

ALASKA LEGISLATURE SPECIAL COMMITTEE/SUBJECT FILES 8672

2521 SCOMM 110: LONG TERM CARE TASK FORCE, 1998

DRAFT**DECLARATION OF IRREVOCABLE TRUST**

_____, hereinafter referred to as Settlor, establishes this Trust this ____ day of _____, 1998.

ARTICLE I - NAME OF TRUST

This Trust shall be known as the _____ IRREVOCABLE INCOME TRUST. The beneficiaries of this Trust are _____ during his lifetime and the State of Alaska after his death.

ARTICLE II - APPOINTMENT OF TRUSTEE

Settlor hereby appoints _____ as Trustee of this Trust.

ARTICLE III - TRUST ESTATE

This Trust is to be composed only of pension, and Social Security, and other income receivable by (and accumulated income in the Trust), including but not limited to retirement pension payments. No "resources," as that term is defined for purposes of Social Security, are to be deposited into the trust. In accordance with the Health Care Financing Administration (HCFA) Region X "State Agency Letter Number 94-27," and the HCFA "State Medicaid Manual" section 3259.7(C), although the trust is irrevocable, Settlor's right to receive the income is not being irrevocably transferred to the Trust. Rather, each income payment as it is deposited into the Trust is irrevocably committed to the Trust.

ARTICLE IV - DISPOSITION OF INCOME AND PRINCIPAL

4.01 Distributions While the Beneficiary is Neither a Nursing Home Resident Nor Enrolled in Project Choice

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(a) While the Beneficiary is not a nursing home resident and not enrolled in Project Choice, the Trustee shall pay to or expend for the benefit of the Beneficiary such amounts as can be disbursed while maintaining the Beneficiary's eligibility for Medicaid in accordance with the Alaska Public Assistance and Medicaid manuals and the HCFA "State Medicaid Manual" section 3259.7(c)(4). Disbursements from the Trust in any given month directly to the Beneficiary, or to third parties under such circumstances that Medicaid policy deems such disbursements to be income to the Beneficiary, cannot, when combined with any other countable income for that month (and, if the Beneficiary is living with his spouse, the spouse's countable income for that month), exceed the "Adult Public Assistance Need Standard" of the State of Alaska for the Beneficiary's household configuration, currently set at the following amounts:

- \$917, if the Beneficiary lives alone independently,
- \$758 , if the Beneficiary lives in another's household,
- \$1103, if the Beneficiary marries and he and his spouse live together independently and the spouse is neither disabled nor over 65 years old,
- \$871, if the Beneficiary marries and he and his spouse live together in another's household and the spouse is neither disabled nor over 65 years old,
- \$1359, if the Beneficiary and spouse live together independently and the spouse is either disabled or over 65 years old,
- \$1129, if the Beneficiary and spouse live together in another's household and the spouse is either disabled or over 65 years old.

(b) Income to the Trust which is not disbursed in accordance with the preceding paragraph may be disbursed to pay bills or expenses on the Beneficiary's behalf only if (1) such disbursements are made directly to the third-party vendors and not to the Beneficiary or the Beneficiary's spouse, and (2) such disbursements do not count as in-kind income under the applicable regulations of the Supplemental Security Income program, 20 CFR 416.1102 and 1103. That is, moneys can be disbursed to third-party vendors for items which are not food, clothing or shelter, and which cannot be used to obtain food, clothing or shelter. Such purchases may include: medical care and services not covered by Medicaid; social services; and excluded nonliquid resources under 20 CFR 416.1210 et seq. (other than food, clothing and shelter).

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(c) Income to the Trust not disbursed in accordance with (a) or (b) above can be used to pay income tax which may be owed by the Trust (not those taxes owed by the Beneficiary), or administrative attorney's fees which the Trust is obligated to pay.

(d) Income to the Trust not disbursed in accordance with (a), (b) or (c) above can be used to pay third-party vendors for food, clothing and shelter expenses of the Beneficiary *only if* the disbursements from the Trust directly to the Beneficiary under subsection (a) above during that month are reduced by the appropriate amount under either the "one-third reduction rule" or the "presumed value rule", 20 CFR 416.1130 et seq., whichever applies to the Beneficiary's then-present living situation.

(e) Income to the Trust not disbursed in accordance with (a), (b), (c) or (d) above shall be accumulated in the Trust.

4.02 Distributions While the Beneficiary is Not a Nursing Home Resident But Is Enrolled in Project Choice (Home and Community Based Waiver Program)

(a) While the Beneficiary is not a nursing home resident but is enrolled in Project Choice, the Trustee shall pay to or expend for the benefit of the Beneficiary such amounts as can be disbursed while maintaining the Beneficiary's eligibility for Medicaid, in accordance with 42 USC 1396a(q), 42 USC 1396p(d)(4)(B), 42 USC 1396r-5(b), (d) and (e), 42 USC 1396a(r), and section 5670 of the Alaska Medicaid Manual. Disbursements from the Trust in any given month directly to the Beneficiary, or to third parties under such circumstances that Medicaid policy deems such disbursements to be income to the beneficiary, cannot, when combined with the Beneficiary's other countable income for that month, exceed the "Nursing Home 300% Eligibility Standard" of the Division of Medical Assistance of the State of Alaska, currently \$1452 per month.

(b) As long as the Beneficiary is enrolled in Project Choice, the Trustee is to expend funds disbursed from the Trust each month in accordance with the Project Choice budget approved by the applicable agencies. Within the limits of that budget, the Trustee may expend funds disbursed from the Trust each month in accordance with the "post-eligibility" requirements

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of the Division of Medical Assistance of the State of Alaska for Project Choice, currently found at section 5670 of the Alaska Medicaid Manual. Funds are to be disbursed in the following order:

- (1) The Trustee is to disburse a Personal Needs Allowance to the Beneficiary of that amount which, when combined with the Beneficiary's other countable income, will bring the Beneficiary's total monthly countable income to the "Nursing Home 300% Eligibility Standard" of the Division of Medical Assistance of the State of Alaska (currently \$1482).
- (2) If the Beneficiary is married, the Trustee may next disburse to the Beneficiary's spouse an amount sufficient to bring the spouse's total income up to the monthly spousal allowance limit (currently \$2019) per month). To avoid any problems with a potential transfer-of-assets penalty under 42 USC 1396p(c), these particular disbursements of the Trust estate are to be used by the Trustee only for the benefit of the Beneficiary's spouse so long as the Trust exists, and cannot be distributed by the Trustee to any other individuals or entities for any other purpose. Any disbursements made to the Beneficiary's spouse are to be payable only to the Beneficiary's spouse and not jointly to the Beneficiary and the spouse, so that these disbursements are not mistakenly treated as income to the Beneficiary under 42 USC 1396r-5(b).
- (3) If the Beneficiary has dependent family members (children under age 21, children over 21 who may be claimed by either spouse as a tax dependent, or parents and/or siblings of either spouse who may be claimed by either spouse as a tax dependent), the Trustee may then disburse to the Beneficiary's spouse (if the spouse is caring for such family members) or to the family members themselves or other appropriate individuals, the appropriate amount under section 5670(3) of the Alaska Medicaid Manual. If such dependent family members are living with the Beneficiary's spouse, the Trustee is to disburse an amount sufficient to bring each dependent's total income up to the dependent-living-with-spouse allowance limit (currently \$673 per month). If such dependent family members are living elsewhere, the Trustee is to disburse an amount sufficient to bring the total income for such dependents up to the Aid to Families with Dependent Children (AFDC), or successor Alaska Temporary Assistance Program (ATAP), need standard for a household of that number of dependents under an "adult not included" household (currently \$517 for one and an additional \$117 for each additional dependent). Any disbursements made to the Beneficiary's spouse are to be payable only to the Beneficiary's spouse and not jointly to the Beneficiary and the spouse, so that these disbursements are not mistakenly treated as income to the Beneficiary under 42 USC 1396r-5(b). Any disbursements made to or on behalf of dependents of the Beneficiary similarly are not to be payable to the Beneficiary solely or jointly.
- (4) If the Beneficiary has Medicare or other insurance premiums, the Trustee may next disburse funds to the insurer to pay those premiums. Such disbursements are to be made directly to the insurer in accordance with 20 CFR 416.1103(a)(6) so that they do not count as income to the Beneficiary.
- (5) If the Beneficiary has incurred medical expenses not covered by Medicaid or private health insurance (including expenses from before the Beneficiary

became eligible for Medicaid), the Trustee may next disburse funds to the payees to pay those expenses. Such disbursements are to be made directly to the provider in accordance with 20 CFR 416.1103(a)(1) so that they do not count as income to the Beneficiary.

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If the Alaska Division of Medical Assistance changes its policies to permit additional allowances, the Trustee may, at Trustee's discretion, disburse funds for those allowances also. If the Alaska Division of Medical Assistance modifies or revokes one of the above-listed allowances, the Trustee is to modify the disbursements to conform to the new policies.

(c) After all permissible allowances, any remaining funds in the Trust may, within the constraints of the Project Choice budget, be paid directly to any provider of medical care or services to the Beneficiary. In accordance with the Health Care Financing Administration Region X "State Agency Letter Number 94-27," the Trustee shall make these payments at intervals specified by the Alaska Division of Medical Assistance; in the absence of explicit directives, these payments shall be made monthly. Such disbursements are to be made directly to the provider in accordance with 20 CFR 416.1103(a)(1) so that they do not count as income to the Beneficiary.

(d) Income to the trust which is not disbursed in accordance with (a), (b) or (c) above, shall be accumulated in the Trust.

4.03 Distributions While the Beneficiary is a Nursing Home Resident

(a) While the Beneficiary is a nursing home resident, the Trustee shall pay to or expend for the benefit of the Beneficiary such amounts as can be disbursed while maintaining the Beneficiary's eligibility for Medicaid, in accordance with 42 USC 1396a(q), 42 USC 1396p(d)(4)(B), 42 USC 1396r-5(b), (d) and (e), 42 USC 1396a(r), and section 5670 of the Alaska Medicaid Manual. Disbursements from the Trust in any given month directly to the Beneficiary, or to third parties under such circumstances that Medicaid policy deems such disbursements to be income to the beneficiary, cannot, when combined with the Beneficiary's other countable income for that month, exceed the "Nursing Home 300% Eligibility Standard" of the Division of Medical Assistance of the State of Alaska, currently \$1482 per month.

(b) As long as the Beneficiary is a resident of a Nursing Home, the Trustee is to expend funds disbursed from the Trust each month in accordance with the "post-eligibility" requirements

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of the Division of Medical Assistance of the State of Alaska for Medicaid coverage of nursing home patients, currently found at section 5670 of the Alaska Medicaid Manual. Funds are to be disbursed in the following order:

(1) The Trustee is to disburse the first \$75.00 each month to the Beneficiary as a Personal Needs Allowance. Since this amount does count as income to the Beneficiary, the Trustee can only disburse that portion of the \$75.00 which, when combined with the Beneficiary's other countable income, does not cause the Beneficiary's total countable income for that month to exceed \$1482.

(2) If the Beneficiary is married, and the Beneficiary's spouse is not institutionalized, the Trustee may next disburse to the Beneficiary's spouse an amount sufficient to bring the spouse's total income up to the monthly spousal allowance limit (currently \$2019 per month). To avoid any problems with a potential transfer-of-assets penalty under 42 USC 1396p(c), these particular disbursements of the trust estate are to be used by the Trustee only for the benefit of the Beneficiary's spouse so long as the Trust exists, and cannot be distributed by the Trustee to any other individuals or entities for any other purpose. Any disbursements made to the Beneficiary's spouse are to be payable only to the Beneficiary's spouse and not jointly to the Beneficiary and the spouse, so that these disbursements are not mistakenly treated as income to the Beneficiary under 42 USC 1396r-5(b).

