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EXAMINING ABUSES OF MEDICAID ELIGIBILITY RULES

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH CARE, DISTRICT OF COLUMBIA, CENSUS AND THE NATIONAL ARCHIVES

OF THE

COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM

HOUSE OF REPRESENTATIVES

ONE HUNDRED TWELFTH CONGRESS

FIRST SESSION

SEPTEMBER 21, 2011

Serial No. 112–90

Printed for the use of the Committee on Oversight and Government Reform

Available via the World Wide Web: http://www.fdsys.gov
http://www.house.gov/reform

U.S. GOVERNMENT PRINTING OFFICE

71–967 PDF WASHINGTON : 2012

For sale by the Superintendent of Documents, U.S. Government Printing Office
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EXAMINING ABUSES OF MEDICAID ELIGIBILITY RULES

WEDNESDAY, SEPTEMBER 21, 2011

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH CARE, DISTRICT OF COLUMBIA, CENSUS AND THE NATIONAL ARCHIVES,
COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM,
Washington, DC.

The subcommittee met, pursuant to notice, at 10 a.m. in room 2247, Rayburn House Office Building, Hon. Trey Gowdy (chairman of the subcommittee) presiding.

Present: Representatives Gowdy, Gosar, DesJarlais, Davis, Clay, and Cummings [ex officio].

Staff present: Brian Blase, professional staff member; Will L. Boyington and Nadia A. Zahran, staff assistants; Christopher Hixon, deputy chief counsel, oversight; Sery E. Kim, counsel; Mark D. Marin, senior professional staff member; Jaron Bourke, minority director of administration; Yvette Cravins, minority counsel; Ashley Etienne, minority director of communications; Devon Hill and Adam Koshkin, minority staff assistants; and Jennifer Hoffman, minority press secretary.

Mr. GOWDY. Good morning. Welcome to everyone.

This is a hearing on examining abuses of Medicaid eligibility rules. Pursuant to committee rules, I will read the mission statement.

We exist to secure two fundamental principles. First, Americans have a right to know the money Washington takes from them is well spent. Second, Americans deserve an efficient and effective government that works for them. Our duty on the Oversight and Government Reform Committee is to protect these rights. Our solemn responsibility is to hold government accountable to taxpayers because taxpayers have a right to know what they get from the government.

We will work tirelessly in partnership with citizen watchdogs to deliver the facts to the American people and to bring genuine reform to the Federal bureaucracy. This is the mission of the Oversight and Government Reform Committee.

I will now recognize myself for an opening statement and then the gentleman from Illinois, ranking member, Mr. Davis.

As this committee's mission statement just made clear, Americans have a right to know the money Washington takes from them is well spent. Americans also have the right to know whether social programs that were designed for a specific purpose have been hi-

jacked wittingly or unwittingly by those who have figured out how to game the system.

Today, we will examine alleged abuses of Medicaid eligibility rules. As we do, we are guided by the principle that each dollar taken from a private citizen has a real cost and government needs a compelling rationale for taking that dollar.

To be clear, this country has a rich history of providing a social safety net for the elderly and the indigent. Some seek to turn the safety net into a hammock or trampoline. Not only is this fiscally irresponsible, it erodes the very little public trust people have left in the institutions of government.

Without question, the Medicaid program is on an unsustainable course. Over the past two decades, national Medicaid spending has increased from less than $75 billion per year to over $400 billion per year. At the State level, Medicaid growth has put tremendous pressure on budgets and is crowding out other State priorities such as education and public safety. At the Federal level, Medicaid growth has the same effect. Plus, it is contributing to our national debt at more than 40 cents of each dollar is borrowed.

Medicaid is a means tested welfare program designed to provide medical care to the poor and disabled. But, today's testimony will reveal that Medicaid is not being used solely by the indigent. Although Medicaid technically has income and asset tests, these tests are easy to circumvent and abuse. In fact, an entire cottage industry has arisen seeking to educate the wealthy on how to transfer or hide assets, so taxpayers can pay for their long term care.

In 1982, Congress made it clear all of the resources available to an institutionalized individual, including equity in a home which are not needed for the support of a spouse or dependent children, will be used to defray the costs of supporting the individual and the institutions. Despite this congressional intent, all the resources available to the institutionalized individual are not being used to defray the taxpayers' cost of supporting these individuals.

According to the CMS, less than 1 percent of the money spent on nursing home care is recovered. The art of artificially impoverishing oneself to gain Medicaid coverage has spawned a stand alone industry. Medicaid planning is pervasive. A Google search which includes quotes around Medicaid planning yield over a half million hits. Popular books are available like the one entitled, "How to Protect Your Family's Assets from Devastating Nursing Home Costs: Medicaid Secrets."

This book includes tips on how to title your homes so you don't lose it to the State, how to make transfers to family members that don't disqualify you from Medicaid, how annuities make assets disappear, smart tricks for spending down your assets, what to change in your will to save thousands of dollars if your spouse ever needs nursing home care to avoid the State's reimbursement claim, following the nursing home resident's death. Government programs should not have secrets and artificially impoverishing oneself to become eligible for a program that was not designed for you is wrong.

In 2006, the Europost ran an article about Medicaid millionaires in one county in the State. In that year, nine millionaires had taxpayers paying for their Medicaid bills. One man, worth nearly $2 million, had Medicaid pick up over $80,000 in nursing home costs

for his wife. One woman, worth $1.6 million, had Medicaid pick up over $200,000 in nursing home costs for her husband.

Since half of New York's Medicaid bill is financed by Federal taxpayers, taxpayers in my home State of South Carolina are paying for millionaires on Medicaid in New York.

About once a decade, Congress revisits the eligibility rules for Medicaid to crack down on their abuse. In 1993 the Omnibus Budget and Reconciliation Act, Congress required States to do a State recovery. In the 2005 Deficit Reduction Act, Congress closed some loopholes and extended Medicaid's look-back period. Today's testimony will reveal whether previous congressional action in this area has worked.

We all know that tough choices are coming and that there will be strong partisan differences about the way forward. Today's hearing offers us an opportunity to explore an area where there should be genuine bipartisan agreement. Medicaid was intended for the poor and the disabled. Millionaires should not be on welfare. If the rules of Medicaid allow individuals with sizable portfolios to qualify for the program and protect the inheritance of their children, then Medicaid needs reforming.

[The prepared statement of Hon. Trey Gowdy follows:]

Mr. Gowdy's opening statement:

As this Committee's mission statement makes clear, Americans have a right to know that the money Washington takes from them is well spent. Americans also have the right to know whether social programs that were designed for a specific purpose have been hi-jacked wittingly or unwittingly by those who have figured out how to game the system. Today, we will examine alleged abuses of Medicaid eligibility rules. As we do, we are guided by the principle that each dollar taken from a private citizen has a real cost and that government needs a compelling rationale for taking that dollar. To be clear, this country has a rich history of providing a social safety net for the elderly and the indigent. But some seek to turn the safety net into a hammock or a trampoline. Not only is this fiscally irresponsible, it erodes the very little trust people have left in the institutions of government.

Without question, the Medicaid program is on an unsustainable course. Over the past two decades, national Medicaid spending has increased from less than $75 billion per year to over $400 billion per year. At the state level, Medicaid growth has put tremendous pressure on budgets and is crowding out of other state priorities, such as education, and putting pressure for tax increases. At the federal level, Medicaid growth has the same effect plus it is contributing to our national debt as more than 40 cents of each dollar is borrowed money.

Medicaid is a means-tested welfare program, designed to provide medical care to the poor and disabled, but today's testimony will reveal that Medicaid is not being used solely by the indigent. Although Medicaid technically has income and asset tests, these tests are easy to circumvent and abuse. In fact, an entire cottage industry have arisen seeking to educate the wealthy on how to transfer or hide assets so taxpayers can pay for their long term care.

In 1982, Congress made it clear that "all of the resources available to an institutionalized individual, including equity in a home, which are not needed for the support of a spouse or dependent children will be used to defray the cost of supporting the individual in the institution." Despite this Congressional intent, all the resources available to the institutionalized individual are not used to defray the taxpayer cost of supporting these individuals. According to the CMS, less than one percent of the money spent on nursing home care is recovered.

The art of artificially impoverishing a person to gain Medicaid coverage has spawned a stand-alone industry. Medicaid planning is pervasive. A Google search which includes quotes around Medicaid planning yields over half a million hits. Popular books are available, like one titled How to Protect Your Family's Assets from Devastating Nursing Home Costs: Medicaid Secrets. The book includes tips on: how to title your home so you do not lose it to the state; how to make transfers to family members that won't disqualify you from Medicaid; how annuities make assets "disappear"; smart tricks for "spending down" your assets; what to change in your

will to save thousands of dollars if your spouse ever needs nursing home care avoiding the state's reimbursement claim following the nursing home resident's death." Government programs should not have secrets and artificially impoverishing oneself to become eligible for a program that was not designed for you is wrong.

In 2006, the NY Post ran an article about Medicaid millionaires in one county in the state. In that year, 9 millionaires had taxpayers paying their bills for Medicaid. One man was worth nearly $2 million and he had Medicaid pick up over $80,000 in nursing home costs for his wife. One woman was worth $1.6 million and she had Medicaid pick up over $200,000 in nursing home costs for her husband. Since half of New York's Medicaid bill is financed by federal taxpayers, taxpayers in my state of South Carolina are paying for millionaires on Medicaid in New York.

About once a decade, Congress revisits the eligibility rules for Medicaid to crack down on their abuse. In the 1993 Omnibus Budget and Reconciliation Act, Congress required states do estate recoveries. In the 2005 Deficit Reduction Act, Congress closed some loopholes and extended Medicaid's look-back period. Today's testimony will reveal whether previous Congressional action in this area has worked.

We all know that tough choices are coming and that there will be strong partisan differences about the way forward. Today's hearing offers us an opportunity to explore an area where there should be genuine bipartisan agreement. If the rules of Medicaid allow individuals sizeable portfolios to qualify for the program and protecting the inheritances of their children, then Medicaid needs reform.

Mr. GOWDY. With that, I now recognize the gentleman from Illinois, the ranking member, Mr. Davis.

Mr. DAVIS. Thank you very much, Mr. Chairman. Let me thank you for holding this very important hearing.

I also want to thank all of the witnesses for being here. I would especially like to thank Ms. Julie Hamos who probably just came in this morning on the flight that I usually take when I want to get here by 10 a.m. And, sometimes the traffic is difficult and you have a hard time making it. Thank you very much, Julie.

Mr. Chairman, I appreciate the importance of this hearing and I am happy to have dialog on this very critical issue.

Since its inception in 1965, I have always said that Medicaid and Medicare were the best things that happened to health care, especially for elderly and low income people in this country, since the Indians discovered corn flakes. I am a firm believer that those individuals who have no other recourse, who have no other way to be cared for, should, in fact, be cared for by the resources that we make available to them.

The Medicaid Program funds one of six of all personal health spending in the United States. Additionally, Medicaid spending has increased to over $400 billion last year. This number gives us pause. Those of us who continue to view Medicaid solely as a budget challenge are missing the mark. This program involves real people and is about real people and their needs.

Policy solutions that focus only on limiting public obligations or long term care financing do the citizens of our country a great injustice. Realistically, individuals and families bear the majority of care giving and financial consequences. Families and friends provide upwards of 80 percent of long term care in the United States. I am open to new ideas to facilitate the care of people across all age groups who are needy and certainly not for those who are simply greedy.

But these discussions cannot be filled with flawed assumptions about peoples' resources. The vast majority of Medicaid's enrollees have limited resources, including the 33 million children, the 11 million persons with disabilities, the 17 million non-disabled adults and the 6 million seniors.

In Illinois, more than 2.7 million Illinois seniors, children and individuals with disabilities rely on Medicaid services and programs. Long term care is a valued program. It includes medical as well as non-medical care to those who have a chronic illness or disability. Long term care helps meet health or personal needs. Most long term care is to assist people with support services such as activities of daily living like dressing, bathing and using the bathroom. Long term care can be provided at home in the community, in assisted living or in nursing homes. The dignity and peace of mind given to people who utilize these services is immeasurable.

Certainly there are those who attempt to misuse the system, but the vast majority of enrollees are simply those who otherwise would not have the wealth or income for such personal daily care. These bad actors must not cause us to throw up our hands and surrender.

I have a term that I often use that says, "I don't ever want to throw out the baby with the bath water." I want to throw out all

of the waste, abuse and misuse of the program that we possibly can. Medicaid must continue to provide coverage based on Federal standards that ensure maximum access for low income and special needs populations with funding allocations based on the needs of these populations.

A meaner Medicaid is not a sufficient solution. Now is not the time to reduce access. Compassion and common sense must prevail. Affordable, accessible quality health care should not be a partisan or political issue but a human one.

Last, I am proud that Ms. Hamos has agreed to join us and I am delighted again that she was able to make it.

I agree with you, Mr. Chairman, I agree wholeheartedly that those individuals who are misusing the system, those individuals who are using it as a way to make sure that they can transfer wealth, all of those efforts that are underway to provide subterfuge, to provide ways to deny access to individuals who really need the services. I will work with you and other Members of this body to exercise, to carve out and get rid of all those individuals and those opportunities.

