaid.

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P.O. Box 7113 Albany, New York 12224 • PH: 518-434-3100 • FAX: 518-434-3130 • info@empirecenter.org

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