(3) If the Beneficiary has dependent family members (children under age 21, children over 21 who may be claimed by either spouse as a tax dependent, or parents and/or siblings of either spouse who may be claimed by either spouse as a tax dependent), the Trustee may then disburse to the Beneficiary's spouse (if the spouse is caring for such family members) or to the family members themselves or other appropriate individuals, the appropriate amount under section 5670(3) of the Alaska Medicaid Manual. If such dependent family members are living with the Beneficiary's spouse, the Trustee is to disburse an amount sufficient to bring each dependent's total income up to the dependent-living-with-spouse allowance limit (currently \$673 per month). If such dependent family members are living elsewhere, the Trustee is to disburse an amount sufficient to bring the total income for such dependents up to the Aid to Families with Dependent Children (AFDC), or successor Alaska Temporary Assistance Program (ATAP), need standard for a household of that number of dependents under an "adult not included" household (currently \$517 for one and an additional \$117 for each additional dependent). Any disbursements made to the Beneficiary's spouse are to be payable only to the Beneficiary's spouse and not jointly to the Beneficiary and the spouse, so that these disbursements are not mistakenly treated as income to the Beneficiary under 42 USC 1396r-5(b). Any disbursements made to or on behalf of dependents of the Beneficiary similarly are not to be payable to the Beneficiary solely or jointly.

(4) If the Beneficiary has Medicare or other insurance premiums, the Trustee may next disburse funds to the insurer to pay those premiums. Such disbursements are to be made directly to the insurer in accordance with 20 CFR 416.1103(a)(6) so that they do not count as income to the Beneficiary.

(5) If the Beneficiary has incurred medical expenses not covered by Medicaid

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or private health insurance (including expenses from before the Beneficiary became eligible for Medicaid), the Trustee may next disburse funds to the payees to pay those expenses. Such disbursements are to be made directly to the provider in accordance with 20 CFR 416.1103(a)(1) so that they do not count as income to the Beneficiary.

(6) If the Beneficiary is single and without dependents, and the Beneficiary has a home, and the Beneficiary's physician has certified the Beneficiary is likely to return home within six months, the Trustee may then disburse funds in the amount of the single non-institutionalized Adult Public Assistance standard (currently \$917) to maintain the Beneficiary's home. Since this amount may count as income to the Beneficiary, the Trustee can only disburse that portion of this amount which, when combined with the Beneficiary's other countable income, does not cause the Beneficiary's total countable income for that month to exceed \$1482).

If the Alaska Division of Medical Assistance changes its policies to permit additional allowances, the Trustee may, at Trustee's discretion, disburse funds for those allowances also. If the Alaska Division of Medical Assistance modifies or revokes one of the above-listed allowances, the Trustee is to modify the disbursements to conform to the new policies.

(c) After all permissible allowances, the remaining funds permitted to be disbursed from the trust in any particular month are to be paid to the nursing home providing care to the Beneficiary to help meet the Beneficiary's cost of care. In accordance with the Health Care Financing Administration Region X "State Agency Letter Number 94-27," the Trustee shall make these payments at intervals specified by the Alaska Division of Medical Assistance; in the absence of explicit directives, these payments shall be made monthly. Such disbursements are to be made directly to the provider in accordance with 20 CFR 416.1103(a)(1) so that they do not count as income to the Beneficiary.

(d) Income to the trust which is not disbursed in accordance with (a), (b) or (c) above, shall be accumulated in the Trust.

4.04 Management of the Trust

(a) Should the Beneficiary become a resident of a state other than Alaska, the above references to standards, allowances, or other amounts set by the Alaska Division of Medical Assistance shall be replaced by parallel references to the standards, allowances and other amounts set by the Medicaid agency of the state in which the Beneficiary becomes a resident.

(b) The Trustee shall administer the Trust in such a way as to maintain the Beneficiary's eligibility for Medicaid services, or medical coverage under any similar or successor programs. The Trustee shall take into consideration the applicable resource and income limitations of any public assistance programs for which the Beneficiary is eligible when determining whether to make any distributions. The Trustee need not administer the Trust in such a way as to maximize the Beneficiary's cash income from public assistance sources.

(c) In the event the Trustee is requested by any department or agency to release the principal or income of the Trust, in excess of the amounts authorized by paragraph 4.01, 4.02 or 4.03 above, to or on behalf of the Beneficiary to pay for equipment, medication, or services that other agencies or organizations are authorized to provide, or in the event the Trustee is requested by any department or agency administering such benefits to petition the Court or any other administrative agency for the release of Trust principal or income for this purpose, the Trustee shall deny such request and is directed to defend, at the expense of the Trust created herein, any contest of this Trust or attack of any nature. The Trustee shall have complete discretion in the defense of any such claim, including the management of all litigation which might result. Trustee is also authorized, in Trustee's complete discretion, to settle, in whole or in part, or otherwise compromise any such claim or litigation.

(d) No interest in the principal or income of this Trust shall be anticipated, assigned, or encumbered, or be subject to any creditor's claim or to legal process, prior to its actual receipt by Beneficiary. No part of the corpus hereof, nor principal or undistributed income, shall be subject to the claims of voluntary or involuntary creditors for the provision of care and services, including residential care, by any public entity, office, department or agency of any state, or of the United States or any other governmental agency, except as provided in paragraph 4.05(b) below.

4.05 Termination and Disposition

(a) This Trust will terminate upon the Beneficiary's death.

(b) Upon termination of the Trust, after any remaining reasonable administrative

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expenses relating to this Trust have been paid, the Trustee shall distribute and deliver the residue as follows: to the extent that the Alaska Medicaid program (or the Medicaid program of another state) has expended funds on behalf of the Beneficiary, the Trustee is directed to reimburse the Alaska Division of Medical Assistance up to the amount of such expenditures (and if the Beneficiary has received Medicaid benefits from another state, the Trustee is to reimburse that state's Medicaid agency, reimbursing each state in proportion to the amounts expended by that state); following that, the Trustee is directed to deliver the entire remainder of such residue (if any) to the beneficiary's estate.

(c) At the request of, or with the consent of, the Alaska Division of Medical Assistance, the Trustee may make advance payments on the obligation under paragraph 4.05(b) above to use the remaining corpus (if any) upon termination to reimburse the Alaska Division of Medical Assistance for medical expenditures made for the Beneficiary. The Trustee may do this by disbursing the accumulated income in the Trust to the Alaska Division of Medical Assistance at such times and in such amounts as the Trustee in her discretion deems advisable. Such disbursements are to be credited against the Trust's obligation under paragraph 4.05(b) above.

4.06 Additional Powers of Trustee

The Trustee may seek the counsel and assistance of any state and local agencies that have been established to assist the handicapped or mentally disabled, and may consult with any other appropriate persons or agencies. However, the Trustee shall not in any event be liable to Beneficiary, the remainder beneficiaries of the Trust or any party for her acts as Trustee hereunder so long as the Trustee acts reasonably and in good faith. For example, the Trustee shall not be liable for the failure to identify each and every program or resource that might be available to Beneficiary on account of her disabilities.

ARTICLE V - TRUST ADMINISTRATIVE AND PROTECTIVE PROVISIONS

5.01 Jurisdiction

This Trust shall be administered expeditiously consistent with its terms, free of judicial

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intervention and without order, approval or other action by any court, subject only to the jurisdiction of a court being invoked by the Trustee or other interested parties or as otherwise provided by law.

5.02 Inalienability

The Beneficiary shall not have any right to anticipate, sell, assign, mortgage, pledge or otherwise dispose of or encumber all or any part of the Trust estate nor shall any part of the Trust estate including income, be liable for the debts or obligations of the Beneficiary or be subject to attachment, garnishment, execution, creditor's bill or other legal or equitable process, except as provided in paragraph 4.05(b) above.

5.03 Benefits Payable to Trustee

Trustee shall not be obligated to undertake litigation for collection of any benefits or assets payable by reason of the death of Beneficiary, including but not limited to such benefits under life insurance policies, employee benefit plans or other contracts, plans or arrangements providing for payment or transfer at death which are payable directly to her unless she is indemnified to her satisfaction against any liability and the expenses of such litigation. Payment of Trustee and the receipt of or release by her shall fully discharge any payor, and no payor need inquire into or take notice of this Declaration of Trust or see to the application of such payment. Notwithstanding anything in this Declaration of Trust to the contrary, any benefits or assets payable to this Trust shall not be subject to the claims against the estate of Beneficiary nor shall such benefits be subject to the control of the personal representative of Beneficiary nor be included in the property administered as part of the probate estate of Beneficiary until released to the estate by the Trustee.

5.04. Irrevocability

This Trust is not revocable by the Settlor, the Beneficiary or the Trustee. This Trust terminates only in accordance with Paragraph 4.05 above.

ARTICLE VI - POWERS OF TRUSTEE**6.01 Grant**

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In administering this Trust, the Trustee shall have all the powers and duties granted to, or imposed upon, trustees by the laws of the State of Alaska, as now existing or hereafter amended to liberalize such powers, except that, in addition, limitation, or modification thereof, the Trustee shall have the following rights, powers and duties:

a. Waiver of Accounting

The Trustee shall not be required to render any periodic accounting. However, upon written request of the Beneficiary, the Beneficiary's attorney, any court-appointed conservator, or a court-appointed Visitor, the Trustee shall furnish the Superior Court and the Beneficiary with an itemized statement showing all of the receipts, disbursements and distributions during the last accounting year of the Trust and how they were credited to, or debited from, the income and principal accounts of the Beneficiary's beneficial interest, and a list of, and the approximate value of, each item of property comprising such beneficial interest at the end of such year. The records of Trustee with respect to the Trust estate shall be open at all reasonable times to the inspection of the Beneficiary and his/her accredited representatives.

b. Trust Management

The Trustee shall hold, manage, care for, and protect the Trust as a fiduciary. Subject only to the duties and restrictions otherwise provided by this Trust or by applicable law, the Trustee may perform every act in the management of the Trust that individuals may perform in the management of like property owned by them free of any trust, and the Trustee may exercise every power with respect to each item of property of the Trust which individuals owning like property free of trust may exercise. By way of illustration, but not of limitation, the Trustee shall have the following powers and, except to the extent inconsistent with this Trust, those now or hereafter conferred by law:

(i) Manage Property

To manage and control any property for any period of time, though

commencing in the future or extending beyond the terms of this Trust

(ii) Sell Property

To sell at public or private sale, contract to sell, grant options to purchase, convey, exchange, transfer, and otherwise deal with the Trust property and any investments thereof for such price and upon such terms as the Trustee deems advisable.

(iii) Carry Insurance

To carry insurance against such risks and for such amounts and on such terms as the Trustee deems necessary or advisable for the protection of the Trust or the Beneficiary hereunder; to purchase health, accident, and/or hospitalization insurance for the benefit of the Beneficiary hereunder; to continue in effect or to terminate any such insurance; and to pay, from income or principal, any premiums or other charges.

(iv) Register Property in Name of Trustee

To cause any property, real or personal, which may be delivered to or acquired as an asset of the Trust to be registered in the name of the Trustee.

(v) Control Claims

To settle, compromise, contest, prosecute or abandon claims or demands in favor of, or against, the Trust.

(vi) Exercise Powers Until Final Distribution

To exercise all powers and authority, including any discretion, conferred herein after the termination of any Trust created hereunder until such Trust is fully distributed.

