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and Vice Chairman Roscoe Bartlett (R-6-MD)

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

On February 8, 2006, President Bush signed into law the Deficit Reduction Act of 2005 (DRA). Although the DRA does not address all the problems nor implement all the solutions proposed by the Center for Long-Term Care Reform, it does go a long way in the right direction. Following is a summary of the provisions of the DRA related to long-term care, an explanation of how and why they advance the cause of rational long-term care financing policy, and comments about what more needs to be done. (Endnote 1)

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

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

THE DRA AND MEDICAID LTC ELIGIBILITY

The Look Back Period

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

Note that this change is the latest in a series of laws making Medicaid's transfer of assets restriction longer and stronger. The process began with the Tax Equity and Financial Responsibility Act of 1982 which allowed states at their option to impose a transfer of assets penalty of up to two years for assets improperly transferred within the previous two years. The Medicare Catastrophic Coverage Act of 1988 made the transfer of assets penalty mandatory for state Medicaid programs to impose, extended the look back period to 30 months, and increased the upside limit of the potential penalty to 30 months. Finally, the Omnibus Budget Reconciliation Act of 1993 extended the look back period to a full three years for general transfers and to five years for transfers into a trust. Thus, the DRA merely extends the look back period for general transfers to equal the same period used since 1993 for transfers to trusts.

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

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

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

The Medicaid eligibility penalty for transferring assets applies only to assets transferred for less than fair market value and for the purpose of qualifying for the program. The penalty period in months is equal to the amount of assets improperly transferred divided by the average cost of a private nursing home in the state. For example, \$100,000 divested without compensation for the purpose of becoming eligible for Medicaid would incur a 20-month penalty if the average cost of a nursing home in the state is \$5,000 per month. But this full penalty as intended by Congress was rarely imposed. The reason is that under previous law, the penalty period began at the date the assets were transferred.

This fact gave rise to the widely recommended "half-a-loaf" Medicaid planning strategy. In other words, don't give away the whole \$100,000 at once and incur the full 20-month penalty. Rather, give away \$50,000, incur a ten-month penalty, spend the other \$50,000 as you choose or convert it to an exempt asset, bide your time and apply for Medicaid ten months later without having spent any of your own money for long-term care.

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

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

Assets transferred for any other reason than to qualify for Medicaid are not penalizable. Gifts to families or charities for other reasons have been and remain exempt under federal law. Furthermore, asset transfers that would incur a penalty are much less likely to occur now than before because the "half-a-loaf" divestment strategy no longer works. Medicaid planning attorneys who recommend it will be vulnerable to malpractice lawsuits. The far more likely scenario is that instead of transferring their assets to qualify for Medicaid as before, people will preserve their wealth and use it to pay privately for long-term care. That's good for seniors because private payors have more choices among a wider range of better long-term care services than Medicaid recipients do. It's good for long-term care providers because they desperately need more private patients paying market rates for their services to make up for Medicaid's dimly low reimbursement rates.

Undue Hardship Waivers

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

If a transfer of assets eligibility penalty would deny medical care or food, clothing, shelter, or other necessities of life to a Medicaid applicant, then the applicant, the

applicant's representative, and even the long-term care facility itself may request a hardship waiver allowing the applicant to receive Medicaid benefits in spite of the improper, penalizable asset transfer. The law even permits payments to long-term care facilities while Medicaid eligibility is pending for up to 30 days. State Medicaid programs are required to notify recipients of the hardship waiver option. Finally, members of Congress and the American Health Care Association have appealed to the Centers for Medicare and Medicaid Services to build strong protections into the regulations that will be published to implement the Deficit Reduction Act's stricter eligibility provisions. (Endnote 2) The devastating consequences predicted by opponents of the Deficit Reduction Act before and after its passage are thus highly unlikely to occur.