Again, I thank you for the hearing and look forward to the testimony of the witnesses.

Mr. GOWDY. I thank the gentleman from Illinois.

I would now recognize the gentleman from Arizona, the vice chairman of the subcommittee, Dr. Gosar.

Dr. GOSAR. Mr. Chairman, I would like to echo the concerns that you shared about the unsustainable growth in Medicaid spending.

This is a significant problem in my State of Arizona. The crippling recession of late has affected my State tragically, reducing the money in the General Fund by $2 billion in only a couple short years. The Governor and legislature are finding of the biggest expenses the State has is its Medicaid Program.

In a time when this program meant for low income people in need of basic health care is facing deficits, we need to explore critical reforms that will ensure limited Medicaid dollars reach those who need it most. I think we will find today that long term care eligibility standards in current Federal law do not achieve this goal.

I also agree with you that this hearing should be bipartisan. We have strong disagreements with the massive Medicaid expansion contained in the President's takeover of health care, but we should be able to find common ground. The taxpayer program should not serve as inheritance protection and that the rules that can be navigated so millionaires can qualify for welfare are in desperate need of reform.

According to the law firm, Wright, Abshire in Houston, TX, even if a client's assets are substantial, the firm will be in almost every case be able to successfully achieve a satisfactory plan for the client to preserve assets. An organization in California called Nursing Home Solutions states, "We get middle class families excellent nursing home care funded by Medi-Cal." This advertising makes Medicaid planning sound like the proverbial free lunch.

But while the individual family benefits from taxpayers supporting long term care services received by that individual, there are also clear costs. The obvious cost is to future generations and

business owners who will have to pay this bill and who have the result of less capital to invest in the economy. The less obvious cost is that nursing homes and long term care providers are harmed by more individuals receiving Medicaid's low reimbursement rate.

So the policy question is, who should bear the burden of paying the cost of long term care? It would be convenient to say the other guy, but what happens when the other guy is tapped out? Taxpayers are simply tapped out and our Nation is running a $1.6 trillion deficit for the third straight year.

Our friends on the other side of the aisle may say this cost should be socialized, but that solution is misguided for two reasons. The first is that we need to be figuring out ways to reform Medicare and Medicaid, not to expand it. The second is that it runs counter to the obvious principle that individuals spend their own money better than they spend other people's money. Since the private sector does most things better than the government, can the private sector play a role in figuring out a way out of this problem?

I respectfully assert that the free market solutions have never been able to take hold in the market for long term care because of Medicaid. Since it is so easy to get taxpayers to foot a person's long term care needs, individuals don't have any incentive to plan for these expenses.

Don't take my word for it, whoever, In 2008, Jeff Brown at the University of Illinois and Amy Finklestein of MIT wrote an article entitled, "The Interaction of Public and Private Insurance, Medicaid and a Long Term Care Insurance Market." This article appeared in the Nation's most prestigious peer-reviewed economics journal, American Economic Review.

The findings are that all but the wealthiest households in the country have virtually no reason to purchase long term care insurance. This is because a private policy pays for many benefits that simply replace benefits Medicaid would have paid for. It is important to note that Brown and Finklestein did not even account for the art of Medicaid planning. They assumed that people actually have to spend down their assets in order to qualify for Medicaid.

Therefore, it is unfair to criticize the private, long term care insurance industry for lack of policies. A private insurer is not competing on a level playing field with Medicaid since Medicaid is so heavily subsidized.

The way I see it is, the choice is clear. We can fail to reform these rules. This would continue to allow relatively affluent individuals on welfare to discourage all of us from taking seriously the possibility of needing to take care of long term care in the future. This failure will doom the whole system as a whole.

The alternative is to reform the rules and reduce the loopholes. Real reform should prevent affluent people from qualifying for welfare with the effect of preserving the inheritance of their adult children. Real reform would also promote personal responsibility and awaken Americans to the fact that while living longer is a great thing, it comes with the possibility of requiring assistance. Real reform would preserve taxpayer dollars to assist genuinely needy individuals in getting care. Real reform would reduce Medicaid burden on State budgets and the Federal budget and would decrease the amount of money that Washington borrows from abroad.

Mr. Chairman, thank you for calling this hearing. I eagerly await the testimony of our witnesses to learn more about this issue and steps that can be taken to reform the program.

I yield back.

Mr. GOWDY. I thank the gentleman from Arizona.

I would also like to recognize and thank the gentlemen from Missouri and Tennessee, respectively, for their presence and their contributions to this subcommittee.

Members may have 7 days to submit opening statements and extraneous material for the record.

It is now my pleasure to welcome our distinguished panel of witnesses. I will introduce you at once and then we will go from my left to right, your left to right, in terms of opening remarks.

Mr. Stephen Moses is the president of the Center for Long-Term Care Reform. Mr. David Dorfman is an attorney with the law offices of David A. Dorfman. Ms. Janice Eulau is the assistant administrator, Medicaid Services Division, Suffolk County Department of Social Services. My friend, Mr. Davis, joins me in introducing and welcoming the Honorable Julie Hamos, director of the Illinois Department of Healthcare and Family Services.

Pursuant to committee rules, all witnesses will be sworn before they testify, so I would ask you to please rise and raise your right hands.

[Witnesses sworn.]

Mr. GOWDY. Let the record reflect that the witnesses answered in the affirmative.

Mr. Moses, we will start with you. The lights, which I hope you can see, mean what they traditionally mean. Green means go. Yellow, unlike in real life does not mean speed up and see if you can get under it, means you have about a minute left and then, red means conclude your last comment if you can.

With that, again on behalf of all of us, thank you. We are honored to have such a distinguished group of witnesses.

Mr. Moses.

STATEMENTS OF STEPHEN MOSES, PRESIDENT, CENTER FOR LONG-TERM CARE REFORM; DAVID DORFMAN, ATTORNEY, LAW OFFICES OF DAVID A. DORFMAN; JANICE EULAU, ASSISTANT ADMINISTRATOR, MEDICAID SERVICES DIVISION, SUFFOLK COUNTY DEPARTMENT OF SOCIAL SERVICES; AND JULIE HAMOS, DIRECTOR, ILLINOIS DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

STATEMENT OF STEPHEN MOSES

Mr. MOSES. Thank you, Mr. Chairman and members of the committee. Thank you for inviting me to speak to you about Medicaid and long-term care financing today.

I have worked in this field since 1981, first as a career U.S. Government employee with the Health Care Financing Administration, the predecessor of the current CMS; then for the Inspector General of the U.S. Department of Health and Human Services; and since 1989, in the private sector. I am currently president of the Center for Long-Term Care Reform.

In each of these roles, I conducted national and State studies of Medicaid and long-term care financing. My remarks today are fully developed and documented in published reports available on our Web site at centerltc.com.

Medicaid is supposed to be a long-term care safety net for people in dire financial need. Instead, it has become the dominant payer for most Americans who require extended care at home or in a nursing, including the middle class and even the affluent. How can this be true if Medicaid is a means-tested public assistance program? That is the key question before you today. Here is the answer.

Although everyone says Medicaid eligibility requires low income, that is untrue for people over the age of 65 who need long term care. Federal rules require most States to deduct medical expenses, including the cost of nursing home care, from applicants' income before determining eligibility. Some States apply income caps but these are easily evaded by means of special income diversion trusts. Bottom line, income almost never disqualifies anyone for Medicaid long term care eligibility.

What about assets? It is true that cash and negotiable securities over $2,000 are disqualifying in most States, but it doesn't matter how people spend down to that level as long as they don't give away their assets. Financial advisors frequently tell clients to purchase exempt assets, take a world cruise, throw a big party, all non-disqualifying spend-down methods.

Just how many exempt assets can applicants retain and still qualify for Medicaid long-term care benefits? There really is no meaningful limit. Exempt home equity is capped at $500,000 to $750,000 which is 13 to 20 times the amount protected in England's socialized health care system.

The following resources are exempt without any limit: one business including the capital and cash-flow; individual retirement accounts or IRAs; one automobile; prepaid burial plans not only for the Medicaid recipient but for all immediate family members; term life insurance which allows recipients to evade the Medicaid estate recovery mandate; and household goods and personal belongings, all without any capped limits.

The Federal regulations and policies that require these exemptions are documented in our report entitled, "Medi-Cal Long-Term Care: Safety Net or Hammock." Medi-Cal is Medicaid in California and these problems and issues apply nationwide.

Married applicants for Medicaid LTC benefits can retain substantially more income and assets than single people, up to $2,739 per month of income and half the joint assets of the couple up to $109,500. If the healthy spouse's personal income and assets are below these levels, the Medicaid spouse's income and assets are transferred to bring him or her up to the limit. These spousal impoverishment protections increase annually with inflation.

Because of these very generous basic eligibility rules, the vast majority of America's elderly qualify easily for Medicaid when they need long term care. The conventional wisdom that people must spend down into impoverishment before Medicaid will help is demonstrably untrue. Only the most affluent need to consult Medicaid planners and use special legal techniques such as trusts,

transfers, annuities, life estates, life care contracts and promissory notes to qualify.

The other panelists will discuss Medicaid planning. The key point I want to make is that we need to remember that egregious Medicaid planning is only the tip of the iceberg. The bigger problem is that Medicaid's basic eligibility rules allow most people to qualify after they need long term care and without spending down their wealth first.

To conclude, easy access to Medicaid has the effect of desensitizing the public to long term care risks and costs. Medicaid's home equity exemption prevents people from using reserve mortgages to finance home care. With most of their assets protected by Medicaid, few people plan early to save, invest or insure for long term care.

Well intentioned public policy has turned into a perverse incentive discouraging responsible long term care planning. Furthermore, consuming scarce public welfare resources to indemnify affluent baby-boomer heirs of well-to-do seniors hurts the poor instead of helping. It is like friendly fire in the class war.

Medicaid could save up to $30 billion per year if people had to consume their home equity before qualifying for public benefits as is true in England. The program's most expensive dual eligible recipients could be reduced by 20 percent. Reverse mortgages to fund long term care would thrive and generate new jobs and tax revenue.

The private long term care insurance market would expand creating even more jobs and revenue, but most importantly, relieving the financial pressure on Medicaid in this way would enable the program to survive as a quality safety net for those who are truly in need.

My analysis explaining how Medicaid can save $30 billon per year by encouraging financing of long term care through private financing alternatives has been made available to the committee.

Thank you.

[The prepared statement of Mr. Moses follows:]

Testimony before the House Oversight and Government Reform Subcommittee on Healthcare by Stephen A. Moses, President, Center for Long-Term Care Reform (www.centerltc.com) on September 21, 2011

"Medicaid Long-Term Care Benefits: Friendly Fire in the Class War"

Mr. Chairman and members of the Committee: thank you for inviting me to speak to you about Medicaid and long-term care financing.

I've worked in this field since 1981, first as a career federal employee with the Health Care Financing Administration, then for the Inspector General of the U.S. Department of Health and Human Services, and since 1989 in the private sector. I am currently president of the Center for Long-Term Care Reform. In each of these roles, I conducted national and state studies of Medicaid and long-term care financing policy. My remarks today are fully developed and documented in published reports available on our website at www.centerltc.com.

Medicaid is supposed to be a long-term care safety net for people in dire financial need. Instead it has become the dominant payer for most Americans who require extended care at home or in a nursing home, including the middle class and even the affluent. How can this be true if Medicaid is a means-tested, public assistance program? That is the key question before you today. Here's the answer.

Although everyone says Medicaid eligibility requires low income, that is untrue for people over the age of 65 who need long-term care. Federal rules require most states to deduct medical expenses, including the cost of nursing home care, from applicants' incomes before determining eligibility. Some states apply "income caps" but those are

easily evaded by means of special "income diversion trusts." Bottom line, income almost never disqualifies anyone for Medicaid long-term care eligibility.

But what about assets? It is true that cash or negotiable securities over $2,000 are disqualifying in most states, but it doesn't matter how people spend down to that level as long as they don't give their money away. Financial advisors frequently tell clients to purchase exempt assets, take a world cruise, or throw a big party, all non-disqualifying spend down methods.

Just how many exempt assets can applicants retain and still qualify for Medicaid LTC benefits? There really is no meaningful limit. Exempt home equity is capped at $500,000 or $750,000--13 to 20 times the amount protected in England's socialized health care system--but the following resources are exempt *without any limit*:

- One business including the capital and cash flow
- Individual retirement accounts (IRAs)
- One automobile
- Prepaid burial plans for the Medicaid recipient and immediate family members
- Term life insurance, which allows recipients to evade Medicaid's estate recovery mandate
- Household goods and personal belongings

The federal regulations and policies that require these exemptions are documented in our report titled "Medi-Cal Long-Term Care: Safety Net or Hammock?," a copy of which has been made available to the Committee.

Married applicants for Medicaid LTC benefits can retain substantially more income and assets than single people: up to $2,739 per month of income and half the

couple's joint assets not to exceed $109,500. If the healthy spouse's personal income and assets are below these levels, the Medicaid spouse's income and assets are transferred to bring her or him up to the limit. These "spousal impoverishment" protections increase annually with inflation.