(vii) Perform Necessary Acts

Perform other acts necessary or proper for the prudent administration of the Trust, including execution and delivery of necessary instruments and issuance of full receipts and discharges.

(viii) Employment of Agents

The Trustee may employ such agents, attorneys, accountants, brokers,

investment counselors, custodians and appraisers as deemed reasonable; necessary; rely with acquittance upon their legal, tax, investment, or other expert advice, and pay their reasonable fees for their services from the Trust estate.

(ix) Accounting Methods and Equitable Adjustments

The Trustee may select such method of accounting as she deems appropriate. The Trustee shall determine the allocation of receipts and disbursements between income and principal in accordance with the Uniform Principal and Income Act or other similar legislation then in effect.

(x) Trust Expenses

The Trustee shall disburse such amounts from the income or principal of the Trust as the Trustee, in her sole discretion, may from time to time deem necessary or advisable for administrative expenses relating to this Trust, including reasonable attorney's and accountant's fees if, in the Trustee's sole discretion, other satisfactory provisions have not been made for the payment of such expenses.

(xi) Distribution

Trustee may make any payments under this Trust (1) to the Beneficiary's guardian or conservator, (2) to any person deemed suitable by Trustee, or (3) by direct payment of the Beneficiary's expenses.

ARTICLE VII- TRUSTEE SUCCESSION AND ADMINISTRATIVE PROVISIONS

7.01 Resignation

The Trustee may resign by giving thirty days written notice to the Probate Master of the Superior Court for the State of Alaska, Third Judicial District in Anchorage, 303 K Street, Anchorage, AK 99501), and to the Beneficiary, effective at the end of thirty days.

7.02 Vacancy

If the Trustee shall fail to qualify or cease to act, the Superior Court of Alaska shall be authorized to appoint one or more successor Trustees.

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In the event that a guardian or conservator is appointed for the Beneficiary, the conservator of the Beneficiary, or if none, the guardian of such person, may act for the Beneficiary for all purposes under the administrative provisions of this Trust, subject to any constraints on the conservator/guardian set by the appointing court.

7.04 Rights of Successors

Every successor Trustee shall have all the title, rights, powers, privileges and duties conferred on or imposed upon the original Trustee, without any conveyance or transfer. No Trustee need examine the accounts, records and acts of any previous Trustee or any allocation of the Trust estate unless specifically ordered by the court; nor will such successor Trustee be responsible for any act or omission to act on the part of any previous Trustee.

7.05 Corporate Fiduciary

Any corporate successor to the Trust business of a corporate Trustee shall become the successor corporate Trustee with like powers, duties and obligations.

7.06 No Bond

No Trustee, or any successor, shall be required to give any bond in any jurisdiction, and if, notwithstanding this direction, any bond is required by any law, statute or rule of court, no sureties shall be required.

7.07 Compensation

Any Trustee shall be entitled to reasonable compensation commensurate with the services actually performed and to reimbursement for expenses properly incurred.

ARTICLE VIII - MISCELLANEOUS**8.01 Definitions**

Except as otherwise provided, definitions of terms in this Trust shall be as defined in the Alaska Probate Code as amended after the date of this Trust.

The term "countable income" as used in sections 4.01(a), 4.02(a), 4.03(a) and elsewhere

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means income counted for SSI purposes under 20 CFR 416.1102 et seq., as modified by the Alaska Medicaid Manual sections 5020, 5025, and 5630.2. It does not include the Beneficiary's Permanent Fund Dividend (PFD) or Alaska Longevity Bonus (ALB), as long as these are required under state or federal law to be disregarded in determining the Beneficiary's eligibility for Medicaid or equivalent medical assistance. As long as the statutory disregards applicable to the PFD or ALB respectively remain in effect, they are not required to be deposited into the Trust, and need not be taken into account by the Trustee in computing the amount to be disbursed from the Trust to the Beneficiary.

8.02 Governing Law

This Trust shall be construed in accordance with, and governed by, the laws of the State of Alaska.

8.03 Number and Gender

Unless some other meaning and intent is apparent from the content, the plural shall include the singular, and vice versa, and masculine, feminine and neuter words shall be interchangeable.

Signed by _____, Settlor, this ____ day of _____, 1998

SETTLOR

STATE OF ALASKA)
)ss.
THIRD JUDICIAL DISTRICT)

SIGNED, SWORN TO AND ACKNOWLEDGED before me by John Happe, as Settlor of the John Happe IRREVOCABLE TRUST, this ____ day of _____, 1998.

Notary Public in and for Alaska
My commission expires: _____

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Signed by _____, who accepts the office of Trustee of this Trust on the _____ day of _____, 1998.

TRUSTEE

STATE OF ALASKA)
)ss.
THIRD JUDICIAL DISTRICT)

SIGNED, SWORN TO AND ACKNOWLEDGED before by _____, as Trustee of the _____ IRREVOCABLE TRUST, this _____ day of January, 1998.

Notary Public in and for Alaska
My commission expires: _____

CHOICE Program Funding

**Comparison of HCB Waiver Costs
with Cost of Equivalent Institution
Using HCFA 372S Data**

<u>Older Alaskans</u>		<u>FY 96</u>	<u>FY 97</u>
Total Waiver Recipients		206	411
Average Waiver Service Cost	\$	10,374	\$ 11,151
Average Medicaid Non Waiver Service Cost	\$	4,692	\$ 4,984
Total Average Cost per Waiver Recipient	\$	15,066	\$ 16,135
Average Institutional Cost		\$ 55,428	\$ 53,267
Average Medicaid Non Institutional Cost	\$	1,918	\$ 1,852
Total Average Cost per Institutional Recipient	\$	57,346	\$ 55,119
Difference between Waiver and Institutional Cost	\$	42,280	\$ 38,984
 <u>Adults with Physical Disabilities</u>		<u>FY 96</u>	<u>FY 97</u>
Total Waiver Recipients		66	88
Average Waiver Service Cost	\$	15,398	\$ 19,171
Average Medicaid Non Waiver Service Cost	\$	9,430	\$ 14,497
Total Average Cost per Waiver Recipient	\$	24,828	\$ 33,668
Average Institutional Cost		\$ 58,855	\$ 56,210
Average Medicaid Non Institutional Cost	\$	4,096	\$ 3,523
Total Average Cost per Institutional Recipient	\$	62,951	\$ 59,733
Difference between Waiver and Institutional Cost	\$	38,123	\$ 26,065
 <u>People with Mental Retardation or Developmental Disabilities</u>		<u>FY 96</u>	<u>FY 97</u>
Total Waiver Recipients		138	341
Average Waiver Service Cost	\$	31,732	\$ 44,085
Average Medicaid Non Waiver Service Cost	\$	4,030	\$ 6,817
Total Average Cost per Waiver Recipient	\$	35,762	\$ 50,902
Average Institutional Cost		\$ 120,882	\$ 104,842
Average Medicaid Non Institutional Cost	\$	3,170	\$ 2,371
Total Average Cost per Institutional Recipient	\$	124,052	\$ 107,213
Difference between Waiver and Institutional Cost	\$	88,290	\$ 56,311
 <u>Children with Complex Medical Conditions</u>		<u>FY 96</u>	<u>FY 97</u>
Total Waiver Recipients		58	70
Average Waiver Service Cost	\$	21,366	\$ 21,954
Average Medicaid Non Waiver Service Cost	\$	19,630	\$ 21,438
Total Average Cost per Waiver Recipient	\$	40,996	\$ 43,392
Average Institutional Cost		\$ 126,763	\$ 120,658
Average Medicaid Non Institutional Cost	\$	26,377	\$ 25,277
Total Average Cost per Institutional Recipient	\$	153,140	\$ 145,935
Difference between Waiver and Institutional Cost	\$	112,144	\$ 102,543

Note: The HCFA 372S Report compares actual HCB waiver spending to projected Medicaid spending on institutional recipients at comparable age and level of care.

Waiver and Nursing Facility Spending FY 97 and FY 98
Top 100 in Each Category

Information pulled from STARS on 10/1/98 and 10/2/98.

Waiver expenditures are based on claims with eligibility codes o

Long Term Care (LTC) expenditures are based on all claims for

Claims are based on DOS 7/1/96 - 6/30/98 and DOP >= 7/1/96.