Rounding Down and Combining Asset Transfers

The Deficit Reduction Act made two additional changes to the rules bearing on asset transfers that warrant explanation. State Medicaid programs are now barred from "rounding down" fractional periods of ineligibility to determine asset transfer ineligibility periods. Before the DRA, the transfer of assets penalty began at the date of the transfer. This meant that someone could give away an amount equal to the average cost of a nursing home in the state at the beginning of each month and only incur an eligibility penalty equal to the duration of that current month. Some states rounded down the amount of assets transferred to qualify for Medicaid to the next lowest whole amount equal to the average cost of a nursing home. Thus, in such states, a person could give away one dollar less than double the nursing home cost and only be penalized for the single, current month of eligibility. Federal law no longer allows states to round down in this way. Therefore, this provision eliminates the loophole that allowed states to ignore otherwise penalizable asset transfers up to double the average monthly price of a private nursing home minus one dollar. Why would states have allowed that? Who knows, but some did. Not anymore.

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

The Home Equity Exemption

The other major change to Medicaid long-term care eligibility enacted by the Deficit Reduction Act is a reduction in the program's home equity exemption. Previously, Medicaid recipients could retain a home and all contiguous property of unlimited value while receiving long-term care benefits from the welfare program. The DRA places a limit of \$500,000 on home equity, although it allows states at their option to increase that

limit to \$750,000. Critical to note is that this new limit does not apply if a spouse or a minor or disabled child remain living in the home. Starting in 2011, the new home equity exemption limit will increase annually with the Consumer Price Index. Reverse mortgages may be used to reduce home equity down to a level at which the homeowner can qualify for Medicaid. The new home equity limit applies for Medicaid applications filed on or after January 1, 2006.

One might reasonably ask why a \$500,000 limit on home equity for Medicaid eligibility matters much. After all, the median home equity of elderly Americans is only \$85,516. (Endnote 3) Unfortunately, a common Medicaid estate planning strategy is to "hide money in the home." In other words, people can convert a countable resource like cash into an exempt resource simply by investing the money in home improvements or even buying a more expensive house. For the first time since its enactment in 1965, Medicaid now limits that method of qualifying for Medicaid. Although the median home value for seniors is low, the prime candidates for Medicaid planning have homes worth \$250,000 to \$400,000 which they mostly own free and clear of mortgage debt.

Obviously, to have full effect, the home equity exemption needs to be lowered much further to discourage dependency on Medicaid by people of substantial wealth and to encourage the use of home equity conversion to pay for long-term care in lieu of going on welfare. Ironically, the United Kingdom--another European socialized health care system--only allows a home exemption of around \$36,000 for people who receive publicly financed long-term care. Over time, as Medicaid-driven budget pressures at the state and federal levels increase, the program's home equity exemption will undoubtedly drop considerably, ultimately to \$50,000--the level recommended already last year by the National Governors Association--or even lower.

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

Annuities for Self-Impoverishment

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

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

The Deficit Reduction Act put a number of obstacles in the way of using annuities as a Medicaid planning technique, although it didn't eliminate the practice altogether. The DRA requires Medicaid recipients and community spouses to disclose annuities at the time of eligibility determination and at every periodic recertification of eligibility, which usually occurs annually or semi-annually. Beginning with the date of enactment of the new law, the state must be named as remainder beneficiary for annuities held by Medicaid recipients or their spouses. State Medicaid programs must notify the issuer of the annuity of the state's status as remainder beneficiary. At their option, states may require annuity issuers to report income or principal withdrawals from the annuity. States may then deny Medicaid eligibility based on such withdrawals if they exceed allowable limits. Hence forward, purchase of an annuity is a penalizable transfer of assets unless the state is listed as remainder beneficiary in first position for at least the total amount of Medicaid payments made on behalf of the recipient or in second position to a community spouse or minor or disabled child for the same amount. Spousal annuities remain an option under certain circumstances. But the message about annuities in the Deficit Reduction Act is clear: the door is closing on the abuse of annuities as a means to divert responsibility for long-term care financing from affluent individuals to taxpayers at the expense of Medicaid's long-term care safety net for the poor.