Because of these very generous basic eligibility rules, the vast majority of America's elderly qualify easily for Medicaid when they need long-term care. The conventional wisdom that people must spend down into impoverishment before Medicaid will help is demonstrably untrue. Only the most affluent need to consult Medicaid planners and use special legal techniques--such as trusts, transfers, annuities, life estates, life care contracts and promissory notes--to qualify. The other panelists will discuss Medicaid planning. The key point to remember is that egregious Medicaid planning is only the tip of the iceberg. The bigger problem is that Medicaid's basic eligibility rules allow most people to qualify after they need long-term care and without spending down their wealth first.

Easy access to Medicaid has the effect of desensitizing the public to LTC risk and cost. Medicaid's home equity exemption prevents people from using reverse mortgages to finance home care. With most of their assets protected by Medicaid, few people plan early to save, invest or insure for long-term care. Well intentioned public policy has turned into a perverse incentive discouraging responsible LTC planning. Furthermore, consuming scarce public welfare resources to indemnify affluent baby-boomer heirs of well-to-do seniors hurts the poor instead of helping. It's like friendly fire in the class war.

Medicaid could save up to $30 billion per year if people had to consume their home equity before qualifying for public benefits as is true in England. The program's

most expensive "dual eligible" recipients could be reduced by 20 percent. Reverse mortgages to fund long-term care would thrive and generate new jobs and tax revenue. The private long-term care insurance market would expand creating even more jobs and revenue. But most importantly, relieving the financial pressure on Medicaid in this way would enable the program to survive as a quality safety net for the truly needy.

My analysis explaining how Medicaid can save $30 billion per year by encouraging financing of long-term care through reverse mortgages and private insurance has been provided to the Committee.

Thank you for your attention.

Mr. GOWDY. Thank you, Mr. Moses.
Mr. Dorfman.

STATEMENT OF DAVID DORFMAN

Mr. DORFMAN. Good morning, Mr. Chairman, and members of the committee. Thank you so much for having me here this morning.

My name is David Dorfman and for about the last 20 years until January of this year, I practiced Medicaid planning law in Manhattan, Brooklyn and Queens.

I came to elder law out of a family experience. My grandmother and her two sisters all went to Portia Law School, the first law school for women in Boston in the 1930's. I grew up with elder law around the house, when her friends would come over to probate their husbands' wills, to transfer keys to the children, to take care of those family matters that her senior friends had.

When I began my practice, OBRA 93 had just become the law and I attended Bar Association meetings, met leaders in the Medicaid legal field and began teaching other people how the system works because while Medicaid is certainly not a secret program, it is so difficult for people to understand how it works, given the massive unfairnesses and confusion in qualifying for benefits.

My clients would come to me typically because they had a spouse who had Parkinson's or Alzheimer's, a parent who needed care, and they didn't know what to do. They weren't sure what their options were. What we set about doing was educating people as to how the system works and creating an individual, tailored plan, much like for health care, what was the best thing for that particular individual to do.

It might be trusts or annuities, changing title to the home, investing in pensions or insurance, but I am going to suggest that the abuse is a myth. That is not really what is happening. That is not what any of my clients wanted. None of them wanted to game the system. They all wanted to know what should I do, the same way a woman whose husband has had a stroke says to the doctor, what am I supposed to do, they say to the social worker, what am I supposed to do, how am I supposed to live, where will I be living, what will happen to the pension, the social security, who is going to provide the care?

Soup kitchens are free and nobody checks 5 years worth of bank statements and millionaires don't go there for lunch.

In terms of creating a health care system, we don't need a punishment health care system, periods of ineligibility or penalty periods. We need a system that has a cost sharing approach that invites people in so they can access necessary care and share in the costs. That is what people want, not an all or nothing approach. We can't mandate abject poverty because that is what people are terrified of. If that has to be created, no matter what the rules are, people will do whatever they have to do to get the necessary health care for their loved ones or they will suffer and die without care.

I saw people who were increasingly afraid to get care as Medicaid laws became more onerous, people who qualified for benefits, people who were poor and needed health care but didn't fill out the application because they didn't have the bank statements. Let us

create a system that invites people in who need care, not one that punishes them.

Thank you.

[The prepared statement of Mr. Dorfman follows:]

Examining Abuses of Medicaid Eligibility Rules:

For almost twenty years I practiced Medicaid Planning Law in Manhattan, Brooklyn and Queens. Many of my clients were the spouses and children of Alzheimer's and Parkinson's patients. Sometimes patients themselves. They were middle class and in the middle of a health care and financial crisis.

Recognizing the cost of long term care my clients wanted to protect assets and qualify for Medicaid to pay for long term care. Specifically they wanted assistance paying for in home care and nursing home care. They used a variety of techniques to accomplish this. Sometimes it was transferring assets other times spending them. I counseled many clients on the use of trusts and directed others to purchase annuities. I drafted documents to evidence loans and family care agreements. We converted countable resources to non-countable ones and attempted to maximize benefits and minimize costs. In short, we did what anyone would do. Whatever seemed best to protect the family considering health care costs and a families particular financial situation.

I began my practice before OBRA 93. Since then I have studied and taught other about changes in the Medicaid Eligibility Rules. I have taught at the Association of the Bar of the City of New York, the National Academy of Elder Law Attorneys, the Alzheimer's Association, Parkinson's Foundation and many other organizations. I joined many clubs, associations and groups that practiced Medicaid planning and regularly discussed techniques with other lawyers, financial professionals, social workers and others with interest.

I watched the law go from bad to worse. We had a system that needed improvement when I began my practice and changes went steadily in the wrong direction. We created a system the scares sick people and their families with penalties and criminology. It left my clients not knowing what to do and not accessing necessary care when they needed it.

The methods to qualify people for Medicaid have not changed very much in essence even as the names and document were adjusted. At the same time the burden of every applicant has grown enormously. People do not have five years of documented financial history. They do not know what disqualifying transfer means. Everyone is afraid of being penalized.

The problem was rarely an abuse of rules. It was the rules themselves. Our rules should guide people with illness to care. They should not stand as a barrier between sick people and their ability to get the care that they need. The current rules are onerous, convoluted and counterintuitive. They cause people to suffer and die without receiving care because of fear. Instead we need a cost sharing approach, not a poverty one.

Looking for an imaginary cheater we have rules that are overly burdensome to the patients and their families that need our help. Current and preposed rules delay

necessary care rather than effectuating it. The problems are not even the case of a few people abusing the system causing a burden on everyone but the image of abuse causing harm. Do not be afraid that undeserving sick people will be provided with care.

I never met a client who was not willing to share the burden of the cost of care. Only people who were afraid that they'd run out of money and be without. They were afraid that their families would suffer. They wanted the best possible plan.

Our system must be one of care and not penalties. A period of ineligibility is a prescription for abuse. The abuse of not being cared for. We cannot tell sick people that they are ineligible for care but must instead reform our rules to direct people to care with a cost sharing approach.

We protect peoples homes some of the time. People do not understand life estates, estate recovery, intent to return home. We protect homes but not the income necessary to pay the costs of maintaing those homes. People should be cared for in their homes, not in nursing homes. Protect them in their homes and provide cost sharing that enables care without abject poverty.

My short conclusion is that abuse of Medicaid Eligibility Rules is a myth. A Powerful and potent myth but a myth nonetheless. I met almost no one who wanted to cheat. Only people who wanted to do what was the best, most responsible thing for their loved ones.

Those who did cheat and were caught by the Office of Revenue and Investigations settled cases easily and for pennies on the dollar.

Everyone is entitled to some amount of care when they are in need. However we had a system that is not fair or equitable providing generously for some and not at all for others.

We must have a system that invites people in with a cost sharing approach. Not a system that has penalties and punishments for the elderly who need care

We should not be afraid of a complex system that can adjust for patients in may different circumstance. Each patient receives an individualized plan of care and the care system preform better on this basis. Medicaid too can be individualized to provide cost sharing for each beneficiary, not an all or nothing approach.

Promulgating more onerous transfer of asset rules will not deter the most creative individuals or planners. It only hurts more typical beneficiaries. Currently creative planning allows gifts and applications to begin penalties followed by return of assets to cure them. Our most novel discussions include fantasy ideas like Medicaid planning through baseball cards. While potentially lawful, no actual client wanted to use this kind of approach.

People want security and care. They save for a lifetime and fear running out of money and being left without. Seniors take their own lives to avoid being a burden on their families. Proper Medicaid law can ease these burdens.

An Alzheimer's patient in a New York City nursing home can cost spend Fourteen Thousand dollars a month on care. In the alternative Medicaid will pay the same nursing home about Ten Thousand dollars a month for the same care. Caring for an Alzheimer's patient does not really cost that much. Most patients receive family care in the home at a fraction of the cost.

Rich people do not go to our soup kitchens. Food pantries do not ask for five years of bank statements. The food is free and yet not abused.

Provide basic, humane benefits to everyone without penalties. Do not fear sick people getting care and not paying for it. The people who can afford it will buy better care. Provide something for everyone without a penalty system and everyone will benefit.

Finally, please consider the Veterans Administration Medical Foster Care Homes as an approach that should be duplicated in our Medicaid program.

I have never received any federal grants or contracts and testify on my own behalf.

David Dorfman

Mr. GOWDY. Thank you, Mr. Dorfman.
Ms. Eulau.

STATEMENT OF JANICE EULAU

Ms. EULAU. Good morning, Chairman Gowdy, Ranking Member Davis and members of the subcommittee. Thank you for the opportunity to speak to you today about this important topic.

My name is Janice Eulau and I have been employed by the Suffolk County, New York Department of Social Services for the past 36 years. I currently serve as the assistant administrator for the Medicaid Program in that county.

Approximately 180,000 individuals receive Medicaid in Suffolk County with 5,300 in receipt of nursing home care. In 2010, the nursing home care costs for those 5,300 individuals was $429.9 million with a Federal cost of $213.7 million.

As a long-time employee of the local Medicaid office, I have had the opportunity to witness the diversion of applicants' significant resources in order to obtain Medicaid coverage. It is not at all unusual to encounter individuals and couples with resources exceeding $500,000, some with over $1 million.

There is no attempt to hide that this money to exists, there is no need. There are various legal means to prevent those funds from being used to pay for the applicant's nursing home care. Wealthy applicants for Medicaid's nursing home coverage consider that benefit to be their right, regardless of their ability to pay themselves. There is limited understanding that Medicaid nursing home care remains a means tested program not an entitlement program. This misunderstanding seems to be perpetuated by the elder law and Medicaid estate planning industry.

The two most often used by single clients is the promissory note. Half of the applicant's excess resources transfer to the children without compensation. This transfer results in a penalty period where Medicaid will not pay for nursing home care, approximately 1 month for every $10,000 transferred. The other half of the excess resource is also transferred to the children but in return for a promissory note which will produce an income stream to cover the cost of care during the penalty period. Our county regularly sees promissory notes in excess of $150,000 with matching, uncompensated transfers.

For couples, the most common method of preserving resources is spousal refusal. In this case, the spouse in the nursing home transfers all resources beyond those he is allowed to keep to the well spouse living at home, since transfers to a spouse do not incur a penalty period. In New York, the institutionalized spouse may retain $13,800. The spouse living at home can retain up to $109,000. In addition, the home and prepaid burial expenses are exempt.

Any amount in excess of these resources is deemed available to meet nursing home costs. However, Federal law allows the spouse at home to refuse to support the applying spouse and requires States to then base Medicaid eligibility determination on the income and assets of only the applying spouse.

States then have the right to bring support proceedings against the refusing spouse. My county has pursued the refusing spouse in the past. However, in family court, we are only allowed to address

the excess income and attach resources for past Medicaid payments. Any future proceedings would need to be addressed in New York Supreme Court, a process that would take months or years for each case and severely strain our limited local resources.

The remedy for these abuses lies in education as well as changes to law. Many seniors believe that Medicare and their supplemental insurance policy will pay for the nursing home care when in fact these policies will only pay up to 100 days of care and only under certain circumstances.

Medicaid communication through their annual handbook and their official Web site is woefully lacking information in this area. Not surprisingly, wealthy seniors fail to realize the value or need for long term care insurance. Having a better understanding of the limits of Medicaid would enable seniors to make timely and informed decisions regarding their future care needs. In addition, incentives for the purchase and use of long term care insurance should be provided by the Federal Government.

I also respectfully suggest that the law allowing spousal refusal be adjusted to enforce the current resource limit and allow the spouse at home to petition court for higher resource levels should his or her circumstances call for such an increase instead of requiring the State to address each refusal. Allowing wealthy spouses to ignore their financial responsibility to one another is a policy we cannot afford.

In closing, I would hope that the Medicaid Program can fulfill its original mission, to provide quality health coverage to individuals who are unable to afford such care or the insurance to pay for this care. However, individuals with resources above and beyond the level prescribed by law should not be allowed to fund their children's inheritance while the taxpayers fund their nursing home care. I strongly believe this is not a partisan issue. I also believe in the merits of the Medicaid Program but feel just as deeply that these issues regarding resource diversion need to be addressed.

Thank you.