Waiver and Nursing Facility Spending FY 97 and FY 98
Top 100 in Each Category

Rank	Adult Waiver		Old Age Waiver		MR/DD Waiver		Kids Waiver		LTC	
	FY97 PAID	FY98 PAID	FY97 PAID	FY98 PAID	FY97 PAID	FY98 PAID	FY97 PAID	FY98 PAID	FY97 PAID	FY98 PAID
1	\$249,486	\$97,665	\$85,161	\$82,308	\$222,768	\$245,640	\$211,499	\$170,137	\$195,176	\$202,847
2	\$97,923	\$83,607	\$67,151	\$76,265	\$216,195	\$222,992	\$196,140	\$129,409	\$183,360	\$202,095
3	\$86,998	\$79,954	\$62,116	\$72,476	\$210,465	\$219,712	\$152,029	\$117,519	\$183,104	\$199,029
4	\$86,824	\$76,645	\$61,962	\$65,525	\$197,173	\$204,529	\$121,764	\$110,804	\$182,496	\$197,354
5	\$75,935	\$68,282	\$57,908	\$63,849	\$176,571	\$184,257	\$118,374	\$105,354	\$181,837	\$195,568
6	\$70,732	\$64,123	\$57,860	\$62,754	\$151,605	\$172,111	\$117,716	\$103,224	\$177,456	\$193,939
7	\$67,856	\$61,532	\$54,941	\$54,717	\$143,384	\$158,492	\$101,250	\$103,110	\$176,538	\$193,755
8	\$67,337	\$57,436	\$52,984	\$53,802	\$143,307	\$156,980	\$93,679	\$102,674	\$175,093	\$192,314
9	\$66,825	\$56,934	\$52,497	\$51,620	\$142,945	\$147,135	\$92,380	\$100,020	\$173,710	\$191,295
10	\$65,396	\$56,213	\$50,640	\$51,227	\$141,911	\$145,236	\$84,766	\$93,598	\$171,766	\$191,216
11	\$64,454	\$55,583	\$49,337	\$50,557	\$136,471	\$144,114	\$80,669	\$92,741	\$170,666	\$189,239
12	\$64,160	\$53,919	\$47,177	\$48,910	\$135,900	\$140,923	\$77,129	\$85,478	\$170,345	\$183,245
13	\$57,018	\$50,892	\$46,134	\$48,544	\$135,248	\$140,263	\$76,981	\$81,108	\$167,865	\$170,494
14	\$54,065	\$49,843	\$45,814	\$46,885	\$134,926	\$140,193	\$72,160	\$78,950	\$165,985	\$165,671
15	\$50,434	\$47,729	\$45,174	\$46,243	\$134,452	\$135,850	\$69,538	\$78,357	\$165,487	\$153,165
16	\$48,836	\$46,668	\$44,733	\$46,056	\$134,013	\$134,952	\$68,329	\$76,523	\$162,726	\$150,837
17	\$48,706	\$45,538	\$44,422	\$45,547	\$131,917	\$134,308	\$63,701	\$76,391	\$155,459	\$150,794
18	\$47,010	\$45,426	\$44,028	\$45,198	\$131,299	\$133,626	\$61,961	\$71,401	\$149,696	\$147,962
19	\$45,982	\$44,959	\$44,006	\$44,396	\$130,867	\$132,009	\$57,324	\$71,171	\$149,656	\$146,384
20	\$45,953	\$44,715	\$43,892	\$43,985	\$130,560	\$131,029	\$54,517	\$70,449	\$148,385	\$144,834
21	\$45,789	\$43,606	\$43,078	\$43,557	\$130,312	\$129,383	\$54,505	\$68,715	\$148,327	\$137,685
22	\$45,566	\$43,177	\$42,574	\$43,001	\$129,567	\$128,813	\$51,993	\$63,037	\$147,426	\$136,776
23	\$45,539	\$42,057	\$41,770	\$43,000	\$129,010	\$128,311	\$50,430	\$60,048	\$147,367	\$135,410
24	\$44,901	\$41,906	\$41,587	\$42,481	\$128,864	\$127,371	\$49,933	\$59,508	\$145,111	\$135,397
25	\$44,574	\$39,669	\$41,571	\$42,287	\$128,452	\$125,845	\$48,466	\$57,112	\$144,519	\$134,527
26	\$43,095	\$39,242	\$40,849	\$41,809	\$128,391	\$126,122	\$47,019	\$55,548	\$143,848	\$134,373
27	\$43,083	\$37,217	\$39,741	\$41,796	\$127,328	\$126,115	\$46,610	\$53,721	\$143,362	\$132,782
28	\$42,986	\$36,558	\$38,772	\$41,726	\$125,460	\$124,563	\$42,437	\$52,790	\$142,425	\$130,022
29	\$42,942	\$35,790	\$38,671	\$41,683	\$125,448	\$124,169	\$42,425	\$51,214	\$141,150	\$128,665
30	\$42,766	\$33,400	\$38,645	\$41,654	\$125,309	\$124,044	\$41,153	\$48,673	\$140,458	\$128,078
31	\$42,304	\$32,445	\$38,350	\$41,312	\$124,168	\$123,922	\$38,970	\$48,424	\$136,978	\$127,826
32	\$40,537	\$32,291	\$38,134	\$41,050	\$123,608	\$123,411	\$38,545	\$45,257	\$136,848	\$127,762
33	\$39,994	\$32,175	\$37,800	\$41,050	\$122,162	\$123,001	\$37,653	\$44,692	\$136,717	\$126,527
34	\$38,087	\$31,965	\$37,072	\$40,816	\$121,902	\$121,976	\$36,319	\$44,579	\$136,015	\$125,913
35	\$36,590	\$31,681	\$36,847	\$39,906	\$121,810	\$119,697	\$33,799	\$42,178	\$135,930	\$125,778
36	\$35,056	\$31,598	\$36,233	\$39,870	\$119,870	\$119,430	\$32,783	\$38,717	\$135,596	\$125,544
37	\$33,743	\$31,425	\$35,954	\$39,800	\$119,115	\$117,388	\$32,218	\$38,105	\$131,637	\$124,556
38	\$31,890	\$30,725	\$35,396	\$39,582	\$115,071	\$115,673	\$32,176	\$35,437	\$130,023	\$124,459
39	\$30,827	\$30,023	\$35,260	\$39,483	\$107,311	\$115,527	\$31,735	\$31,591	\$129,472	\$124,449
40	\$30,543	\$29,875	\$35,202	\$39,258	\$98,936	\$114,974	\$31,647	\$31,364	\$129,199	\$124,347
41	\$30,401	\$29,077	\$34,814	\$39,017	\$97,954	\$111,861	\$31,046	\$31,199	\$127,951	\$123,798
42	\$29,579	\$29,031	\$34,543	\$38,726	\$94,906	\$110,624	\$30,914	\$30,303	\$127,733	\$123,617
43	\$28,488	\$27,459	\$34,436	\$38,442	\$91,541	\$110,340	\$30,339	\$29,791	\$127,059	\$123,161
44	\$28,148	\$27,367	\$34,422	\$38,404	\$83,298	\$109,379	\$29,578	\$28,575	\$126,805	\$123,082
45	\$28,071	\$27,048	\$34,261	\$37,847	\$79,961	\$106,862	\$28,940	\$27,896	\$124,109	\$122,640
46	\$27,594	\$25,317	\$34,115	\$37,817	\$79,856	\$106,294	\$28,242	\$27,624	\$123,276	\$122,490
47	\$27,077	\$25,307	\$34,040	\$37,508	\$79,393	\$104,814	\$24,211	\$26,973	\$122,645	\$122,486
48	\$26,528	\$25,107	\$33,376	\$37,183	\$77,804	\$104,542	\$23,910	\$26,230	\$122,643	\$121,213
49	\$26,129	\$24,423	\$33,330	\$37,173	\$76,101	\$104,174	\$23,193	\$25,306	\$122,448	\$120,659
50	\$25,409	\$22,608	\$33,279	\$37,152	\$75,722	\$103,108	\$23,129	\$24,807	\$121,605	\$120,641
51	\$24,559	\$22,445	\$32,691	\$36,966	\$75,706	\$102,718	\$21,041	\$23,609	\$120,984	\$120,582
52	\$24,144	\$22,244	\$32,625	\$36,907	\$74,022	\$101,182	\$19,890	\$22,364	\$120,969	\$120,360
53	\$23,769	\$21,513	\$32,612	\$36,904	\$73,782	\$100,560	\$19,862	\$21,306	\$120,442	\$119,939
54	\$23,443	\$19,395	\$32,508	\$36,693	\$72,593	\$99,785	\$19,841	\$21,041	\$120,248	\$119,828
55	\$23,400	\$19,222	\$32,354	\$36,691	\$71,095	\$99,090	\$18,791	\$20,662	\$119,782	\$119,687
56	\$22,855	\$18,598	\$32,223	\$36,524	\$69,978	\$98,884	\$18,246	\$20,152	\$119,642	\$119,602
57	\$22,561	\$18,571	\$32,147	\$36,440	\$68,864	\$97,594	\$18,211	\$20,101	\$118,884	\$119,488
58	\$21,422	\$18,216	\$31,958	\$35,948	\$68,605	\$95,684	\$17,896	\$19,014	\$117,245	\$119,251
59	\$21,374	\$18,211	\$31,836	\$35,684	\$66,908	\$95,271	\$17,348	\$17,745	\$117,224	\$119,072
60	\$20,320	\$18,181	\$31,762	\$35,251	\$66,249	\$93,447	\$13,708	\$15,532	\$116,320	\$118,623

**Waiver and Nursing Facility Spending FY 97 and FY 98
Top 100 in Each Category**

Rank	Adult Waiver		Old Age Waiver		MR/DD Waiver		Kids Waiver		LTC	
	FY97 PAID	FY98 PAID	FY97 PAID	FY98 PAID	FY97 PAID	FY98 PAID	FY97 PAID	FY98 PAID	FY97 PAID	FY98 PAID
61	\$20,210	\$18,169	\$31,761	\$35,246	\$66,129	\$92,926	\$12,922	\$15,116	\$116,255	\$118,214
62	\$19,970	\$18,084	\$31,165	\$35,219	\$64,936	\$91,307	\$12,153	\$12,507	\$115,754	\$117,743
63	\$19,845	\$17,668	\$31,145	\$35,209	\$64,296	\$91,278	\$11,701	\$11,685	\$115,751	\$117,621
64	\$17,748	\$16,256	\$31,055	\$35,157	\$64,230	\$89,887	\$11,611	\$11,575	\$115,706	\$117,499
65	\$16,301	\$15,324	\$30,600	\$35,143	\$63,701	\$89,760	\$11,083	\$11,328	\$115,666	\$117,401
66	\$15,245	\$14,855	\$30,580	\$35,100	\$63,489	\$89,129	\$10,046	\$10,094	\$115,459	\$116,949
67	\$15,221	\$14,381	\$30,531	\$35,022	\$62,765	\$88,762	\$9,897	\$7,822	\$115,411	\$116,809
68	\$14,836	\$14,184	\$30,146	\$34,910	\$62,515	\$88,298	\$8,590	\$7,644	\$115,385	\$116,809
69	\$14,829	\$13,676	\$29,967	\$34,586	\$61,233	\$87,035	\$7,029	\$5,157	\$115,127	\$116,618
70	\$13,802	\$13,662	\$29,784	\$34,026	\$61,005	\$86,806	\$6,110	\$4,812	\$114,955	\$116,567
71	\$13,347	\$13,495	\$29,776	\$33,765	\$60,844	\$86,138	\$5,813	\$4,659	\$114,633	\$115,982
72	\$11,942	\$13,414	\$29,596	\$33,714	\$59,405	\$84,964	\$845	\$3,614	\$114,166	\$115,822
73	\$11,915	\$12,750	\$29,479	\$33,690	\$59,343	\$83,713	\$0	\$3,377	\$114,071	\$115,750
74	\$11,888	\$12,378	\$29,423	\$33,622	\$59,340	\$82,911		\$200	\$113,851	\$115,287
75	\$10,362	\$12,367	\$29,258	\$33,204	\$59,055	\$82,874			\$113,568	\$114,872
76	\$8,878	\$12,336	\$29,214	\$33,130	\$58,414	\$82,867			\$113,383	\$114,544
77	\$8,745	\$12,296	\$29,096	\$33,064	\$58,385	\$82,283			\$112,905	\$114,376
78	\$8,590	\$12,191	\$28,962	\$32,911	\$58,011	\$82,257			\$112,784	\$113,894
79	\$7,274	\$12,024	\$28,546	\$32,704	\$57,745	\$82,072			\$112,711	\$113,585
80	\$7,250	\$11,910	\$28,220	\$32,542	\$57,713	\$81,612			\$112,631	\$113,524
81	\$4,609	\$9,770	\$28,170	\$32,516	\$57,692	\$80,585			\$112,627	\$112,608
82	\$4,429	\$9,677	\$28,113	\$32,485	\$57,621	\$80,560			\$112,481	\$112,358
83	\$3,509	\$8,892	\$28,086	\$32,341	\$57,528	\$80,547			\$112,450	\$112,260
84	\$3,298	\$8,489	\$27,977	\$32,338	\$57,487	\$79,889			\$112,171	\$112,229
85	\$2,916	\$8,132	\$27,968	\$32,335	\$57,458	\$78,921			\$112,150	\$112,168
86	\$2,648	\$8,065	\$27,878	\$32,266	\$57,331	\$77,489			\$112,006	\$111,912
87	\$1,140	\$7,838	\$27,771	\$32,252	\$57,068	\$77,447			\$111,719	\$111,028
88	\$762	\$7,671	\$27,622	\$32,237	\$57,067	\$77,175			\$111,551	\$110,757
89	\$532	\$7,394	\$27,020	\$32,199	\$56,784	\$77,109			\$110,819	\$110,426
90	\$315	\$7,243	\$26,776	\$32,041	\$56,628	\$77,097			\$110,599	\$110,346
91	\$209	\$7,081	\$26,653	\$31,682	\$56,111	\$77,024			\$110,067	\$109,825
92	\$193	\$6,899	\$26,472	\$31,468	\$56,072	\$76,436			\$109,373	\$109,567
93	\$36	\$5,738	\$26,393	\$31,259	\$55,756	\$76,188			\$109,237	\$108,693
94	\$14	\$5,580	\$26,193	\$31,235	\$55,685	\$74,437			\$109,188	\$108,650
95		\$5,528	\$26,187	\$31,180	\$54,995	\$73,579			\$109,016	\$108,579
96		\$5,465	\$26,053	\$31,099	\$54,652	\$73,260			\$108,943	\$108,522
97		\$5,313	\$25,857	\$31,074	\$54,609	\$72,924			\$108,793	\$108,296
98		\$5,224	\$25,479	\$30,716	\$54,540	\$72,667			\$108,627	\$108,279
99		\$4,881	\$25,477	\$30,639	\$54,495	\$72,637			\$108,376	\$107,867
100		\$4,598	\$25,378	\$30,635	\$54,346	\$72,438			\$108,312	\$107,646
average	\$32,562	\$27,747	\$36,306	\$39,852	\$94,249	\$109,966	\$46,012	\$47,013	\$131,259	\$130,950

FY96 100 most expensive

Information pulled from STARS on 2/23/96

Expenditures are based on claims with eligibility codes of 40 - 45.