Transfer of Assets Before Income

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

In more detail, community spouses of institutionalized Medicaid recipients are allowed to retain half the couple's joint assets not to exceed \$99,540. This is called the Community Spouse Resource Allowance or CSRA. Community spouses may also retain a Minimum Monthly Maintenance Needs Allowance (MMMNA) which has an upper limit of \$2,488.50. These figures for the CSRA and MMMNA are current as of 2006 and increase annually with the Consumer Price Index. The CSRA and MMMNA were

introduced in the Medicare Catastrophic Coverage Act of 1988 (MCCA '88) in order to put an end to the problem of "spousal impoverishment." Originally, the CSRA was limited to \$60,000 and the MMMNA, \$1,500.

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

Here's how the Deficit Reduction Act changes that arrangement. Prior to the DRA, state Medicaid programs could allow community spouses to increase their income up to the MMMNA in either of two ways. The "income first" rule required them to take income from the institutionalized spouse first before taking assets. This approach resulted in Medicaid receiving less of the recipient's income to offset his cost of care but it left excess assets vulnerable to resource limits. The other "asset first" approach allowed the community spouse to receive extra assets from the institutionalized spouse in addition to the CSRA up to a total amount the interest on which would bring her up to the MMMNA. Medicaid planners sought out opportunities to utilize this "asset first" approach. They routinely advised their clients to find the lowest possible interest rate returns in order to maximize the amount of assets transferable from the institutionalized to the community spouse to bring the latter up to her MMMNA. It was reportedly commonplace for families to be able to shelter up to several hundreds of thousands of dollars from Medicaid asset eligibility limits in this way. The Deficit Reduction Act prohibits this practice and mandates the "income first" rule. Unless Medicaid applicants find other ways to shelter or divest excess assets, this change should encourage more people to spend their money for long-term care in the private marketplace instead of gaming Medicaid to preserve large amounts.

CCRCs, SCINs, and Life Estates

Finally, the Deficit Reduction Act curtailed three additional Medicaid planning techniques. The new law allows state Medicaid programs to count Continuing Care Retirement Community (CCRC) and Life Care Community (LCC) admission contracts as countable resources. CCRCs and LCCs usually charge entrance fees which are sometimes refundable if the resident never needs the high-cost nursing home care for which the fees are intended to provide. Medicaid planners had found a way to shelter such fees thus allowing residents to get the money back AND get Medicaid to pay for their nursing home care. This was a serious problem for the retirement communities

because of Medicaid's low reimbursement rates, which are often less than the cost of providing the care. The DRA permits states to eliminate this eligibility loophole which Medicaid planners employed to evade spend-down requirements at long-term care facilities' expense.

The DRA changes Medicaid eligibility rules to include certain funds used to purchase a promissory note, loan or mortgage among countable assets unless repayment terms are actuarially sound, provide for equal payments and prohibit the cancellation of the balance upon the death of the lender. This provision makes funds used to purchase certain promissory notes, loans or mortgages vulnerable to the transfer of assets penalty. It stops the ever-popular Medicaid planning device known as SCINs (self-canceling installment notes) and other similar loopholes previously used to qualify for Medicaid. Last but not least, the DRA treats the purchase of a "life estate" as a penalizable asset transfer unless the purchaser resides in the home for at least one year after the date of purchase. So ends the hit list of Medicaid planning gambits successfully targeted by the Deficit Reduction Act.

Effective Dates

Now, a word about effective dates. The provisions of the DRA are effective as indicated in the law except if state legislation is required to implement them. If so, then the new rules take effect "the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act." Medicaid planners are touting this potential delay of implementing these new rules as one last opportunity to plan for Medicaid, a Medicaid planning fire sale as it were. Here's how one Medicaid planning publication put it: "The bottom line is if you have been hesitating about seeing an attorney about long-term care planning, hesitate no longer. If you have considered protecting some assets for your loved ones in case you later require long-term care, you should contact a qualified elder law attorney now." (Endnote 4) This is precisely the sort of abuse--lucrative for lawyers, but devastating for taxpayers, Medicaid, and poor people legitimately dependent on public assistance--that the Deficit Reduction Act attempted, evidently with some considerable success, to curtail.