[The prepared statement of Ms. Eulau follows:]

Janice Eulau
September 21, 2011

Testimony before the Subcommittee on Health Care, District of Columbia, Census and the National Archives

Topic: Examining Abuses of Medicaid Eligibility Rules

Good Morning Chairman Gowdy, Ranking Member Davis and members of the committee and thank you for the opportunity to speak to you today about this important topic.

My name is Janice Eulau and I have been employed by the Suffolk County New York Department of Social Services for the past 36 years. I currently serve as the Assistant Administrator for the Medicaid program in that county. Approximately 180,000 individuals receive Medicaid in Suffolk with 5,300 in receipt of nursing home care. In 2010 nursing home care for those 5,300 recipients cost $429.9 million with a federal share of $213.7 million.

As a long time employee of a local Medicaid office, I have had the opportunity to witness the diversion of applicants' significant resources in order to obtain Medicaid coverage. It is not at all unusual to encounter individuals and couples with resources exceeding a half million dollars, some with over one million.

There is no attempt to hide that this money exists; there is no need. There are various legal means to prevent those funds from being used to pay for the applicant's nursing home care.

Wealthy applicants for Medicaid's nursing home coverage consider that benefit to be their right, regardless of their ability to pay themselves. There is limited understanding that Medicaid for nursing home care remains a means-tested government program, not an entitlement program. This misunderstanding seems to be perpetuated by the Elder Law and Medicaid Estate Planning industry.

A tool most often used by single clients is the promissory note. Half of the applicant's excess resource is transferred to the children without compensation. This transfer results in a penalty period where Medicaid will not pay for nursing home care, approximately 1 month for every $10,000 transferred. The other half of the excess resource is also transferred to the children, but in return for a promissory note which will produce an income stream to cover the cost of care during the penalty period. Our county regularly sees promissory notes in excess of $150,000 with matching uncompensated transfers.

For couples, the most common method of preserving resources is spousal refusal. In this case, the spouse in the nursing home transfers all resources beyond those he is allowed to keep to the well spouse living at home, since transfers to a spouse do not incur a penalty period. In New York the institutionalized spouse may retain $13,800, the spouse living at home can retain up to $109,000. In addition, the home and pre-paid burial expenses are exempt. Any amount in excess of these resources is deemed available to meet nursing home costs. However, federal law allows the spouse at home to refuse to support the applying spouse and requires states to then base the Medicaid eligibility determination on the income and assets of only the applying spouse. States have the right to bring support proceedings against the refusing spouse. My county has pursued the refusing spouse in the past, however family court is only able to address the excess income and attach resources for past Medicaid payments. Any further proceedings would need to be addressed in New York's Supreme Court, a process that would take months or years for each case and strain our limited local resources.

Janice Eulau
September 21, 2011

The remedy for these abuses lies in education as well as changes to law. Many seniors believe that Medicare and their supplemental insurance policies will pay for their nursing home care, when, in fact, these policies will only pay up to 100 days of care, and only under certain circumstances. Medicare communication through their annual handbook and on their official website is woefully lacking information in this area. Not surprisingly, wealthy seniors fail to realize the value or need for Long Term Care Insurance. Having a better understanding of the limits of Medicare would enable seniors to make timely and informed decisions regarding their future care needs. In addition, incentives for the purchase and use of Long Term Care Insurance should be provided by the federal government.

I also respectfully suggest that the law allowing spousal refusal be adjusted to enforce the current resource limits and allow the spouse at home to petition the court for higher resource levels should his/her circumstances call for such an increase instead of requiring the state to address each refusal. Allowing wealthy spouses to ignore their financial responsibility to one another is a policy we cannot afford.

In closing, I would hope that the Medicaid program can fulfill its original mission to provide quality health coverage to individuals who are unable to afford such care or the insurance to pay for care. However, individuals with resources above and beyond the level prescribed by law should not be allowed to fund their children's inheritance while the taxpayers fund their nursing home care. I strongly believe that this is not a partisan issue. I also believe in the merits of the Medicaid program, but feel just as deeply that these issues regarding resource diversion need to be addressed.

Thank you.

Mr. GOWDY. Thank you, Ms. Eulau.
Ms. Hamos.

STATEMENT OF JULIE HAMOS

Ms. HAMOS. Thank you.

Good morning, members of the subcommittee and Mr. Chairman.

I am Julie Hamos, director of the Illinois Department of Healthcare and Family Services, which among our other responsibilities, manages one of the largest Medicaid programs in the Nation. Illinois serves 2.7 million clients through Medicaid and SCHIP at an overall program cost of $16.6 billion.

Today, we are talking about eligibility policies for Medicaid long term care and this, for us in Illinois, is a most propitious time to be talking about this since we are tackling this exact issue. As a new director of HFS last April, I learned that Illinois' previous administration had not yet implemented the Federal DRA that passed in 2006.

Accordingly, almost immediately when I came in, we set to work to create rules involving Medicaid eligibility for long term care, rules that incorporate the DRA but go beyond it to actually deal with the loopholes that you are hearing about today since we have now learned from the experiences of other States.

Some of those loopholes are, in fact, spelled out in the Council for Long Term Care Report that I have read very closely. I have to be honest and tell you that this is a struggle in Illinois to convince our legislative rulemaking committees to adopt these rules. This is not a Democrat nor Republican problem. There seems to be, much to my surprise, a bipartisan acceptance of the so-called Medicaid estate planning practices that allow people to divest their assets in order to qualify for Medicaid nursing homes. The paper, I think, articulates the problem which is that there is no stigma attached to this.

We agree with you that it is our responsibility to eliminate any abuse in the Medicaid Program and we are working hard right now to move along on some of these reforms. Today, I would like to touch on two other issues that have the potential to drive down Medicaid costs for long term care.

Of our 2.7 million clients, 14 percent are seniors and adults with disabilities, yet these 14 percent of Medicaid clients incur 54 percent of the costs. Many of these same clients are also expensive dually eligible Medicare clients. While we are fully committed to providing for their care and maintenace, most of them really are low income and very vulnerable people, and they need long term care, but our focus is all about service delivery reform.

Illinois historically has had an institutional bias building up state-operated institutions and nursing home beds. We currently have an excess of 15,000 empty nursing home beds, so we have overbuilt on that side but we have failed to invest in home and community-based services, obviously at a much better cost.

We believe that we can achieve Medicaid savings and promote a higher quality of life for seniors and disabled who prefer to stay in their homes by rebalancing our long term care system to shift from nursing homes and make investments in home and community-based services.

In addition, many health care services are fragmented for both Medicaid and Medicare and result in unnecessary and wasteful hospitalizations with the revolving door of admissions and readmissions to acute care hospitals, to psych wards of hospitals and to free-standing psychiatric hospitals.

In order to drive down these costs, Medicaid must, in conjunction with Medicare for those who are dually eligible, provide care coordination for these most complex and expensive clients who have chronic health and behavior health conditions with the goal of keeping them healthier, stable in the community and not in hospitals but in community-based long term care.

I just want to convey to you that in this period of the Affordable Care Act planning, we are spawning an era of innovation in the health care delivery system. Federal CMS is offering incentives and guidance almost daily to encourage us to focus on quality healthcare and health outcomes in home and community-based settings that will ultimately result in cost savings for both Medicaid and Medicare.

I urge you to maintain the Federal funding for State Medicaid programs and funding for these Federal demonstrations, waivers, innovations and policy initiatives. They present the unique opportunity to truly transform the Medicaid Program into a more effective and efficient health care system.

Thank you.

[The prepared statement of Ms. Hamos follows:]

ILLINOIS DEPARTMENT OF
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TESTIMONY BEFORE U.S. HOUSE SUBCOMMITTEE ON

HEALTH CARE, DISTRICT OF COLUMBIA, CENSUS AND NATIONAL ARCHIVES

September 21, 2011

Thank you for inviting me to testify before this Subcommittee. I am Julie Hamos, the Director of the Illinois Department of Healthcare and Family Services, which, among other responsibilities, manages one of the largest Medicaid Programs in the nation. Illinois serves 2.7 million clients through Medicaid and SCHIP, at an overall program cost of $16.6 billion.

You have asked us to comment on eligibility policies for Medicaid long-term care. This is a most propitious time for us to be discussing this, as we are tackling this exact issue in Illinois. As a new director of HFS last April, I learned that Illinois' previous administration had not yet implemented the federal DRA that passed in 2006.

Accordingly, we set to work to create rules involving Medicaid eligibility for nursing homes – rules that incorporate the DRA, but also, as authorized by federal law, to attempt to close loopholes that had been discovered by our colleagues in other states. Some of those loopholes are spelled out in the paper on the New York Medicaid Program written by the Center on Long Term Care.

I have to be honest in telling you that it is a struggle to convince our legislative rule-making committee to adopt these rules. This is not a Democratic problem, nor a Republican problem – it is a bipartisan acceptance of so-called "Medicaid planning" practices that allow people to divest their assets in order to qualify for Medicaid nursing homes. The paper articulates the problem: there is no stigma attached to this practice – to the detriment of the most low-income and vulnerable people who need our scarce Medicaid dollars even more. We agree with you that it is our responsibility to eliminate any abuse of the Medicaid Program.

Today, I would like to discuss two additional long-term care issues that have the potential to drive down the costs of Medicaid. Of our 2.7 million clients, 14% are seniors and adults with

disabilities, yet these 14% of Medicaid clients incur 54% of our costs. Many of these same clients are also expensive dually-eligible Medicare clients. While we are fully committed to providing for their care – and most need some form of long-term care -- these clients are a major focus for service reform. Illinois historically has had an institutional bias, building up state-operated institutions and nursing home beds. We have overbuilt nursing homes with 15,000 empty beds today, and underfinanced home and community based services. We spend at least three times as much for a nursing home stay than for the limited set of in-home services we offer to seniors. We will achieve Medicaid savings – and promote a higher quality of life for seniors and the disabled who would prefer to stay at home – by rebalancing our long-term care system to shift from nursing homes to investments in home and community-based services.

In addition, many healthcare services are fragmented and result in unnecessary and wasteful hospitalizations, with a revolving door of admissions and readmissions to acute care hospitals, to psych wards of hospitals and to free-standing psychiatric hospitals. In order to drive down these costs, Medicaid must – in conjunction with Medicare for those who are dually-eligible – provide care coordination for these most complex and expensive clients with chronic health and behavioral health needs, with the goal of keeping them stable and healthier, not in hospitals but in community-based long-term care.

Let me conclude by relaying that the Affordable Care Act is sparking an era of innovation in the healthcare delivery system. Federal CMS is offering incentives and guidance, almost daily, to encourage us to offer coordinated services that focus on quality care and health outcomes, in home- and community-based settings, that will ultimately result in cost savings for Medicaid as well as Medicare.

I urge you to maintain the federal funding for state Medicaid programs and funding for these federal demonstrations, waivers, innovations and policy strategies. They present an opportunity to truly transform the Medicaid Program into a more effective and efficient healthcare system.

Julie Hamos, Director, Department of Healthcare and Family Services, Julie.hamos@illinois.gov

Mr. GOWDY. Thank you.

I will recognize myself for 5 minutes of questions.

Mr. Dorfman, what is the purpose of Medicaid?

Mr. DORFMAN. The purpose of Medicaid is to provide health care.

Mr. GOWDY. Universal health care or just for the indigent?

Mr. DORFMAN. The program has financial qualifications which——

Mr. GOWDY. I hadn't gotten to those yet. I am just asking you a general question. Do you think the purpose of Medicaid is to provide universal health care or only for the indigent?

Mr. DORFMAN. Health care for anyone who qualifies for the program.

Mr. GOWDY. Do you agree with me that there is a difference between actual indigency and legal indigency?

Mr. DORFMAN. Absolutely, there is an incredible distinction.

Mr. GOWDY. So people can voluntarily impoverish themselves?

Mr. DORFMAN. People can voluntarily impoverish themselves.

Mr. GOWDY. To become eligible for government programs?

Mr. DORFMAN. Absolutely.

Mr. GOWDY. Do you think that is consistent with the underlying purpose and mission behind Medicaid?

Mr. DORFMAN. It absolutely can be, yes.

Mr. GOWDY. You seem to take exception to my characterization of people gaming the system. You don't believe that millionaires who voluntarily impoverish themselves so their heirs can inherit money and taxpayers can provide for their Medicare, you don't consider that gaming the system?

Mr. DORFMAN. No, because that is not most of what happens or the way it happens. There are those aberration cases.

Mr. GOWDY. Are there millionaires who have voluntarily impoverished themselves so their children can have an inheritance and we can pay for their long term care?

Mr. DORFMAN. That is not the typical experience across 20 years of doing Medicaid planning, although there are certainly exceptions.

Mr. GOWDY. When people come, and I am not trying to violate any attorney-client privilege, but when people come to seek your counsel, how often do they come by themselves and how often do they come with their adult children?

Mr. DORFMAN. They frequently come with their adult children. It is almost always with either a spouse or an adult child, unless it is an isolated individual who doesn't have family.

Mr. GOWDY. You consider your client to be whom, the individual or the children?

Mr. DORFMAN. The client is always the individual, but the individual is almost always concerned about what is going to happen to their spouse or family members.