Claims are based on DOS 7/1/95 - 6/30/96 and DOP >= 7/1/95.

Expenditure Rank	Type of Waiver	Months Eligible	FY96 (DOS) Expenditures
1	old age	12	\$53,611.66
2	old age	12	\$41,980.74
3	old age	12	\$41,046.57
4	old age	12	\$40,304.91
5	old age	12	\$39,912.13
6	old age	12	\$39,308.40
7	old age	12	\$38,475.02
8	old age	12	\$37,511.45
9	old age	12	\$37,124.83
10	old age	12	\$37,104.68
11	old age	12	\$36,612.04
12	old age	12	\$36,151.95
13	old age	12	\$35,899.08
14	old age	12	\$35,670.17
15	old age	12	\$35,013.55
16	old age	12	\$34,447.12
17	old age	12	\$34,233.64
18	old age	12	\$33,911.55
19	old age	12	\$33,777.17
20	old age	12	\$32,884.10
21	old age	11	\$32,378.36
22	old age	12	\$32,361.65
23	old age	12	\$30,872.46
24	old age	12	\$30,487.77
25	old age	12	\$29,944.27
26	old age	8	\$29,822.00
27	old age	12	\$29,719.05
28	old age	10	\$29,284.85
29	old age	12	\$28,829.27
30	old age	12	\$28,626.81
31	old age	12	\$28,581.64
32	old age	12	\$28,260.14
33	old age	12	\$28,146.00
34	old age	12	\$28,105.72
35	old age	12	\$28,094.97
36	old age	10	\$27,919.48
37	old age	12	\$27,816.88
38	old age	12	\$27,520.80
39	old age	12	\$27,471.09
40	old age	12	\$27,309.34
41	old age	8	\$26,854.24
42	old age	12	\$26,844.58

FY96 100 most expensive

43 old age	12	\$26,793.97
44 old age	12	\$26,124.43
45 old age	12	\$25,404.85
46 old age	12	\$25,368.92
47 old age	11	\$25,324.74
48 old age	12	\$25,264.54
49 old age	12	\$24,409.30
50 old age	12	\$24,106.57
51 old age	12	\$23,788.76
52 old age	12	\$23,505.23
53 old age	12	\$23,090.95
54 old age	2	\$22,993.43
55 old age	12	\$22,411.06
56 old age	8	\$22,291.65
57 old age	12	\$21,706.73
58 old age	11	\$21,554.47
59 old age	12	\$21,359.59
60 old age	12	\$21,068.20
61 old age	11	\$20,703.72
62 old age	12	\$20,499.08
63 old age	6	\$20,336.01
64 old age	7	\$20,004.28
65 old age	12	\$19,881.15
66 old age	12	\$19,776.28
67 old age	10	\$19,660.03
68 old age	6	\$19,522.29
69 old age	12	\$19,334.78
70 old age	12	\$19,045.55
71 old age	9	\$18,381.98
72 old age	12	\$18,263.27
73 old age	7	\$17,343.49
74 old age	11	\$16,856.19
75 old age	7	\$16,764.80
76 old age	4	\$16,722.99
77 old age	5	\$16,513.67
78 old age	9	\$16,104.63
79 old age	12	\$16,002.32
80 old age	11	\$15,851.14
81 old age	9	\$15,366.13
82 old age	7	\$15,034.07
83 old age	5	\$14,943.56
84 old age	6	\$14,937.33
85 old age	6	\$14,147.72
86 old age	8	\$13,929.50
87 old age	5	\$13,800.41
88 old age	12	\$13,626.58
89 old age	12	\$13,616.95
90 old age	4	\$13,530.49
91 old age	12	\$13,371.70

FY96 100 most expensive

92	old age	11	\$13,215.11
93	old age	12	\$12,842.54
94	old age	5	\$12,785.59
95	old age	4	\$12,443.16
96	old age	5	\$12,408.18
97	old age	5	\$12,258.16
98	old age	12	\$11,879.57
99	old age	10	\$11,868.68
100	old age	7	\$11,835.28

FY96 25 most expensive

Information pulled from STARS on 2/23/98.

Expenditures are based on claims with eligibility codes of 30 - 35; 70 - 75; and 80 - 82.

Claims are based on DOS 7/1/95 - 6/30/96 and DOP >= 7/1/95.

Expenditure Rank	Kids Waiver		Adult Waiver		MR/DD Waiver	
	Months	FY96 (DOS)	Months	FY96 (DOS)	Months	FY96 (DOS)
	Eligible	Expenditures	Eligible	Expenditures	Eligible	Expenditures
1	12	\$157,245.48	12	\$66,585.57	12	\$124,078.58
2	12	\$151,392.35	12	\$65,867.65	12	\$95,648.81
3	7	\$125,766.36	12	\$57,553.78	12	\$71,787.91
4	12	\$121,524.68	1	\$56,785.00	12	\$69,959.47
5	12	\$100,440.30	12	\$49,641.55	12	\$69,842.15
6	12	\$91,977.15	12	\$49,428.82	12	\$69,237.19
7	12	\$74,968.61	12	\$49,072.50	12	\$63,962.22
8	12	\$72,228.27	12	\$48,455.08	12	\$62,612.36
9	8	\$67,979.48	6	\$47,484.60	12	\$61,635.36
10	10	\$67,409.98	12	\$45,961.83	12	\$61,086.69
11	12	\$54,773.76	12	\$44,215.72	12	\$60,274.02
12	12	\$52,599.45	8	\$43,900.07	12	\$56,280.66
13	6	\$50,108.45	12	\$43,633.19	12	\$55,826.59
14	12	\$50,030.02	12	\$43,371.47	12	\$55,320.00
15	12	\$49,660.15	12	\$43,204.33	12	\$54,711.45
16	12	\$45,476.30	11	\$39,639.33	12	\$54,453.59
17	12	\$45,068.85	12	\$37,900.37	12	\$53,697.82
18	12	\$43,362.45	10	\$33,928.89	12	\$53,517.20
19	12	\$41,597.95	2	\$33,914.86	12	\$53,037.43
20	12	\$40,538.51	12	\$33,449.87	12	\$53,018.13
21	5	\$39,024.92	2	\$32,236.29	10	\$52,723.67
22	12	\$38,684.17	6	\$28,675.07	12	\$52,624.84
23	12	\$36,649.40	12	\$28,379.95	12	\$52,459.24
24	7	\$35,392.26	7	\$26,217.04	12	\$52,391.44
25	5	\$30,773.27	12	\$25,893.22	12	\$52,068.41

LTC Private Insurance

Issue Brief: Long-Term Care Insurance

Definition: Long-term care typically refers to a wide range of services for people with a prolonged physical illness, disability or cognitive disorder. Long-term care services aim to help people with chronic conditions compensate for limitations in their ability to function independently and may include daily activities in the home, respite care, home health care, adult day care, and care in a nursing home.

Findings:

Medicare does not provide for the custodial long-term care services that so many elderly need.

Most Americans do not have long-term care insurance nor will they be able to afford it. According to AARP, only six percent of elderly Americans have private insurance policies and most studies estimate that only 10 to 20 percent of the elderly can afford good-quality private long-term care insuranceⁱ.

As a result, the responsibility for paying for the long-term care services rests on individuals until they deplete their saving and become eligible for the Medicaid program. Nationwide, 35 percent of the Medicaid program budget goes to long-term care, a percentage almost certain to grow as baby boomers ageⁱⁱ.

The most significant reason that Americans are not purchasing long-term care insurance policies is the high premium cost, particularly for those most likely to purchase them, namely persons 65 and older. Premiums escalate as people age. Data from the Health Insurance Association of America shows that policies that pay \$100 a day for nursing care and \$50 a day for home care average \$1,881 for those who buy at age 65, jumping to \$5,889 for those age 79ⁱⁱⁱ. Policies are costly in part because most are sold individually and carry high administrative costs. Preexisting condition limitations provisions also exclude some from the market.

Most long-term insurance policies are bought by upper-middle and upper-income elderly persons with substantial assets. As such, their purchase is expected to have a limited impact on public spending (Medicaid). Medicaid savings, resulting from the purchase of long-term care plans, are projected at 2 - 4 percent for policies sold to the elderly.^{iv}

Alternatives/Impacts and Costs:

Given the limitations of the current market for private long-term care insurance, public subsidies to promote its purchase are often proposed. One approach is to provide employers with a tax subsidy for the purchase of policies. A tiny but expanding market of employer-sponsored insurance has developed. However, in a key difference from acute care policies where employers historically have paid a large share of the cost of the insurance, most employers are offering them on an employee-pay-all basis.

Some state governments like other employers are promoting long-term care coverage to their own employees. Alaska was the first state to offer long-term care as an optional benefit at the time an employee retires. The plan design is now 10 years old and the retirement boards are meeting to review it and its increased costs.

A second strategy is to provide a tax deduction or credit to individuals for the purchase of private long-term care insurance. Tax incentives for employers and individuals were part of HIPAA. A significant problem with tax incentives is the probability that most of the tax incentives will be for people who would have purchased policies anyway^v.

A third strategy is to waive some or all of the Medicaid asset depletion requirements for purchasers of qualified long-term care plans. Four states are participating in a related long-term care insurance demonstration project funded by the Robert Wood Johnson Foundation. Under the project, individuals with long-term care insurance who reach their maximum benefit coverage are allowed to become eligible for Medicaid and keep all or some of their assets. To date, more than 28,000 policies are in place.

All of these strategies will undoubtedly encourage Americans to purchase long-term care insurance, but to what extent is not known.

ⁱ The Urban Institute. "Can Private Insurance solve the Long-term Care Problems of the Baby Boom Generation?", Washington, D.C., March 9, 1998.

ⁱⁱ National Conference of State Legislatures. "Long-Term Care Insurance: States Seek to Encourage Sales", *State Health Notes*. Washington, D.C., Volume 19, No. 284, September 14, 1998.

ⁱⁱⁱ Government Accounting Office. "Long-Term Care: Baby Boom Generation Presents Financing Challenges". Washington, D.C. GAO/T-HEHS-98-107, March 9, 1998.

^{iv} The Urban Institute.

^v Ibid.

LTC Choice

A Simple, Cost-Free Solution to the Long-Term Care Financing Puzzle

presented by the

Center for Long-Term Care Financing

"Dedicated to ensuring quality long-term care for all Americans"

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- We demonstrate that the solution to the long-term care financing puzzle is to persuade people to consider and to confront the risk of long-term care while they are still young, healthy, and affluent enough to save or insure privately.
- We offer a simple, cost-free solution called *LTC Choice*.
- *LTC Choice* requires the United States Government to provide information about long-term care risk and financing options to all citizens as soon as possible, but no later than their 65th birthdays.
- Under *LTC Choice*, every individual may choose to show proof of private insurance or adequate financial reserves to pay for long-term care and thus abstain from public financing entirely and avoid all other reporting requirements.
- Alternatively, anyone who is unable or chooses not to show proof of private long-term care financial protection would have to acknowledge formally in writing that any future eligibility for publicly financed long-term care is contingent upon spending down nearly all his or her income and assets for care expenses first.
- Requiring all citizens to confront the *LTC Choice* long before the insurable event occurs will radically increase the proportion of Americans who plan responsibly for long-term care and drastically reduce the incidence of artificial impoverishment to qualify for Medicaid.
- With over \$10 trillion about to pass by inheritance to the baby boomers from the WWII generation, Americans have no shortage of private money to save or insure for long-term care.
- All we need to do is eliminate the perverse incentives in the current system that enable denial of long-term care risk and discourage responsible, early planning.