The DRA and the Long-Term Care Partnership Program

The second major set of provisions of interest to us in the Deficit Reduction Act authorizes expansion of the Long-Term Care Partnership Program. The LTC Partnership Program began as an experimental project funded by the Robert Wood Johnson Foundation in the late 1980s. It was the brainchild of Dr. Mark Meiners, an economist who did the early research that established long-term care as an insurable risk and helped to launch the product and the market as viable economic enterprises. Dr. Meiners recognized that Medicaid crowded out most demand for long-term care insurance. He reckoned that a positive incentive to buy the protection might prevail where Medicaid's toothless spend-down rules had little effect. He designed the partnership program to provide just such an incentive by forgiving the Medicaid spend-down requirement in an amount equal to the amount of insurance protection purchased and used. The program

differed in New York somewhat, but conceptually that was the idea and the way the program was implemented in Connecticut, Indiana and California. For example, buy \$100,000 worth of long-term care insurance, use it up, and qualify for Medicaid while keeping \$102,000 of your own money instead of having to "spend down" to the ostensible limit of \$2,000 otherwise required.

All went well at first. More and more states were gearing up to implement the LTC partnership program as the decade of the 1990s began. But then came a devastating blow. When Congress mandated Medicaid estate recoveries in the Omnibus Budget Reconciliation Act of 1993 (OBRA '93), Congressman Henry Waxman (D, CA) who was then Chairman of the House Energy and Commerce Committee (the germane committee for Medicaid in the U.S. House of Representatives) refused to exempt any future LTC partnership states from the new requirement. Thus, while new partnership states might exempt assets for purposes of eligibility, they could not exempt the same assets from estate recovery. Figuring that this change eliminated the LTC partnership's incentive to buy insurance, states stopped implementing new partnerships and the program languished until now. The Deficit Reduction Act repealed the "Waxman amendment" and authorized new state LTC partnership programs to exempt protected assets from estate recovery as well as from eligibility limits. Everyone expects the popular LTC partnership programs to expand rapidly nationwide with that obstacle removed.

While the DRA removes the major obstacle to new partnership programs, it also imposes some new requirements. To qualify for the partnership program, long-term care insurance policies must be "tax qualified," meaning they need to qualify for the limited tax deduction authorized by the Health Insurance Portability and Accountability Act of 1996. They must meet the National Association of Insurance Commissioners' model regulations and Act as of October 2000. They must provide for benefit increases or options especially for younger insureds. The DRA mandates reporting for insurers and training for agents who market partnership policies. There are minimum data set reporting requirements to ensure proper evaluation of the programs. By January 1, 2007, the Secretary of the Department of Health and Human Services is supposed to publish "standards for uniform reciprocal recognition," that is to say portability guidelines that will help to make partnership benefits available in one state equally available in others. The Secretary is also required to report annually to the Congress on the LTC partnership programs' progress. Finally, the DRA establishes a National Clearinghouse for Long-Term Care Information, with funding of \$3 million per year from 2006 to 2010, to help educate consumers about the risk and cost of long-term care and the importance of buying private insurance protection.

Likely Impact of LTC Partnerships Enhanced by Medicaid Eligibility Changes

The long-term care insurance industry is clearly thrilled by this expansion of the LTC partnership program. It will enhance the market for their product. Long-term care providers are also enthusiastic, although less so, inasmuch as the benefits of having more insured private payers someday in the future won't benefit providers as soon as it will help insurers. Ironically, however, LTC insurers seem to have hardly noticed the changes

in Medicaid eligibility and LTC providers actually opposed one of the most important modifications, e.g. the change in the date of the asset transfer penalty.

Why ironic? Without the provisions of the DRA that tightened Medicaid long-term care eligibility, it is unlikely that expansion of the long-term care partnership program would have had much effect. Studies conducted of the partnerships programs in the four original states indicate that they helped expand the long-term care insurance market on the margin, but they hardly made a qualitative difference as compared to the market for the product in other, non-partnership states. (Endnote 5) Think about it. Why would someone buy private long-term care insurance many years in advance of needing long-term care, an eventuality about which most consumers are in denial anyway, simply to avoid a Medicaid spend-down liability that didn't really exist in the first place? The answer is: they wouldn't and for the most part they didn't. That's why the original partnership programs were only marginally successful.