Mr. GOWDY. Speaking of spouses, Mr. Moses, what is spousal refusal?

Mr. MOSES. Well, that is a practice recognized primarily in New York and Florida whereby the well spouse, as Ms. Eulau explained, simply refuses to contribute under normal Medicaid requirements for the cost of the care of the Medicaid recipient. Under the law, the Medicaid recipient has to have assigned his or her rights to the

wealth in essence so that the State can go after the well spouse for what is legally owed but this rarely happens because it is so complicated to do.

The Elder Law Bar in frequent annual conferences urges the rest of the country to take advantage of what they consider our right under the Federal law to simply have the spouse refuse to contribute to the cost of the care. It is very, very expensive in New York and Florida. Frankly, I don't think most of the other States have the impunity to try to pull that off.

Mr. GOWDY. Before I ask you about key payments, Mr. Dorfman and I disagree a little bit about the purpose of Medicaid. I think it is for the indigent, he thinks it is for whomever qualifies. What do you think?

Mr. MOSES. Well, there are problems in how Medicaid eligibility is determined so that there are what some people call loopholes but there are provisions in the law that make it quite easy and feasible for people with substantial wealth to qualify. As I explained in my testimony, the real problem is not just the tip of the iceberg which is the egregious Medicaid planning millionaires onto welfare, as Mr. Dorfman was saying, the real problem is that the median elderly person in terms of income and assets walks right onto Medicaid because of all of the exempt assets without limit.

So really it is difficult to characterize the program as a program for the indigent because over the years through the intent of Congress, the program has been expanded. I call it eligibility bracket creep to the point where virtually anyone, if they don't plan ahead to prepare to pay their own long term care, can get Medicaid relatively easily no matter how much money they have.

Mr. GOWDY. My time has expired. The gentleman from Illinois, Mr. Davis.

Mr. DAVIS. Thank you very much, Mr. Chairman.

I think there is generally some consensus that individuals should not gain Medicaid eligibility by inappropriately shielding their wealth. In the studies I have looked at by GAO as well as Kaiser, and some others, it would suggest to me that the numbers of individuals who are able to shield large wealth portfolios is relatively small.

Could I ask if your experiences would indicate that that's the way it goes? Are we finding large numbers of individuals who are millionaires or close to who have large sums who are able to get around the requirements and are inappropriately receiving Medicaid benefits?

Mr. MOSES. Mr. Davis, as I just explained, the egregious Medicaid planning of the millionaires, that is just the tip of the iceberg. What GAO looked at was just one technique of Medicaid planning, transfer of assets. That is not even the most common form of Medicaid planning. There are annuities, life care contracts, the reverse half a loaf strategy using promissory notes. There are any number of ways to get people qualified, but the transfer of assets technique, minor as it is, is still a $1 billion a year according to GAO.

As I can't reiterate enough, the real problem is that most people don't have to use fancy legal planning because they are eligible anyway. This has the effect of having sent the message since 1965 when Medicaid became part of the law to the public that you can

ignore the risk of long term care, you don't have to save, invest or insure for the risk, and when the time comes, may be you die with your boots on and you are home free, but if you do get one of the chronic illnesses of old age—Alzheimer's, Parkinson's and stroke—and you need the expensive care, families who provide 80 percent, as you said in your opening remarks, 80 percent of the care for free, if you have to have the expensive care, then virtually everyone ends up on Medicaid.

The program cannot sustain that weight now so the secret is to target it to the people who need it most and thereby insure a quality safety net for the truly indigent.

Mr. DAVIS. Mr. Dorfman.

Mr. DORFMAN. Millionaires don't want Medicaid. Millionaires still have other law planning issues but not Medicaid planning issues. They want fancy care, they want care that they control. They want to be able to fire the people they don't like and hire the people they do like. Millionaires never come in for Medicaid planning. They do want planning, they do need surrogate decision-makers as they suffer the illnesses of aging, but they don't want Medicaid.

Ms. EULAU. We find that about 60 percent of the people that come in for nursing home care have done some type of Medicaid estate planning. Suffolk County is a fairly affluent county in New York State. That is what we are seeing.

In terms of people receiving long term care in the community, we don't see it as often but we still are seeing it because transfers, if you transfer your money out of your control for community long term care, there is no penalty. We are seeing that as well, may be about 15 percent of the cases.

As soon as I joined AARP, I started receiving invitations in the mail to come to free seminars to talk about Medicaid estate planning.

Mr. DAVIS. Ms. Hamos.

Ms. HAMOS. Congressman Davis, what we are finding in Illinois is that this is more of a middle class family issue than millionaires. I agree with Mr. Dorfman that the millionaires don't want to live in our Medicaid nursing homes. I think that what we are seeing is that middle class families, say if there is a savings, a little pot of money of $100,000, somewhat modest by some peoples' standards, the family doesn't want all of that to go into nursing home care and it is eaten up almost immediately in nursing home care.

That is why in Illinois what we are struggling with our legislative rulemaking committee is that there seems to be this widespread acceptance of that on behalf of middle class families and that is who they are representing but we are learning from other States and we really want we think there are reasonable ways to impose and tighten the eligibility rules that we need to put in place immediately while also maintaining a better service delivery system and reducing the cost of long term care generally.

We are trying to do it at both ends because there are so many costs for low income people that are wasteful and unnecessary. We could do a better job just by revising and reforming our service delivery system.

Mr. DAVIS. Thank you very much. I yield back, Mr. Chairman.

Mr. GOWDY. I thank the gentleman from Illinois.

The gentleman from Arizona, Dr. Gosar.

Dr. GOSAR. Mr. Dorfman, can you please give me the typical assets of a client that would qualify for Medicaid that comes to you?

Mr. DORFMAN. A typical client that comes to me has a home, a co-op, a condominium worth approximately $500,000; they have approximately $100,000 in retirement savings; they are a married couple and they have approximately $30,000 in cash assets.

Dr. GOSAR. Ms. Eulau, would you kind of agree with some of those, could you confirm those?

Ms. EULAU. We are seeing assets much greater than that. People often come and have total resources of over $300,000–$400,000 total beyond their home, beyond prepaid burial expenses, beyond those things they are allowed to have. In New York, we take the Federal resource standard, choose the highest resource standard for the community spouse in a nursing home care situation. They are allowed to keep $109,000 of the combined resources and we very often find that it is significantly higher than that.

Probably most of the people that do some kind of Medicaid estate planning could at least pay for 3 to 6 months of care on their own and many could pay for 2 years or more.

Dr. GOSAR. Staying with you, when you see someone that genuinely needs Medicaid long term care and cannot afford it, do you see an average person come in like that? How many times do they not qualify or not get it? Do you see someone like that?

Ms. EULAU. That should qualify for resources that don't get it?

Dr. GOSAR. Yes.

Ms. EULAU. No, we don't. If they qualify, they would be receiving it.

Dr. GOSAR. Ms. Hamos, you talked about the rebalancing aspect of care. Can you tell me a little bit more about that, kind of like a home care aspect and what's your idea and kind of give me some balance about why that would reduce the cost of long term care?

Ms. HAMOS. In Illinois, we really do have this institutional bias. I guess again, there are some powerful special interests behind maintaining State operated facilities as well as nursing homes and that is why we really did over invest in those over time that we have 15,000 empty nursing home beds right now. We paid three times as much at least to maintain someone per month in a nursing home bed than what we are providing with a limited set of services for seniors who stay at home.

What we are really working on now is looking at how we could increase the package of services to keep people in their home to keep them from having to go into nursing homes which is obviously a much more expensive form of long term care.

Dr. GOSAR. If we paid for this rebalancing, can you actually cite examples that would actually show us that we save money?

Ms. HAMOS. Yes. We will be able to.

Dr. GOSAR. We would be able to. Is there something right now you can point to, a State that actually shows we save money? It seems to me there isn't. Actually, there isn't, is there, because we can't find it. What we will actually do in rebalancing is open the exposure to more expenses for folks at home.

Ms. HAMOS. That hasn't been our experience yet. We are putting place a different kind of system and the kind of services people need in their home. Yes, sometimes it is very expensive to keep people in their homes, people who are really chronically ill or have very severe disabilities but there are people who can maintain themselves in their home and have a higher quality of life, at a much reduced cost, and we are going to show not just cost neutrality but real savings in this arena.

Dr. GOSAR. But it doesn't exist.

Mr. Moses, can you actually answer that question too?

Mr. MOSES. I am not aware of any State that has actually reduced the cost of long term care due to rebalancing. There are certain countervailing factors to consider such as people would rather get their care at home. You make a popular form of service delivery available under Medicaid, it creates a stronger incentive for people to find ways to qualify, not to say we shouldn't provide home and community-based care. We should but you need to understand why we have an institutional bias in long term care.

That is because Medicaid made nursing home care free in 1965 and resulted in there being no market for privately financed home and community-based services. That is why that infrastructure isn't out there. It is why we are trying to retrofit the home and community-based system on a nursing home-based system funded by welfare which never has enough money to provide adequate financing.

So it is I think not a very satisfactory solution to expand home community-based care under Medicaid unless and until you get the eligibility hemorrhage that this hearing is about under control. Otherwise, you will just create more and more incentives for people to rely on Medicaid.

The best way to get access to home and community-based care is to be able to pay privately. Then you get red carpet access to the best possible care.

Dr. GOSAR. It is more about the qualifying than anything?

Mr. MOSES. Yes.

Mr. GOWDY. I thank the gentleman from Arizona.

I would now recognize the gentleman from Maryland, the ranking member of the full committee, Mr. Cummings.

Mr. CUMMINGS. Thank you, very much.

Ms. Hamos, in Maryland there is an organization in my district, Visiting Nurses Association, you know you might want to credit them that has home care. That is what they do. They are one of the few organizations in Maryland who are increasing jobs by leaps and bounds because they are saving people money, allowing people to stay in their homes and most of these people are seniors. So it does work. I just visited them about 2 weeks ago. We just have to be innovative and I think you are going in the right direction.

Mr. Moses, so you would have the government pay less money with regard to Medicaid and then for patients to do what? What would you have them do? Be brief because I have a lot of questions.

Mr. MOSES. You have scarce public welfare resources available. All I am suggesting is that you target them to the people who are most in need and create incentives for the affluent and the middle

class before they are too old to and too infirm to plan for long term care and prepare to pay privately so they don't become dual.

Mr. CUMMINGS. So you would advocate for them getting insurance?

Mr. MOSES. Well there are many ways to prepare, you can save and invest, but insurance is one way. Home equity is the huge pot of money out there.

Mr. CUMMINGS. With people losing their homes in my district big time, value going down, I am not sure about that one.

I want to go back to something Mr. Davis said. He said this is a multifaceted problem but one that we can find a reasonable solution. I want to thank you, Mr. Chairman, for calling this hearing, but I want us to be clear on where we are.

Mr. Moses, you were invited by the majority and your bio states that you are the president of something called the Center for Long-Term Care Reform. I guess this is meant to sound like a think tank. Your bio also states that you have testified before most of America's State legislatures, something that think tanks often do, is that right?

Mr. MOSES. Yes.

Mr. CUMMINGS. Mr. Moses, when I asked my staff to learn more about you, to try to understand where you were coming from, it seems that your views are really nothing more than the views of the insurance industry, hardly a disinterested or objective observer. Isn't it true that the policy advocacy center you operate is a for profit company? Is that right, is it for profit?

Mr. MOSES. Yes.

Mr. CUMMINGS. Isn't it true that when you applied to IRS in 2000 for recognition for tax exemption, your group was told it was better classified as a "business league" for the long term care insurance industry?

Mr. MOSES. No. The organization was originally certified as a 501(c)(3) charitable nonprofit. I didn't feel I could carry the overhead of that, so I decided to become what I call a no profit because I just couldn't carry the overhead of being a nonprofit.

Mr. CUMMINGS. I understand. Isn't it true that your organization stated in June 2000 in correspondence to the IRS that historically all the Center for Long-Term Care Reform's funding has been contributed by the long-term care insurance industry? Is that right? Did you report that?

Mr. MOSES. I have a membership organization, so individual members contribute $150 a year in order to get my publication and I have corporate members as well.

Mr. CUMMINGS. I just want to make sure we understand who is funding you.

Was the funding to originate the Center paid for by the long-term care insurance industry?

Mr. MOSES. Some of the funding for the Center.

Mr. CUMMINGS. When you say some, was that 50 percent, 90 percent?

Mr. MOSES. Probably most in the early stages, all the first year and less over time.

Mr. CUMMINGS. Isn't it true that your organization's principal purpose is to advocate for the purchase of long-term care insurance?

Mr. MOSES. No, that is not true. If you can permit me to answer the question fully, I will explain.

Mr. CUMMINGS. Sure, briefly, because I have a lot of questions and what I may have to do is just get your written response, but I want to be fair to you.

Mr. MOSES. Maybe another Member will allow me to answer your question in such a manner that can appease you.

My roots are, sir, in government service. I was an 18 year, U.S. Government employee. I discovered that Medicaid is intended to be for the poor and was not being so used effectively. I have become an advocate first as a Federal employee working for the Health Care Financing Administration, then for the Inspector General, writing national studies that have led to changes in Federal law.