*LTC Choice: A Simple, Cost-Free Solution to the Long-Term Care Financing Puzzle***Executive Summary***How can America solve the long-term care financing problem?*

- The publisher of this study, the Center for Long-Term Care Financing, is dedicated to ensuring high quality long-term care for all Americans.
- The problem of how to finance long-term care for the baby boom generation rivals Medicare and Social Security as the most serious social policy challenge facing the United States.
- Today, America's long-term care service delivery and financing system is fragmented, dysfunctional, and plagued by problems of access, quality, reimbursement, discrimination and institutional bias.
- Nevertheless, we know exactly what we would like our country's long-term care system to provide: universal access to top-quality care for rich and poor alike in the least institutional settings possible.
- Pundits, politicians and policy-makers recognize the problem; they know what the solution should look like; why can't they get the job done? That is the long-term care financing puzzle.
- In this report, we explain how America's long-term care system came to its current sorry state by tracing the history of long-term care financing since the establishment of Medicaid and Medicare.
- We disprove and discard the conventional wisdom that catastrophic long-term care spend-down is widespread and therefore requires expanded public financing.
- We prove and adopt the position that virtually everyone can obtain public financing of long-term care through Medicaid or Medicare after being stricken by chronic illness. This fact explains why so few people plan ahead for the risk of long-term care.

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Preface

What is the Center for Long-Term Care Financing?

This report is the first public policy paper of the Center for Long-Term Care Financing. Another version of this paper will be published as the chapter on long-term care financing in Ken Dychtwald's forthcoming anthology *Toward Healthy Aging*.

Stephen Moses and David Rosenfeld established the Center for Long-Term Care Financing in April 1998. The Center's mission is to promote universal access to top-quality long-term care by encouraging private financing and discouraging welfare financing of long-term care for most Americans.

The Center for Long-Term Care Financing advocates public policy that targets scarce public resources to the neediest, while encouraging people who are young, healthy and affluent enough, to take responsibility for themselves. We believe that private insurance and investment can guarantee quality long-term care for prosperous seniors and help save the Medicaid long-term care program for the truly needy. Toward these ends, the Center offers a range of fee-for-service products to public and private clients including consulting, publishing, training and public speaking. The Center for Long-Term Care Financing also publishes a periodic on-line news service called "LTC Bullets" which covers the latest information and trends in long-term care financing. This publication is available free of charge.

The two principals in the Center for Long-Term Care Financing have many years of experience between them in the fields of long-term care policy, public welfare, aging, law and social work. Stephen Moses was formerly Director of Research for LTC, Incorporated and a senior analyst for the Health Care Financing Administration and the Office of Inspector General of the U.S. Department of Health and Human Resources. He is nationally recognized as an

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expert and innovator in the field of long-term care. David Rosenfeld is an attorney and MSW with a growing reputation as an author and speaker on long-term care issues. He specializes in ethical questions affecting elder law. Biographical profiles of Mr. Moses and Mr. Rosenfeld are provided at the end of this report.

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Introduction

What is the long-term care financing puzzle?

Long-term care in the United States is more than a challenging public policy problem. It is a fascinating puzzle as well. In fact, the question "How will we pay for the needs of a rapidly aging population?" raises a whole continuum of conundrums. For example, why does a prosperous nation like ours warehouse its World War II generation in welfare-financed nursing homes? Why are most Americans in denial about the risks of long-term care when the media warn us constantly about an impending demographic Armageddon? Why do we agree on so many of the problems and solutions of long-term care service delivery and yet fail year after year to initiate decisive corrective action? This report will answer these questions, solve the underlying puzzle, and propose an affordable public policy solution.

Conventional wisdom and scholarly consensus agree: America faces a potentially cataclysmic long-term care financing crisis in the foreseeable future. The evidence of impending danger lies everywhere we look: undeniable trends in aging demographics; reduced availability of informal caregivers; doubts about the quality of formal long-term care; inadequate supply of low-cost home- and community-based services; rapidly escalating nursing-home expenses; poorly structured delivery systems; dwindling public finances; increasingly resistant taxpayers; declining ability or willingness of families to pay privately for long-term care; cracks in our public and private pension systems; and the approaching retirement of the baby boom generation. These are the elements of consensus on the problem.

Just as the public and the experts have come to agree on the problems, they also concur on the architecture of an ideal long-term care system. Certain optimal features show up consistently in task-force reports, think tank studies, policy papers, and published articles. These

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include: generous eligibility for assistance; integrated acute and long-term care; easy access at a single point of entry; quality control; case or care management; uniform client needs assessment; asset protection; home- and community-based care; nonmedical social services (such as housekeeping and personal care); adult day care; respite care; supportive housing such as assisted living and adult foster homes; pre-admission screening; custodial, skilled, and sub-acute nursing-home care; services to meet the special needs of geriatric, developmentally disabled, mentally ill, and other patients; and coordination of public financing sources (primarily Medicaid and Medicare). These are the elements of consensus on the solution.

Here is the puzzle: We know what is wrong with long-term care in the United States. We know how to design an optimal service delivery system. We live in the world's wealthiest society. Why can't we come together politically and professionally to get the job done?

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Historical Perspective

How did America's long-term care system become so dysfunctional?

Academics, pundits, and politicians have struggled for decades with the challenge of financing long-term care. Grand designs for reform like the Pepper Commission's report and the Clinton Health Plan have failed to attract public support. Incremental changes like expanding Medicaid (nursing home) and Medicare (home health) coverage have hastened the current fiscal crisis. When nothing you do seems to work, but your predicament is so desperate you cannot give up, the best strategy is to examine your premises.

Most scholarship on long-term care focuses on the *status quo*, laments the familiar problems, advocates the usual solutions, and blames inaction on a lack of money caused by stingy taxpayers and cold-hearted politicians. If there is a fundamental underlying fallacy in our approach to long-term care, this commonplace analysis will not identify or correct it. The sad fact is: if we keep doing what we have always done, we will keep getting what we have always gotten. Instead, we must ask ourselves: *How did our long-term care system come to be the way it is?* and *What do we need to do differently to achieve more desirable results?*

In 1965, America was just starting to have a serious problem with long-term care. People were living longer, but dying more slowly—of chronic illnesses that caused frailty and cognitive impairment. Older Americans needed more and more long-term care at the very time when women, the traditional caregivers, were entering the formal workforce in much greater numbers. This was when a prosperous private market in low-cost home- and community-based services, geriatric care management, and long-term care insurance might have developed in the United States. It did not.

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Instead, with every good intention, the new federal Medicaid program offered publicly-financed long-term nursing-home care. This benefit, initially unencumbered by transfer of assets restrictions and estate recovery requirements, confronted families with a very difficult choice. They could pay out-of-pocket for the home care and community-based services seniors prefer or they could accept nursing-home care paid for by the government. Most people chose the safety and financial benefits of the government's Medicaid option. Therefore, the market for home care withered, private long-term care insurance failed to develop, and Medicaid-financed nursing-home care flourished.

The nursing-home industry took full advantage of this new public financing source by building many new facilities. To have failed to do so would simply have been bad business. As fast as the industry could build them, the new nursing-home beds filled with Medicaid residents. Stunned by the cost, Medicaid attempted to control the construction of new beds with Certificate of Need (CON) programs based on the principle that "we cannot pay for a bed that does not exist." By the mid-1970s, health planning for nursing homes was in full swing. It worked. Fewer new beds were built.

Capping bed supply, however, predictably drove up price and demand. The nursing-home industry raised charges to compensate for the limitation on new beds. What the government saved by restricting bed supply, it lost to nursing-home rate increases. Consequently, Medicaid nursing-home costs grew faster than ever. In response, Medicaid capped reimbursement rates. This move impelled the nursing-home industry to increase private-pay reimbursement rates to compensate. The more the government pushed Medicaid rates down, the more the industry pushed private-pay rates up. So began the highly problematic differential

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between Medicaid rates and private-pay rates. Today, on average, Medicaid pays only 80% of private-pay rates.

Higher private-pay rates made Medicaid more attractive than ever to private payers. The public's desire to obtain public assistance for long-term care expenses led to pressure on legislators to loosen standards for Medicaid eligibility. A long process of eligibility bracket creep gradually made Medicaid nursing-home benefits available even to upper middle-class people. Anyone who had or could obtain the expertise to manipulate Medicaid's highly elastic eligibility rules became eligible. A whole sub-practice of law—Medicaid estate planning—developed to take advantage of this new opportunity. Artificial self-improvement, touted frequently in the national media and in local financial planning ads, became a clever solution to the long-term care financing problem.

With the supply and price of nursing-home beds capped by government fiat and with Medicaid eligibility increasingly generous, nursing-home occupancy skyrocketed to an average of 95% nationally. Given high demand and severely limited supply, nursing-home operators could fill their beds easily with low-paying Medicaid patients. To achieve adequate operating margins, however, nursing homes had to attract a sufficient supply of full-paying private patients or cut costs drastically. Yet, if they tried to attract more lucrative private payers with preferred treatment or accommodations, the nursing homes were deemed guilty of discrimination against Medicaid patients. If they tried to cut costs instead, they came under fire for technical violations or quality problems. In response, Congress and state governments pressured the industry to provide higher quality care without discriminating against low-paying Medicaid recipients. Given the program's fiscal duress, however, Medicaid could not offer higher reimbursement rates to achieve these goals.

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Caught between the rock of low reimbursement and the hard place of quality mandates, the nursing-home industry put up a strong fight. Armed with the Boren Amendment, a federal law that required Medicaid to provide reimbursement adequate to operate an efficient nursing facility, many state nursing-home associations took the battle to court. By this time, however, state and federal Medicaid expenditures were increasing so quickly and taxpayers had become so reluctant to pay for growing public spending that large increases in Medicaid nursing-home reimbursements were out of the question, regardless of which side won the lawsuits. The issue is moot now, of course, because the Boren Amendment was repealed by the Balanced Budget Act of 1997.

In the meantime, a wave of academic speculation in the late 1970s indicated that paying for home- and community-based services (HCBS) instead of nursing-home care could save a lot of money. For years, therefore, Medicaid has experimented with HCBS waivers as a cost-saving measure. In time, however, hard empirical research produced a near consensus that (desirable as they are) home- and community-based services do not save money overall. Medicaid and, more recently, Medicare expenditures for long-term personal and home care have soared in tandem with nursing-home expenditures. It remains true, ironically, that because of the public's aversion to nursing-home care, institutional bias is Medicaid's strongest cost containment tool, one of its gravest deficiencies, and the biggest single obstacle to the expansion of privately-financed home- and community-based long-term care services.

In a nutshell, just as heavy demand was building for a privately financed senior services market in the 1960s, Medicaid co-opted the trend by providing easy access to subsidized nursing-home care. Confronted with a choice between paying out-of-pocket for a lower level of care or receiving a higher level of care at much less expense, seniors and their families made the

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predictable economic choice. Naturally, the potential market for long-term care insurance and privately-financed home- and community-based services languished. Medicaid nursing-home caseloads and expenditures increased rapidly and drastically. In response, Medicaid capped bed supply and reimbursement rates, which led inevitably to excessively high occupancy, private-pay rate inflation, discrimination against low-paying Medicaid patients, and serious quality of care issues.