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

The DRA and Home and Community-Based Services Under Medicaid

The third and final major set of provisions in the Deficit Reduction Act bearing on long-term care relates to the expansion of home and community-based services (HCBS) funded by Medicaid. The DRA makes HCBS an option coverable under the Medicaid state plan without a special waiver as previously required. States may limit enrollment in the program to control expenditures. They can also elect not to comply with "statewideness," the requirement governing most services offered by Medicaid which says they must be made available at substantially the same level and in the same form everywhere in the state. Receipt of home and community-based services will no longer require that the Medicaid recipient have a medical need for nursing home level of care in order to qualify for HCBS, an ironical contradiction seemingly inimical to recipients' best interests, that was mandated under the waiver programs. At their option, states may allow recipients to purchase and control their own care thus extending the idea of consumer-driven health care into the arena of welfare-financed long-term care. States must provide for quality control of HCBS. These provisions are effective January 1, 2007.

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

Won't Medicaid be more attractive when it provides home care, assisted living and other community-based services, not just nursing home care? Won't people be more likely to search for ways to qualify for Medicaid by means of artificial self-improvement and consulting Medicaid planners? Won't they be less likely to buy long-term care insurance, which requires big premiums to qualify for benefit payments covering HCBS that Medicaid will now be offering for free? Yes, expansion of Medicaid to cover HCBS more liberally than in the past could have caused all those negative consequences, except for the fact that the DRA also tightened Medicaid's eligibility limits. Therefore, once again, just as the new constraints on Medicaid long-term care eligibility promise to enhance the effectiveness of the long-term care partnership program, they will also mitigate any damage that might have been done by expanding the program's coverage of HCBS and making Medicaid therefore more attractive as a long-term care payor. Medicaid will be a better, more attractive program for a smaller number of recipients who genuinely need its help.

Conclusion

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

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

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

Stephen A. Moses is president of the Center for Long-Term Care Reform in Seattle, Washington. The Center's mission is to ensure quality long-term care for all Americans. Steve Moses writes, speaks and consults throughout the United States on long-term care policy. He is the author of the study "Aging America's Achilles' Heel: Medicaid Long-

Term Care," published by the Cato Institute (www.cato.org). Learn more at www.centerltc.com or email smoses@centerltc.com.

Endnote 1: The report of the Conference Committee of the House of Representatives and the Senate for the Deficit Reduction Act of 2005 is available at http://thomas.loc.gov/cgi-bin/cpquery/?sel=DOC&&item=&r_n=hr362.109&&sid=cp109lxkwK&&refer=&&db_id=cp109&&hd_count=&. The Conference Report describes the provisions of the original bills passed by the House and Senate and the provisions of the compromise reached in the Conference Committee and ultimately passed by both Houses in identical form with the exception of the clerical error mentioned above.

Endnote 2: AHCA Press Release, "Long Term Care Associations Backing U.S. Rep. Peter King's Effort to Ensure Nation's Most Vulnerable Seniors Protected During DRA Implementation Period, March 28, 2006, <http://www.ahca.org/news/nr060328a.htm>.

Endnote 3: He, Wan, Manisha Sengupta, Victoria A. Velkoff , and Kimberly A. DeBarros, U.S. Census Bureau, Current Population Reports, P23-209, 65+ in the United States: 2005, U.S. Government Printing Office, Washington, DC, 2005, Table 4-10: Median Net Worth and Median Net Worth Excluding Home Equity for Households by Age of Householder and Monthly Household Income Quintile: 2000, p. 108, <http://www.census.gov/prod/2006pubs/p23-209.pdf>.

Endnote 4: *ElderLaw Answers*, "Congress Passes Bill Containing Punitive New Medicaid Transfer Rules" at <http://www.elderlawanswers.com/resources/article.asp?id=5221§ion=4>.

Endnote 5: Nelda McCall, editor, *Who Will Pay for Long Term Care?: Insights from the Partnership Programs*, Health Administration Press, Chicago, Illinois, 2001.