When I decided I couldn't get it done within the Federal Government, I left to be on the outside but my mandate, my mission is to preserve Medicaid as a safety net for people who need it such as the people in this room.

Mr. CUMMINGS. Then you and I are in agreement on that. On that point, I have to ask you this consistently with what you said so you can have further opportunity to explain. In a fund-raising appeal letter, does your organization brag that it may be "long term care industry's top producer" and isn't it true that in your fiscal year 2000 fund-raising letter, you assert "the Center would open the floodgates of demand for your products?" In your 2000 fund-raising appeal, you were attempting to raise $1 million, and requested $10,000 from brokers and $20,000 from small carriers. Will you provide this committee with a comprehensive list of donors to your organization?

Mr. MOSES. You are talking about 11 years ago. That organization, the Center for Long-Care Financing doesn't exist anymore. That was a 501(c)(3) charitable nonprofit. We are now a no-profit, as I explained, and I do not have to and will not disclose all of my donors. Most of them, about a third, are individuals who just believe in what we are doing and make a contribution annually. There are corporate members, some from the insurance industry, some from the provider industry.

Mr. CUMMINGS. Were Charles and David Cook included in it?

Mr. MOSES. No.

Mr. CUMMINGS. Thank you very much, Mr. Chairman.

Mr. GOWDY. The gentleman from Tennessee, Dr. DesJarlais.

Dr. DESJARLAIS. Thank you, Mr. Chairman, and thanks to the panel.

Mr. Moses, I think we will just kind of continue where we left off there because I find this really an interesting and important hearing. Clearly, we are facing Federal deficits that are unsustainable. We have health care programs that are in jeopardy whether it is Medicare or Medicaid. I think what we are trying to do here today is preserve Medicaid for those that really need it.

We have a large group in here who should have been very interested in this because clearly those are the ones who need it. For the past two decades as a primary care physician, I have struggled

with the frustration of getting care for people who really need it and everybody knows people getting it who don't need it. To me this hearing should be a very bipartisan thing.

Mr. Dorfman mentioned the wife who is talking to the doctor of a husband who has just had a stroke, wondering what do I do and indeed, that is a frightening time. Clearly, if the government isn't there, then what indeed does she do, who does she turn to? Does she turn to family, does she turn to her resources?

We are hearing talk right now that the rich need to pay their fair share. This hearing is about people being responsible for themselves and not relying on the Federal Government when they can afford to do it. I applaud you and everyone who is here today trying to solve this problem because clearly our government cannot afford to pay long term care for everybody in this country. We have to have a better solution. I think that is why we are here.

Do you think it is better that people have insurance and prepare for long term care than not?

Mr. MOSES. Yes. Here is my problem. My goal is to preserve Medicaid as a safety net for people in need. Unfortunately, people in need don't have money to donate to organizations like mine. The people who don't are the ones who might benefit from a change in Medicaid policy that protects the program for the poor.

Where would we go if there weren't a $500,000 home equity exemption? Families would tap their home equity after age 62 through products like reverse mortgages which enable them to remain in the home and purchase that home and community-based care that we would rather people have.

Once home equity becomes something that is at risk in case you have a long term care problem, once Medicaid stops being free inheritance insurance for the baby boom generation, then the boomers will plan ahead and will be more likely to buy the insurance that enables them to pay privately.

If we could divert only 20 percent of the people who are likely to become the dual eligibles that are only 15 percent of the Medicaid population but 39 percent of the cost, 70 percent of their costs are long term care, if we could divert only 20 percent of them from ever becoming dual eligibles, it would save Medicaid $30 billion a year which is enough by the way to cover the doc fix.

Dr. DESJARLAIS. Briefly, the way things stand now with proper legal counsel, somebody like even Bill Gates or Warren Buffet could qualify for Medicaid?

Mr. MOSES. You could as long as you transferred all your assets 5 years in advance.

Dr. DESJARLAIS. So there is means for people like that to do it if they wanted to do that?

Mr. MOSES. Yes.

Dr. DESJARLAIS. Ms. Eulau, how often do you think someone who is genuinely poor, may be someone who cannot privately finance more than a quarter or so of their long term care has assistance qualifying for Medicaid long term care?

Ms. EULAU. I am sorry?

Dr. DESJARLAIS. I am sorry, that wasn't very clear. How often do you think someone who is genuinely poor, may be someone who cannot privately fund more than a quarter or so of their long term

care, has assistance in qualifying. How often do they get help qualifying for Medicaid long term care?

Ms. EULAU. If they fit under the income resource standards, they would get it all the time.

Dr. DESJARLAIS. Would you say that most of the individuals in nursing homes on Long Island could privately finance at least some of their care?

Ms. EULAU. Yes.

Dr. DESJARLAIS. How difficult is it to recover assets from an estate of an individual who has used Medicaid services?

Ms. EULAU. It is very difficult, especially for spousal refusal, once they have done the refusal and separated out the resource, quite often if the spouse in the community does not need care, they then transfer that money out to their children prior to their death. We can't go after the resources if there is still a spouse in the community and quite often they are doing their own Medicaid estate planning.

Dr. DESJARLAIS. Do you get the sense that people are afraid of the idea of estate recovery? Is that something they fear or not?

Ms. EULAU. I don't think they think about it.

Dr. DESJARLAIS. I was thinking about this hearing and the idea of getting people on insurance. I think people are very naïve. I think a lot of people think Medicare will pay for this. Do you think this would be an area that public service messaging, if they knew this was going away and they didn't have this option, public serving messaging to help get people to obtain long term health coverage might be useful?

Mr. MOSES. It can't hurt but the problem is the public doesn't fail to buy long term care insurance or plan for long term care because they aren't aware of the problem. All the surveys show people know it is a big risk, but they still don't buy. Why, because ignore the risk, avoid the premiums, wait to get sick and the government pays.

Dr. DESJARLAIS. So all the loopholes right now are allowing people to skirt the system, maybe even cheat the system?

Mr. MOSES. Not just the loopholes, just the basic eligibility rules let most people on.

Dr. DESJARLAIS. Once again, it is a case of our government enabling people to skirt the proper channels?

Mr. MOSES. Well intentioned, perverse incentives.

Dr. DESJARLAIS. I yield back.

Mr. GOWDY. I thank the gentleman from Tennessee.

I would now recognize the gentleman from Missouri, Mr. Clay.

Mr. CLAY. Thank you, Mr. Chairman.

According to a 2009 report by the Non-partisan Kaiser Commission on Medicaid and the Uninsured, the number one reason that people who shop for but do not buy long term care insurance is cost. In 2009, the Kaiser report found that long term care insurance premium costs vary significantly depending on the age of the purchaser.

For individuals aged 60 with no partner, the annual premiums for a typical policy average $2,329. For a couple the same age, premiums for the same policy design averaged $3,096 combined for the two people. If purchased at age 70, premiums would cost on aver-

age $4,515 per year for an individual and $6,010 for a married couple.

Another Kaiser study published in June of this year found that half of all Medicare beneficiaries had incomes below $21,100 in 2010. Furthermore, many elderly individuals are already spending a significant amount of their income on health expenses. In 2006, Kaiser found that 1 in 4 Medicare beneficiaries spent 30 percent or more of their income on health expenses and 1 in 10 beneficiaries spent more than half of their income on health expenses.

Ms. Hamos, given that a significant number of Medicare beneficiaries are already spending a large part of their relatively small income on health care expenses, do you think it is realistic to ask your average senior citizen to purchase long term care insurance which is cost prohibitive for many?

Ms. HAMOS. I think you hit the nail on the head. It is cost prohibitive, but I think the key to long term care insurance is that young people need to buy it when it is affordable and they need to be thinking ahead to their own futures and their families' futures. Young people, as we all know, don't think that way. That is the big problem. If people wait until they become seniors, even middle age and close to being seniors, I think most people don't start down that road because it is very expensive.

Mr. CLAY. It is my understanding that long term care insurance premiums have increased significantly above the overall rate of inflation. Isn't it true, Ms. Hamos, that from 1995 to 2005, average age adjusted premiums have increased 59 percent above the overall rate of inflation for individuals aged 55 to 64 and by 32 percent for those aged 65 to 69? Between 2000 and 2005, the more comprehensive policies which often included inflation protection, raised premiums on average 30 percent. Have you found that in your studies?

Ms. HAMOS. This is not my expertise at all but I have read those studies and I have learned that as well about long term care insurance. We would all like to encourage more use of long term care insurance quite honestly I think if it is out there. The insurance companies tell us there is not a robust market for it.

I think what we are hearing today is that in part because Medicaid policy has impacted that, but I would say part of the problem is that it is a costly purchase for a lot of low income and middle income families and they don't really think ahead far enough to be able to buy and hold on to it and maintain it throughout their lives. That is why it is so cost prohibitive and that is why it is increasing because the insurance companies don't see a big market for it.

Mr. CLAY. Thank you for that response.

Mr. Moses, I noticed that your fund-raising solicitation ends by asserting that "Our established credibility as an independent third party voice allows us to perform an essential role that no one else can fill for reasons perceived by self interests." Do you normally disclose to congressional committees and State legislatures that you have testified before the details of your ties to the long term care insurance industry?

Mr. MOSES. It is public knowledge. As your researchers have determined and provided you the information, that is out there. But

as I explained earlier, I am not about selling insurance. I am about saving Medicaid. The problem is, as one of the testimonies explained, between two-thirds and 90 percent of the potential market for long term care insurance is crowded out by the availability of Medicaid. That was in the American Economic Research Journal.

As long as that is the case, as long as the public can ignore the enormous cost of long term care, no financial product is affordable if you don't think you need it.

Mr. CLAY. Will you provide the subcommittee the names of your corporate donors?

Mr. MOSES. No.

Mr. CLAY. Thank you and I yield back.

Mr. GOWDY. I thank the gentleman from Missouri.

Given the impressive panel of witnesses that we have, with your indulgence, we would like to have a second round of 2 minutes each if that is amenable to you all. We are so fortunate to have witnesses like yourselves. We want to be good stewards of your time, so if you have time, 2 minutes. My math's not great, maybe 8 minutes.

Mr. Moses, key payments, is that a phrase you are familiar with and what is it?

Mr. MOSES. The idea of key payments, the notion is that if you are doing Medicaid planning and sheltering or divesting hundreds of thousands of dollars, you don't want to end up in one of those awful Medicaid nursing homes.

Mr. GOWDY. That is exactly why I asked you because there have been two witnesses who have said wealthy people don't want to wind up in one of those gosh awful Medicaid places. The good news for them is there is a way around that.

Mr. MOSES. Absolutely, there is.

Mr. GOWDY. Tell Mr. Dorfman how he can keep his rich clients from having to stay in one of those horrible Medicaid facilities.

Mr. MOSES. This is routinely recommended in the Elder Law Journal articles. Don't worry Mr. and Mrs. Client, we can get you into a nice place because when we divest the rest of your assets, we will hold back $50,000 to $100,000 so that you can pay privately for 6 months to a year. Why does that make a difference? You will get red carpet access to the best quality care because nursing homes, for example, only get about two-thirds from Medicaid what they would get from a private pay resident, so they will roll out the red carpet to attract people who can pay privately. They may have only a few Medicaid beds and be mostly private pay and Medicare. They are the really nice nursing homes and the Elder Law Bar always knows which ones those are.

The problem is while the nicest beds and the best facilities are being filled by people who could have, would have and should have paid their own way, Medicaid people, the appropriate indigent people, can't get into the nice places and they end up in the 100 percent Medicaid places that are the kind of places that 20/20 goes in with the minicams showing people lying in their own waste with bed sores down to the bone.

Mr. GOWDY. To summarize it, because I only have a couple seconds, just save back enough money to be a private pay patient for 3 months at a minimum, perhaps up to 6 months, then quit paying

your private pay, that very nice facility can't kick you out because of your former payment, you could just live off your Medicaid?

Mr. MOSES. Correct.

Mr. GOWDY. There is a way contrary to what has been said this morning. Wealthy people don't have to wind up in those gosh awful Medicaid facilities, they can be at a super nice place if they just get the right legal counsel, right?

Mr. MOSES. A Medicaid planner simply flips the switch, the Medicaid plan kicks in and your private payer becomes a Medicaid recipient overnight.

Mr. GOWDY. I would recognize the gentleman from Illinois, Mr. Davis.

Mr. DAVIS. Thank you very much, Mr. Chairman.

We noticed a number of individuals here earlier in wheelchairs who are part of the disabilities community. For a number of years now, Senator Harkin and I have been working very hard trying to get something passed called Community Choice, which would allow these individuals to live at home and still get the nursing care or the medical care they needed and not have to live in nursing homes to do so.

Of course we have not fared very well with that legislation. We have not been able to get it passed. Since we are looking for ways to save money from Medicaid, what would each one of you think of that? Would that be a way to save some of the money we are currently spending because nursing home care, the average cost, is about $75,000 a year. If individuals could live at home and we pay for the medical services, then it seems we would save a lot of money.

Mr. MOSES. You would indeed target Medicaid to the people who really need it and you will have more than enough resources to provide a full continuum of care from home, community-based care, assisted living and nursing home care but only when it is needed.