Over time, Medicaid nursing-home care acquired a national reputation for unimpeded access, dubious quality, inadequate reimbursement, widespread discrimination, pervasive institutional bias, and excessive cost. Medicaid remains, nonetheless, the only way middle-class people can pay for long-term care without selling their homes nor, if they are clever, liquidating their savings. That is why so many otherwise independent and responsible Americans fail to buy private insurance while they are young and healthy enough to qualify for it and afford it, and end up looking to Medicaid planning as the only way to save their estates or their inheritances. It is the reason why a huge proportion of America's proud World War II generation is dying on welfare in nursing homes.

Today, these historical trends have almost run their course. We are on the verge of a promising, but perilous, new world of long-term care. We are floundering forward, compelled by necessity to change the system somehow. Both the private marketplace and public policy are pushing long-term care in a more consumer-friendly direction. Nursing-home occupancy is declining, with the percentage of occupied beds having dropped from the mid-nineties to the mid-eighties in the past decade. The trend toward privately-financed assisted living is exploding. Medicare has entered the arena with rapid growth in its home care and skilled nursing components. New buzz words dominate our professional jargon. We look to concepts like

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capitation, managed care, dual eligibles, and integration of acute and long-term care for new hope.

Is our dream of a seamless long-term care delivery and financing system just around the next bend in public policy? Or are we at risk of making the same mistakes as in the past, but on a wider scale and with more disastrous consequences? To answer these questions, we need to find a fresh perspective on the past, present, and future of long-term care financing.

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A Conflict of Paradigms

Why do most Americans ignore the risk of long-term care until it is too late?

Whether one reads a newspaper article, a scholarly journal or a full-length book about long-term care financing, one invariably finds an argument that goes something like this:

Long-term care, especially nursing-home care, is extremely expensive. Very few Americans can afford \$3,000 to \$5,000 per month in extra out-of-pocket expenses. Therefore, when stricken by the tragedy of Alzheimer's, Parkinson's, or stroke, most people spend down their life's savings quickly and collapse into poverty. Once impoverished, they qualify for Medicaid, which steps in to pay their bills. Consequently, Medicaid nursing-home costs are skyrocketing, and the government's ability to meet growing long-term care needs is severely strained.

This scenario—call it the *welfare paradigm*—comports with some of the facts. For example: nursing homes *are* very expensive; Medicaid *is* a means-tested public assistance program; approximately two-thirds of all residents in nursing homes *do* receive Medicaid; and Medicaid *does* suffer from severe financial problems. But let us set these matters aside for a moment, step back from the actual long-term care financing system, and ask: If the welfare paradigm is valid, what would we logically expect the long-term care marketplace to look like?

If long-term care impoverishes large numbers of Americans and forces them onto welfare, we would certainly expect seniors and their families: (1) to worry and plan years in advance about the potentially catastrophic costs of long-term care; (2) to avoid nursing-home care as long as possible because of its expense and because of their preference to stay at home; (3) to demand high-quality, low-cost, home- and community-based care alternatives that delay institutionalization and impoverishment; (4) to utilize home equity conversion products (such as reverse annuity mortgages) that can finance home care and postpone liquidation of the family home; and (5) to purchase private long-term care insurance that can protect against catastrophic financial loss caused by home or institutional care.

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In practice, the opposite of these reasonable expectations holds true. First, most families do not plan in advance for the risk of long-term care. That is why so many of them end up in crisis with nowhere to turn but to public assistance. Second, nursing-home care is often the first choice for care, not the last resort. That is why so many people end up in nursing homes who could be cared for at home more comfortably and for less cost. Third, the home- and community-based care sector of the long-term care marketplace has been very slow to develop. That is why many people have no viable choice besides nursing-home institutionalization when a health crisis strikes. Fourth, home-equity conversion has failed, to date, as a private sector financial product, despite strong encouragement from the government. That is why home equity, which is the single biggest financial asset of seniors, goes virtually untapped as a source of financing for quality long-term care. Finally, only about six percent of seniors have purchased private long-term care insurance. That is why nursing-home costs are devastating to most people when they do occur.

The Entitlement Paradigm

Clearly, much of what we would expect rational economic decision makers to do if the welfare paradigm were valid simply does not happen. Instead of torturing the old paradigm to account for these anomalies, we might consider a different view—call it the *entitlement paradigm*:

In America today, people can ignore the risk of long-term care, avoid the premiums for private insurance, wait to see if they ever require formal care and, if necessary, shelter all their income and assets to qualify (virtually overnight) for nursing-home benefits paid for by Medicaid.

Viewed from the standpoint of the entitlement paradigm, the puzzling behavior described above would be far more comprehensible. For example, people do not plan ahead for long-term care because they can wait until the last minute and receive publicly-financed care. They often go to

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nursing homes instead of home care first, despite their preferences, because Medicaid pays generously for nursing-home care, but covers very little home care. Few people want to take advantage of home-equity conversion to finance long-term care or insurance premiums because Medicaid exempts the home and all contiguous property regardless of value. Finally, long-term care insurance is unpopular because most people will not pay full dollar for something they can get from the government at a deep discount.

Thus, if the entitlement paradigm is valid, if Medicaid provides easy access to highly subsidized long-term care, we can easily understand why most people are eligible for Medicaid even before they enter a nursing home,¹ why Medicaid nursing-home census and costs have increased rapidly for many years, why induced demand makes Medicaid financing of home care prohibitively expensive, and why private financing of nursing-home care is declining instead of increasing as a proportion of total costs.² Furthermore, if the entitlement paradigm is valid, many exciting new public policy options open up for us. For example, it could be possible to save taxpayers a lot of money and to empower many more Americans to pay privately for top-quality long-term care simply by making Medicaid a little less desirable and by providing a stronger incentive for people to plan ahead to avoid public assistance. In other words, the solution to the long-term care financing puzzle may reside in merging the two paradigms to gain the benefits of

¹ In fact, the data show that 72.9% of single people, 85.4% of married people, and 77.7% of all people are eligible for Medicaid already when they enter a nursing home. (Frank A. Sloan and May W. Shayne, "Long-Term Care, Medicaid, and Impoverishment of the Elderly," *The Milbank Quarterly*, Vol. 71, No. 4, 1993, p. 585.)

² In 1987, private out-of-pocket expenditures accounted for 49.3% of total nursing-home costs nationally; Medicaid paid for 43.9%; and Medicare paid for 1.4%. In 1996, private out-of-pocket expenditures accounted for 31.4% (down 17.9% since 1987); Medicaid paid for 47.8% (up 3.9%); and Medicare paid for 11.4% (up 10.0%). (Source for 1987 data: personal communication with Helen Lazenby, Health Expenditure Analyst, Health Care Financing Administration on February 16, 1989; source for 1996 data: Katharine R. Levit, *et al.*, "National Health Expenditures, 1996," *Health Care Financing Review*, Vol. 19, No. 1, Fall 1997, p. 195.)

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the welfare system without incorporating its negatives and to eliminate the problems of the entitlement paradigm without sacrificing its advantages.

There is no point, however, in exploring these possibilities further unless the entitlement paradigm is valid. Unfortunately, to most people familiar with the long-term care financing system, the entitlement paradigm will seem highly dubious. Critics of the entitlement paradigm will cite federal and state laws that appear to require impoverishment to qualify for Medicaid. Furthermore, most experts accept the welfare paradigm without challenging it. Certainly, as yet, no one has made the case in the mainstream gerontological literature that the welfare paradigm is invalid and that the entitlement paradigm is a much better model of reality.

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A Phalanx of Fallacies

Why does a fundamental misunderstanding of the long-term care problem still persist?

The welfare paradigm—the perspective that our long-term care financing system's biggest problem is widespread catastrophic spend-down—is invalid. But the welfare paradigm is surrounded by a phalanx of fallacies that shelter it from critical scrutiny. The entitlement paradigm—the perspective that the United States has a publicly-financed long-term care entitlement program that impedes market-based solutions the public prefers—is valid. But the entitlement paradigm contradicts conventional wisdom and must be proved. The remainder of this report will refute the welfare paradigm, confirm the entitlement paradigm, and draw public policy recommendations that follow logically from these conclusions.

A key fallacy of the welfare paradigm is that most people who need long-term care spend down their life's savings and fall, sooner or later, into the social safety net of Medicaid. The truth is very different. Seventy-eight percent of all people who enter nursing homes are already eligible for Medicaid before they are admitted to this expensive level of care.³ The vast majority of all patient days in America's nursing homes are paid for by someone other than the patient. Medicaid alone pays at least in part for 71.7% of all nursing-home patient days.⁴ In 1996, more than three-fourths of all dollars paid for nursing-home services came from a combination of publicly-financed programs including Medicaid (47.8%), social security "spend-through"

³ See footnote #1.

⁴ McKnight's Long-Term Care News, December 1996, p. 3 citing HCIA's Guide to the Nursing Home Industry, 1996.

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(12.8%),⁵ Medicare (11.4%), veterans' benefits and other government sources (2.3%), and from private health insurance (5.2%) or patient out-of-pocket income (not assets).⁶ Empirical evidence of widespread catastrophic asset spend-down in nursing homes is nonexistent. In fact, numerous academic studies recently proved that only 15% to 25% of Medicaid nursing-home patients spent down to qualify (including those who did so artificially through asset divestiture), instead of the 50% to 75% previously thought.⁷

Another important fallacy of the welfare paradigm is that Medicaid eligibility requires impoverishment. The truth is very different. Virtually anyone, regardless of income or assets, can qualify quickly and easily for nursing-home care paid for by the government. Most states place no limit on how much income someone can have and still qualify for Medicaid nursing-home benefits. If one's total medical costs—including nursing-home care—approximate or exceed one's income, one is eligible. Even in the toughest "income cap" states, the median elderly person—in terms of income and assets—qualifies easily for Medicaid nursing-home

⁵ Social security spend-through refers to income most seniors collect in the form of social security benefits which must be contributed toward their cost of care when they receive nursing-home services paid for by Medicaid. According to HCFA: "An estimated 41 percent...of out-of-pocket spending for nursing home care was received as income by patients or their representatives from monthly social security benefits." (Helen C. Lazenby and Suzanne W. Letsch, "National Health Expenditures, 1989," *Health Care Financing Review*, Vol. 12, No. 2, Winter 1990, p. 8.) Applying this percentage to the proportion of nursing-home costs paid out-of-pocket in 1996 (31.4%) gives an estimate of social security spend-through of 12.8% for 1996.

⁶ Katharine R. Levit, et al., "National Health Expenditures, 1996," *Health Care Financing Review*, Vol. 19, No. 1, Fall 1997, p. 195. The proportion of out-of-pocket costs attributable to patient income, other than social security spend-through, is unknown but substantial. Seniors often receive income from their investment assets, for example, which would be spent for long-term care before dipping into the assets themselves. Consequently, the total portion of nursing-home costs paid by sources other than patients' assets could approach as much as 80% to 90%.

⁷ Two or three dozen "spend-down" studies were conducted in the late 1980s and early 1990s. They are easily accessible in the scholarly literature. Some of principal authors were Mark Meiners, Brian Burwell, Joshua Wiener, Korbin Liu, Pam Doty, and Kenneth Manton.

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benefits without complicated estate planning.⁸ The "Miller income trusts" authorized by the Omnibus Budget Reconciliation Act of 1993 lifted the lid on income caps altogether for most people.