Mr. DORFMAN. There is a system we run through VA, the Community Senior Foster Care Program. It is the kind of program that could be duplicated across the entire Medicaid spectrum. An example of what it might do is take three senior veterans suffering from Alzheimer's and Parkinson's, put all three together in a community setting in someone's home and pay them for providing care. It cost a fraction of institutional care and is a model that could be replicated across the system to provide community care.

Ms. EULAU. New York has a waiver program, a long-term home health care program that services clients at home, giving them all the nursing home services they would normally get in a facility in their home, nutrition care, therapy and such. The program itself requires that it not cost more than 75 percent of what it would cost in a nursing home setting. We do try to do that.

Could I also say that I don't really think in my county there are Medicaid nursing home facilities. All of our nursing facilities have about 80 percent Medicaid patients.

Ms. HAMOS. That was surprising to hear. Every State really does have different experiences.

I wanted to reflect on the chairman's questioning before, in our case in Illinois, there are some nursing homes that actually do figure out ways to kick out people when they are done with their re-

sources. They figure out how to transfer them to hospitals and then don't invite them back. It is risky to start out in the fancy nursing home and not know where your granny is going to be a year or 10 months later.

I would say again we think that home and community-based care is more cost effective and a higher quality of care kind of approach for people who are low income, disabled and that is the preponderance of the clients we deal with. I think exactly what Ms. Eulau was talking about is what we are finding too, that we can set a standard for what nursing home care would cost and go below it and meet that standard and provide a higher quality of care.

Mr. DAVIS. Mr. Chairman, I have a couple questions I would like to submit.

Mr. GOWDY. Yes, sir, without objection.

The Chair would now recognize the gentleman from Arizona, Dr. Gosar.

Dr. GOSAR. Mr. Dorfman, do you worry that Medicaid planning exploits taxpayers?

Mr. DORFMAN. No. Medicaid planning is the way to protect the individuals who need the government program set up for their benefit.

Dr. GOSAR. So it doesn't undermine personal responsibility and contributes to a free rider culture?

Mr. DORFMAN. No, not at all. What it is doing is taking an individual in any circumstance and looking at what are the most responsible choices at that moment given the existing government program. Sometimes that means transferring the money to protect the wife who is still living at home when you need a nursing home.

Dr. GOSAR. Mr. Moses, do you worry about the exploits to the taxpayer contributing to a free rider culture in this Medicaid planning?

Mr. MOSES. Yes. The research shows that people don't plan for long term care because Medicaid pays for most of the expensive care later on. It is not that the public knows all there is to know about long term care and plans to go on Medicaid, it is the fact that Medicaid has always paid for most expensive long term care that has kind of desensitized the public to the risk.

That is why all the survey studies show that people are aware that they should have a plan for long term care but they think Medicare covers it which doesn't, but Medicaid does and that is the simple, basic fact that is you could change that, we could preserve Medicaid as a safety net for people in need and if you had to spend some of your own resources before you got help from the government, as you do in England, England only protects $38,000 worth of all assets including home equity. If you had that in place, then you would have a demand for planning, saving, investing and insuring.

Dr. GOSAR. Ms. Eulau, how would you feel about that?

Ms. EULAU. I agree that people don't know enough before they get to that point in their lives about what is going to pay for their care, so I really think there needs to be a lot more education out there. I see commercials every day for Medicaid estate planning on the television and in print. Like I said, I received free seminar invi-

tations myself just as an AARP member in the community. I think there needs to be more education.

The other thing is it really could teach people who is paying for it and I think once people find out that the taxpayer is funding wealthy recipients of care, there's going to be some changes.

Dr. GOSAR. I just want to say I have heard some things here today. I was raised from immigrant grandparents. The American dream was about personal accountability and personal responsibility. When did we lose honor, when did we lose ethics and when did we lose character? What I have heard today astonishes me.

In the other aspect of selling insurance, what is so wrong about selling an insurance plan for somebody to take care of themselves? What is wrong with that?

I am from Arizona and I have seen a group of people who have been on the government dole for the longest period of time fighting to get off it and that is Native Americans. Something is wrong with government provided health care when it can't look at these aspects.

I look at Ms. Hamos, we had DRAs that we were supposed to follow and we are still not there because it is a bipartisan problem. Something is wrong here and we have to look at the whole core. It started in 1965 when we did not identify those proper rules, proper protocols and etiquettes. I am apologizing.

Thank you.

Mr. GOWDY. I thank the gentleman from Arizona.

The Chair would now recognize the gentleman from Missouri, Mr. Clay.

Mr. CLAY. Thank you, Chairman Gowdy.

Mr. Moses, going back to the point about the names of your corporate donors, I just don't find you as a disinterested, public policy expert expressing a personal opinion but in fact, a paid, long term care industry advocate. In the interest of full disclosure, why wouldn't you want to provide the names of your corporate donors to this subcommittee?

Mr. MOSES. I am not required and I choose not to do it. The point is that kind of argument, Congressman Clay, is a logical fallacy. It is called the ad homonym to attack somebody based on aspects other than the quality of their work. I would encourage you to read the many reports that are on our Web site and make a judgment based on facts and not personal attacks.

Mr. CLAY. Mr. Moses, before I came here, I was a State legislator for 17 years and I see the trends of what is going on in the States, that they are quickly shirking their responsibility to take care of the disabled and the people that are older because, first of all, they don't want to raise the necessary revenues to pay their share of Medicaid and are putting less and less in annually to pay for those people who helped build those States and build this country, especially our seniors who happen to be in a long term care facility. You don't want to provide the subcommittee with full disclosure for whatever reason.

Mr. MOSES. I spent 30 years, my career, trying to find ways to save Medicaid for people in need. The only tools I have are private sector industries that stand to gain from a system that would save Medicaid for people in need. If we save Medicaid for people in need,

others, the more affluent people, will need to spend their money instead of hiring attorneys.

They will need to use their home equity through things like reverse mortgages so they can get quality care in the private market. Once their home equity is at risk, they will see the need to buy the insurance and we will take some of the burden off the public programs currently unable to provide guaranteed access to quality care across the whole spectrum of care for people truly in need and we will increase the jobs in the private sector and the tax revenue that enables Congress to do worthwhile things. Right now, we are operating a system that does not achieve its original intent.

Mr. CLAY. I thank you for your response.

Mr. GOWDY. I thank the gentleman from Missouri and on behalf of all of us, we want to thank each of our panelists. It has been informative for all of us and we appreciate your expertise, your professionalism and how you interacted with one another and especially how you have interacted with questioners.

With that, the committee is adjourned and we thank you again.

[Whereupon, at 11:40 a.m., the subcommittee was adjourned.]

[Additional information submitted for the hearing record follows:]

Dedicated to ensuring quality long-term care for all Americans

October 10, 2011

The Honorable Trey Gowdy, Chairman
Committee on Oversight and Government Reform
Subcommittee on Health Care, District of Columbia, Census and the National Archives
2157 Rayburn House Office Building
Washington, DC 20515

Dear Chairman Gowdy:

Pursuant to yours of October 4, 2011, I am submitting herein my replies to questions asked on behalf of the Committee and for the hearing record. As you requested, I have included the text of the questions along with my replies. Thank you for inviting me to testify at the Subcommittee's September 21, 2011 hearing on "Examining Abuses of Medicaid Eligibility Rules."

Reply to Ranking Member Davis's questions:

Question #1: "Mr. Moses, you make allegations of widespread asset transfers among older people in order to fraudulently receive Medicaid assistance for nursing home services. Research by the Urban Institute shows that even the most aggressive approach to recovering transferred assets would yield a savings of only about 1 percent of total Medicaid expenditures for long-term services and supports. Similarly, a Government Accountability (GAO) report on this issue found that the median amount of money transferred was $3000, with older persons with low incomes and disabilities transferring less than those who were less likely to go on Medicaid. Another GAO report found a median amount of $15,152 in transferred for less than fair market value. Do you have any hard evidence apart from anecdotes to refute these findings? Can you document with hard numbers the actual amounts being transferred fraudulently?"

Reply #1: I did not in my testimony, nor have I ever in any of my published writings or otherwise, made "allegations of widespread asset transfers by older people in order to fraudulently receive Medicaid assistance for nursing home services." The premise of your question is false.

If you read my testimony, or anything else I've published, you will see that the problem is not fraud, but rather the ease with which middle class and affluent people qualify legally for Medicaid LTC benefits under the basic eligibility rules. Nothing in the sources you cite contradicts my evidence or argument in any way.

Question #2: Mr. Moses, your testimony is premised at least in part on the argument that Medicaid costs have risen to a large extent by increased numbers of older people going

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on Medicaid to pay for nursing home costs. Are you aware of CMS data showing that the number of older people receiving Medicaid assistance to pay for nursing home costs actually decreased by 23 percent between 1995 and 2008 - even while the older population was increasing by 16 percent? Are you aware that the percentage of older people using Medicaid to pay for nursing home care decreased from 4.6 percent in 1975 to 2.8 percent in 2008? Are these numbers consistent with the allegation that increasing numbers of older people are cheating or trying to game the system to get on Medicaid?

Reply #2: My testimony was not premised in any way on "the argument that Medicaid costs have risen to a large extent by increased numbers of older people going on Medicaid to pay for nursing home costs." The premise of your question is false.

Excessive dependency on nursing homes, or "institutional bias," was caused by Medicaid's paying mostly for nursing home care since 1965. That's why a healthy, private market for home and community-based services (HCBS) never developed. As Medicaid "rebalances" from institutional care to HCBS, the danger is that government services will become even more attractive and expensive at a time when government funding is less and less available. By controlling eligibility in ways I've recommended, Medicaid can cover a full range of home and community-based services for a smaller number of genuinely needy recipients and, at the same time, encourage middle class and affluent people to plan early, save, invest or insure for long-term care, and pay privately for their care, thus relieving Medicaid and tax payers of a huge financial burden and encouraging private sector jobs and new tax revenue.

Question #3: Mr. Moses, you have suggested requiring older people to take out a reverse mortgage, a loan from a private lender, and exhausting the person's home equity before becoming eligible for Medicaid long-term services and supports (LTSS). As you may know, the upfront costs on such loans can be in excess of $10,000 before the person gets a dime in loans. Do you think it is proper for Congress to require people to take out such expensive private loans as a condition of eligibility for public benefits?

Reply #3: It is not necessary to require people to take out a reverse mortgage. There are many ways for consumers to extract the equity from their homes to pay for long-term care. The key point I'm making is that Medicaid should not exempt up to three quarters of a million dollars worth of home equity while paying for the home owner's long-term care services. Doing so has turned Medicaid into free inheritance insurance for boomer heirs and impeded the program's true purpose, to be a quality long-term care safety net for people in need. In my paper titled "Save Medicaid LTC $30 Billion Per Year AND Improve the Program," I've explained my position on this issue in detail: http://www.centerltc.com/pubs/Save_Medicaid_LTC_$30_Billion_Per_Year_AND_Improve_the_Program.pdf.

Question #4: Mr. Moses, you cite a study by the National Council on Aging as a basis for arguing that $30 billion a year in Medicaid savings could be realized by requiring those dually eligible for Medicare and Medicaid to take out reverse mortgages before gaining eligibility. But that report indicates that only about 17 percent of older Medicaid

beneficiaries could be candidates for using a reverse mortgage to pay for LTSS, even using a very broad definition of being a candidate. Only about 60 percent of duals are age 65+, so only roughly 10 percent of duals would even be eligible for a reverse mortgage - and many of them have homes with low values. How could tapping these meager resources generate $30 billion a year?

Reply #4: I do not cite the NCOA study as a basis for "requiring those dually eligible for Medicare and Medicaid to take out reverse mortgages before gaining eligibility." The premise of your question is false.

The point, as I clearly articulate in the paper you cite, is that if Medicaid did not exempt up to $750,000 of home equity, affluent people with homes of great value, would take the risk and cost of long-term care more seriously and plan more responsibly to pay for their own care and protect their real estate wealth. The goal is to prevent people from ending up as dual eligibles because they failed to save, invest or insure for long-term care and, as a consequence, turn to Medicaid by default after they require care.

Question #5: If an individual was single and was receiving Medicaid nursing home care, wouldn't that individual be more likely to sell his or her home, rather than take out a reverse mortgage, since the individual would not be living in his or her home?

Reply #5: Under existing Medicaid eligibility rules, the home remains exempt as long as the Medicaid recipient or his or her representative expresses a subjective intent to return to the home. It makes no difference whether the recipient is able medically ever to return to the home, is single or married, or whether anyone is residing in the home or not. In the absence of estate recovery, which has been mandatory since OBRA 1993, but which most states have not implemented strongly and the federal government has not enforced, the value of the home redounds to the heirs and the cost of the care remains with Medicaid and tax payers.

If Medicaid eligibility rules were changed to exempt a smaller amount of home equity, individuals would need to extract the value of the home to pay for long-term care by various means. Reverse mortgages, either formal ones with a financial institution or informal ones with family members, are one means to put home equity to use to fund LTC. Sale of the home if no exempt relative remains in it is another option. The key point here is that home equity becomes a source of private financing for quality home and community-based services, or assisted living or nursing home care relieving Medicaid of the need to pay for such services and recover from estates.

Sincerely,

Stephen A. Moses

Stephen A. Moses
President

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"Examining Abuses of Medicaid Eligibility Rules"

Subcommittee on Health Care, District of Columbia, Census and the National Archives

Hearing - September 21, 2011 Questions for the Record

Responses by Julie Hamos
Director, Illinois Department of Healthcare and Family Services

1. **Why has Illinois not implemented the provisions of the Deficit Reduction Act (DRA)?**

   HFS Response: The provisions required by the DRA now have been approved as a rule by the Joint Committee on Administrative Rules (JCAR) on October 11, 2011 – after the September 21st Subcommittee hearing. The rules will be filed for adoption the week of October 24th.

2. **Since the DRA has not been implemented, does Illinois have a cap on the amount of home equity an individual is able to exempt and still qualify for Medicaid?**

   HFS Response: The DRA has now been approved in Illinois. The rules contain the upper level of home equity allowed by DRA at $750,000.

3. **Has HHS threatened to cut off the federal financing for Illinois' Medicaid program because of its failure to implement the provisions of the DRA?**

   HFS Response: At the Department of Healthcare and Family Services, we were very concerned about the state's exposure and made the point on numerous occasions that failure to come into compliance would put the state in continued violation of federal Medicaid law, at growing financial risk. On August 4, 2011, HFS arranged a conference call with key CMS representatives, legislators and JCAR staff so that CMS could communicate this important message to policy-makers at the state level.

4. **In your testimony before the Oversight Committee's Health Care Subcommittee you mentioned that Medicaid planning is a problem in Illinois. Can you explain why this is a problem in Illinois and can you provide evidence about how pervasive Medicaid planning is in the state of Illinois?**

   HFS Response: We believe that Medicaid planning is ubiquitous throughout Illinois but have not conducted research to this effect. The elder bar has substantial influence with legislators of both parties, who deliberately and unanimously held up the JCAR rules to prevent HFS from instituting eligibility rules and procedures that would have been more restrictive than DRA.

5. **You testified that "it is our responsibility to eliminate any abuse of the Medicaid program" and that you supported many of the recommendations for reforming Medicaid eligibility supported by Stephen Moses. Specifically, do you support the following:**
   - **Congress passing a resolution that Medicaid should be a safety net for the poor and only the poor**
   - **Reducing Medicaid's home equity exemption**
   - **Placing reasonable limits on the amounts of other assets that people can shelter while qualifying for Medicaid**
   - **Reducing the ability of individuals to create trusts or purchase annuities in order to artificially impoverish themselves and qualify for Medicaid**
   - **Extending the look-back period for asset transfers to ten years**
   - **Prohibiting the practice of spousal refusal**

   HFS Response: We support any and all recommendations if they have the desired effect of focusing scarce Medicaid resources on those who are truly low-income – not those who become intentionally poor by sheltering their assets. We now understand the difficulty of making these changes at the state level; accordingly, we would recommend that the changes referenced above be enacted by Congress as federal law.

   We have concerns about extending the look-back period to ten years, as we understand that financial institutions are not cooperative in assisting with bank records, and it is difficult to expect dated records to be maintained and produced by seniors. It can be very challenging for states to identify unreported assets. We would recommend another approach: federal legislation requiring banks and other financial institutions to cooperate with states' efforts to implement the automated asset verification systems mandated by Section 1940 of the Social Security Act. The purpose of that section cannot be accomplished without an equivalent mandate on banks and financial institutions.

6. **In your testimony you stated that "it is a struggle to convince our legislative rule-making committee to adopt these rules." Can you please explain the difficulties that you have had convincing lawmakers to reform Medicaid eligibility rules? Please explain which interest groups are the most opposed to these reforms.**

   HFS Response: As stated in#4, the elder bar had the greatest political influence in opposing reforms through the 12-legislator, bipartisan, bicameral Joint Committee on Administrative Rules – who were unanimously in synch with the elder bar's demands. The elder bar organized their opposition through the Illinois State Bar Association, the Illinois Chapter of National Association of Elder Law Attorneys, and formed a new organization called Task Force for Senior Fairness. The Task Force "action site" is found at http://www.donthurtgrandma.com/ (note the moniker "do not hurt grandma"). The long-term care facilities and senior groups such as AARP did not play a visible role.

Dorfman:

Possible Response to Questions

NOTE: The answers to all these questions are to be discussed with the understanding that the eligibility rules, as well as their interpretations, vary considerably from state to state, so every generalization made here will have exceptions in one or more states.

1) How difficult is it for someone who has gotten to the point where long-term care is urgently needed to qualify for Medicaid? Please explain:

[It may be most effective to give an authentic responsible case example if possible]

The eligibility rules of the Medicaid program are not interpreted the same way in each state. Several factors contribute to the ability of an individual to qualify for Medicaid, including:

2) Income
3) Assets
4) Previous (past 5 years) gifts to charities, family members, etc.
5) Marital status – spousal impoverishment protections
6) Long-term care insurance coverage

If an individual qualifies (health wise) but can not afford the cost of long-term care in a nursing home, he or she must meet several tests in order to have Medicaid pay the nursing home for his/her care:
This includes:

7) income test
8) asset test
9) look back period
10) spousal protections

2) Based on your experience and expertise, how much does the typical elder law attorney charge in order to assist someone with Medicaid planning?

Elder law attorneys usually provide a variety of services, including drafting wills, living wills, estate planning, advanced care planning, guardianship, long-term care planning, and other advice for their clients. This can include assisting with the Medicaid application process if the individual is unable to pay for nursing home care or has run out of resources to pay for care.

For antitrust reasons, elder law attorneys generally do not share their fee schedules with each other. Therefore it is difficult to generalize about fees.

3) What is generally the minimum value of a family's wealth necessary for people that come in to get assistance with Medicaid planning?

There is no minimum value. Even SSI recipients sometimes seek guidance on eligibility for Medicaid. They may own a home and want to know if they can maintain it even if in a nursing home for a period of time. They may want to know if they can protect a burial plot or certain personal possessions. "Planning" sometimes means merely protecting what they are already entitled to protect, but without professional advice, may forfeit.

4) Please describe the range of typical wealth, including the value of their home equity, for the individual and his or her spouse that you assist in qualifying for Medicaid:

Families who seek counsel from an attorney have a variety of financial backgrounds. Some are well prepared, and have planned for retirement and long-term care needs through savings and long-term care insurance, and others have lived their whole lives as hard-working, middle income families and have exhausted their safety net due to the recent financial crises or expensive health needs. Some never had the means to establish a safety net.

Spouses generally have the most pressing Medicaid planning needs, because without planning, the spouse left in the community (usually the wife) may face unnecessary crushing impoverishment and displacement, after a lifetime of moderate but stable financial solvency. When that happens, they are usually forced in the end to depend more heavily on public benefits than they would have if they had sought professional advice ahead of time.

Wealthy people rarely if ever seek assistance, for there are enormous downsides to depending on Medicaid, financially, emotionally, and in terms of the range and quality of care available. Moreover, millionaires can "self-insure" by using the interest and dividends from their investments to pay for long term care services. Millionaires have never been rushing to get on Medicaid.

Many older adults have been fortunate enough to pay off their mortgages over their lives and do own their homes. Home values vary greatly from area to area and many have dropped significantly in recent years. The home is protected under the law for the use of the spouse. But after the death of the spouse, the state may recoup funds it has spent on Medicaid nursing home care from the sale of the home.

5) Is it true that Medicaid planners don't help people access long term care assistance but rather the main service provided by Medicaid planners is to get the taxpayers to pick up the individual's long-term care costs?

No. Elder law attorneys who provide a range of legal services to older and disabled individuals do not consider themselves Medicaid planners. Further, the advice provided often leads individuals to consider options more favorable than Medicaid. We advise many clients, for example, to consider purchasing long-term care insurance if they can afford it and they do not have preexisting conditions that will lead the insurer to deny them coverage. Indeed, elder law attorneys are probably the most common source of referrals for long-term care insurance other

than insurance brokers themselves.

6) Who do you interact with in the family (individual needing care, his or her spouse, and his or her children)? Please estimate the percentages if you can.

Determining and being clear about "who is the client," is an ethical mandate for elder law attorneys. To protect against undue influence, or any conflict of interest, the client should normally be the older adult or spouse seeking counsel or an individual with a fiduciary relationship to the individual. This can be challenging when the client suffers from dementia or any level of diminished capacity. The American Bar Association has tackled this issue at length, and requires lawyers to adhere to Rule 1.14 of the Model Rules of Professional Conduct when advising a client with diminished capacity:

Rule 1.14 Client With Diminished Capacity:

(a) When a client's capacity to make adequately considered decisions in connection with a representation is diminished, whether because of minority, mental impairment or for some other reason, the lawyer shall, as far as reasonably possible, maintain a normal client-lawyer relationship with the client.

(b) When the lawyer reasonably believes that the client has diminished capacity, is at risk of substantial physical, financial or other harm unless action is taken and cannot adequately act in the client's own interest, the lawyer may take reasonably necessary protective action, including consulting with individuals or entities that have the ability to take action to protect the client and, in appropriate cases, seeking the appointment of a guardian or conservator.

(c) Information relating to the representation of a client with diminished capacity is protected by Rule 1.6. When taking protective action pursuant to paragraph (b), the lawyer is impliedly authorized under Rule 1.6(a) to reveal information about the client, but only to the extent reasonably necessary to protect the client's interests.

As you can see, the client remains the individual who sought legal counsel, and the goal is to maintain a normal client-lawyer relationship with that individual. These issues generally involve the whole family, such as spouses and children who may be primary caregivers. For this reason, I will consult with the spouse and family members, but the client remains the person who sought legal advice.

7) What is the typical advice that you give to a family that wants to artificially impoverish an individual in the household to qualify him or her for Medicaid? What techniques are most commonly used by Medicaid planners? Please explain the techniques.

The ethical obligation of an attorney is to explain the permissible options that an individual has under the law. The only technique that is probably common across all jurisdictions is to take full advantage of exempt resources, such as a pre-need funeral arrangement. Beyond that, the nature of options available differ substantially.

8) What generally happens to the individual's home when they are used for Medicaid? The Tax Equity and Fiscal Responsibility Act made it clear that "all of the resources available to an institutionalized individual, including equity in a home, which are not needed for the support of a spouse or dependent children will be used to defray the cost of supporting the individual in

the institution." Do states generally recoup these resources in order to pay back taxpayers? Are there techniques that Medicaid planners suggest in order for an individual to avoid the state's recovery?

[Again, it may be most effective to give an authentic responsible case example if possible]

9) Rules under TEFRA
10) Rules under DRA
11) States vary in their recoupment of resources and no data is available as far as I know

9) Is it fair to say that a large part of your profession has gotten wealthy from transferring wealth from taxpayers to the spouse and the adult heirs of individuals receiving Medicaid?

No.

10) How effective was the Deficit Reduction Act of 2005 in reducing Medicaid planning and preserving the program for the poor? In your view, did these laws increase the need of individuals for the services of attorneys and other experts to navigate the eligibility rules and qualify them for Medicaid?

The DRA has succeed in making it more difficult to qualify for Medicaid but at some cost to responsible fiscal actions of older adults, such as charitable giving or family support which can be penalized as unwitting illegal transfers. In some cases the DRA actually made it more difficult for an individual who is otherwise eligible for Medicaid to get back a gift that they have made and inadvertently created a penalty period where they are not eligible for Medicaid.

Caseworker review and forensic accounting of five years of an applicant's financial records has bogged down the eligibility process. It could certainly be argued that DRA has created an extraordinary labyrinth of bureaucracy and regulation that greatly impedes the access to services for individuals eligible for Medicaid for long-term services and supports.

It is also uncertain whether incentives in the DRA to encourage long-term care insurance purchases through "partnership programs" are succeeding. This uncertainty perhaps is due to the possibility that by the time a person is interested in purchasing long-term care insurance, he or she may not meet medical underwriting standards to qualify.

11) Can you please explain the concept of 'key money'? Do you feel this technique is somewhat fraudulent? Please explain.

?

12) What do you tend to think about the government's role in paying LTC expenses when they enter your office? What do most people think when they leave your office?

Many older and disabled individuals and their families are under the false impression that

Medicare will pay for long-term care, partly because it does cover the cost of many illnesses. Some confuse the tax and Medicaid rules and think they may gift up to $13,000 per year to another person. When they find out from me or someone else that Medicare does not cover long-term supports and services, or that it is not permissible to gift assets, they are often shocked and extremely upset. Many of them realize that they are now in a crisis situation and they must figure out very quickly how to pay for long-term care.

As an attorney with knowledge about long-term care I help to explain the law, the Medicare and Medicaid programs, and other options. If there is not a crisis at hand, I help them think through their options to plan ahead realistically for long-term care. This varies depending on their health status and resources. If there is a crisis at hand, I help them understand the eligibility requirements and how they may be able to pay for care.

If it has not been crisis management, they often leave with options and ideas for planning for the future. If it is a crisis, they often leave with great concern about how they will manage the difficult times ahead. It is my job to help them through that with information and support.

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