The widely reported \$2,000 Medicaid eligibility limit on assets is highly misleading. Medicaid recipients can keep unlimited exempt assets—such as a home, a business, and a car—of any value. Many other assets are exempt as well. Converting nonexempt assets such as cash into exempt assets such as home equity is the easiest and most commonplace method of Medicaid planning. For married people, qualifying for Medicaid is even easier than for single people. Couples can shelter up to an additional \$80,760 in assets and \$2,019 per month in income as of 1998. Furthermore, these levels increase annually with inflation.

For the well-to-do who can afford professional legal advice, even these generous eligibility limits are easily overcome. Any competent Medicaid estate planner can deliver Medicaid nursing-home eligibility almost overnight to practically anyone for less than the cost of one month in a private nursing home.⁹ The same advisors can evade estate recovery liability for their clients with equal facility. As explained below, these facts remain true despite strong initiatives taken by Congress and the President in 1993, 1996, and 1997 to close Medicaid loopholes, mandate estate recoveries, and criminalize asset transfer advice.

⁸ The Medicaid income cap increases every year with inflation. For 1998, it was \$1,482 per month or \$17,784 per year as compared to an average annual income (in 1995) of \$16,484 for elderly males and \$9,335 for elderly females. (Department of Health and Human Services, Administration on Aging, "A Profile of Older Americans: 1996," Washington, D.C., December 1996, <http://www.aoa.dhhs.gov/aoa/pages/profil96.html>, p. 6.)

⁹ See the box insert on the next page.

*LTC Choice: A Simple, Cost-Free Solution to the Long-Term Care Financing Puzzle***Welfare for the Well-To-Do**

Hundreds of law journal articles over the past 15 years attest to the fact that Medicaid is available to anyone with enough money to hire the right attorney. The following are typical passages from two mass media legal self-help books that provide Medicaid estate planning advice to the lay public.

"So is there any practical way to juggle assets to qualify for Medicaid—before losing everything? The answer is yes! By following the tips on these pages, an older person or couple can save most or all of their savings, despite our lawmaker's best efforts...Here are the best options: Hide money in exempt assets...Transfer assets directly to children tax-free...Pay children for their help...Juggle assets between spouses...Pass assets to children through a spouse...Transfer a home while retaining a life estate...Change wills and title to property...Write a durable power of attorney...Set up a Medicaid Trust...Get a divorce..." (Armond D. Budish, *Avoiding the Medicaid Trap: How to Beat the Catastrophic Costs of Nursing-Home Care*, Henry Holt, New York, 1989, p. 34.)

"We have committed an act of piracy—we have broken into the Fort Knox of Government benefits and uncovered the best legal strategies available to you for claiming your share of the gold from the Government's treasure chest....We'll explain how you can 'strike gold' in the social security [including SSI], Medicare, and Medicaid programs....With this book we are handing you the treasure map, deciphered from a mine of unintelligible government rules and regulations." (Amy and Armond D. Budish, *Golden Opportunities: Hundreds of Money-Making, Money-Saving Gems for Anyone over Fifty*, Henry Holt and Company, New York, 1993, p. xiii.)

LTC Choice: A Simple, Cost-Free Solution to the Long-Term Care Financing Puzzle

Discussion

Why don't people plan ahead for long-term care and buy private insurance?

Shall we assume, therefore, that because government pays for or subsidizes most nursing-home care in the United States, seniors are intentionally planning to go on welfare and into nursing homes if they ever need formal long-term care? Is that why so many of them fail to buy insurance or pay privately for lower levels of care? No! Most people simply do not worry or care about who pays for long-term care. They do not know whether the source of funding is Medicaid, Medicare or Make-a-Wish. They are aware, however, that *somebody* else pays and that the horror stories that magazine articles and insurance agents tell them about losing their life's savings can be ignored with impunity. Ironically, they are right.

The easy, almost universal availability of publicly-financed nursing-home benefits enables widespread public denial concerning long-term care risk. People only insure against real risks, and they naturally hesitate to pay full price for something that is easily available by government subsidy. If the social safety net suddenly disappeared, if people really had to become impoverished before the government helped them out, they would quickly realize they could no longer enjoy the luxury of their denial. They would plan ahead for long-term care risks, buy insurance, tap home equity, employ geriatric care managers to find and coordinate the best available free or fee services, and pay privately for the lowest, least expensive, and best levels of care they could afford.

The social safety net is not going to disappear, however. The third rail of politics—senior benefits—retains sufficient voltage to stifle any politician who might attempt to eliminate long-term care benefits completely. Fortunately, there is a better way to solve the problem and we already have many of the legislative and bureaucratic tools in place to implement it. The

LTC Choice: A Simple, Cost-Free Solution to the Long-Term Care Financing Puzzle

Omnibus Budget Reconciliation Act of 1993 (OBRA '93), President Clinton's first budget, provided much of what is needed. OBRA '93 closed many of the loopholes that made Medicaid eligibility so attractive and required every Medicaid program in the country to recover benefits paid from the estates of deceased recipients. In essence, OBRA '93 told the middle class: "Medicaid is a loan, not a grant. If you don't want to die on welfare and pay for the privilege, then buy long-term care insurance, pay privately for the long-term care services you prefer, and leave public assistance for the poor." The Health Insurance Portability and Accountability Act of 1996 (HIPAA or the Kennedy/Kassebaum Act) went even further. It criminalized certain Medicaid asset transfers executed for the purpose of qualifying for public assistance. HIPAA also made private long-term care insurance more attractive by making the premiums tax-deductible.

Why haven't these changes in public policy already unleashed the full potential of market-based solutions like supportive housing, home equity conversion, private geriatric care management, and long-term care insurance? Unfortunately, America has an entrenched welfare industry that thrives on impoverishing people artificially and profiteering from their dependency. Thousands of Medicaid estate planners throughout the United States work assiduously to pry back open the eligibility loopholes closed by OBRA '93 and to weaken estate recovery. Numerous well-intentioned legal assistance and seniors' organizations aid and abet the private bar by referring affluent seniors to for-profit Medicaid planners. The Health Care Financing Administration (HCFA), which administers Medicaid and Medicare, does not enforce OBRA '93 aggressively, provides little technical assistance to the states, and openly advises Medicaid estate planners on how to circumvent the law. State Medicaid programs, which are experts at providing benefits and spending money, have little aptitude for or interest in controlling eligibility or

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collecting from estates. Many Medicaid eligibility workers actually help people spend down artificially to qualify for nursing-home benefits. The Balanced Budget Act of 1997 diluted the provisions in HIPAA '96 by targeting criminal penalties for asset transfers at Medicaid planners and other financial advisers, while exonerating their clients. Finally, the Medicaid planners and their professional association have mounted a nationwide public relations campaign to repeal criminalization altogether or have the law declared unconstitutional. As so often happens, our public policymakers, and the interest groups that lobby them, have one foot on the accelerator and one foot on the brake of privatizing long-term care financing.

Clearly, the conventional wisdom that public assistance is available only to people after they have impoverished themselves paying for long-term care (the welfare paradigm) is wrong. The reality is that most people qualify easily for Medicaid nursing-home benefits, and virtually anyone can qualify quickly with the right advice (the entitlement paradigm). Consequently, it should come as no surprise that most people in America do not worry in advance about long-term care, that they end up in nursing homes on Medicaid instead of in the less institutional settings they prefer, and that they fail to tap the equity in their homes for long-term care expenses or to purchase private insurance.

Fortunately, this state of affairs is reversible. Today, the political imperatives to reduce government spending and curb entitlements have opened a pathway to major reform. We no longer need to effect incremental change to an obsolete welfare program that is morally, intellectually, and financially bankrupt. By virtue of its excessive cost and its reputation for serious access and quality problems, Medicaid is finished as a long-term care financing system for the middle class. America stands poised on the brink of a revolutionary new approach to long-term care financing.

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Summary of the Problem

What is the bottom line?

The 1970s should have been the golden age of long-term care in America. The gerontological wedge pushed into American demographics during that decade could have opened an era of unprecedented entrepreneurial problem-solving. By now, we would have a market-driven continuum of care seamlessly covering everything from chore services to assisted living to sub-acute care. We would also have an infrastructure of long-term care insurance and home equity conversion to finance it. Public welfare might still have a role to play in long-term care, but that role would not be the tragedy of perverse incentives and unsatisfactory outcomes it is today.

Instead, with every benevolent intent, Medicaid co-opted long-term care by the late 1960s. It impeded the private market for low-cost senior services and housing and discouraged the development of private long-term care insurance by providing free or subsidized nursing-home care. It created a Frankenstein's monster of institutional care by targeting public money only to nursing homes. It stifled competition, thereby impairing access and quality, by constricting bed supply and reimbursement rates artificially. It drove the middle-income consumer out of the private long-term care marketplace by creating a ponderous, publicly-financed monopsony. In time, Medicaid choked the nursing-home industry almost to death with regulations intended to correct the very problems the program itself engendered. Nevertheless, in the absence of affordable alternatives and the means to pay for them, middle-class Americans in the hundreds of thousands are still being directed into Medicaid-financed nursing homes by well-intentioned public administrators and Medicaid estate planning attorneys.

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Public Policy Recommendations

What needs to be done to ensure quality long-term care for all Americans?

What is the solution? Obviously, we cannot dismantle Medicaid overnight and leave the old, the sick, and the frail to fend for themselves. Rather, the first step is to preserve and improve a publicly-financed long-term care program for the truly poor. To command good access and high quality, however, such a program must be able to pay market rates for every appropriate level of care. That will be expensive.

The only way to pay for such a program is to divert the middle class and affluent away from it and into private financing alternatives. This can only be achieved by imposing a strong means test, eliminating all eligibility loopholes, and strictly enforcing estate recovery rules. There is no other option. We have to give Medicaid back to the poor and show everyone else how to plan ahead and remain self-sufficient.

We cannot compel middle-class Americans to impoverish themselves, however, before they receive any assistance from their government. That policy already failed. It invites resentment, fraud, and legal circumvention of the rules. Instead, we must provide a kinder alternative to families who need long-term care, but cannot afford to pay for it without devastating themselves financially.

Given the precarious state of government entitlements, however, public funding for a new middle-class long-term care program is nonexistent. Any new program will have to pay its own way. Fortunately, adequate privately-held resources are readily available in this country to finance market-driven supportive housing and long-term care. In fact, \$1.5 trillion lies illiquid and untapped today in seniors' home equity alone and another \$10 trillion is about to fall into the laps of the baby boomers in the form of inheritance. The secret is to unlock these resources and

LTC Choice: A Simple, Cost-Free Solution to the Long-Term Care Financing Puzzle

put them to work paying for long-term care. Forcing seniors to sell their homes or consume their estates before they can get help is not an acceptable strategy, however. The desire to preserve the family homestead and pass on a legacy is too deeply ingrained in American culture. We must find a more creative, less draconian approach. We recommend *LTC Choice*.

*LTC Choice: A Simple, Cost-Free Solution to the Long-Term Care Financing Puzzle***LTC Choice***How can America afford universal access to top-quality long-term care?*

A better approach to long-term care financing is to let seniors keep their income and assets (including their homes) as long as these resources are needed to support themselves or their immediate dependents. When someone requires care for which the family has insufficient cash flow to pay, let the government guarantee payment of the bill for whatever private service the family chooses. Simultaneously with the initiation of this public assistance, tally the family's income and assets, secure the entire estate with a binding legal encumbrance, and subtract the government-sponsored contributions from the ledger every month. Whatever the family is able and chooses to contribute toward the cost of care is not subtracted from the ledger. Everything the government or its agent contributes plus interest depletes their estate and is recovered upon the death of the last surviving exempt dependent relative. If the ledger is depleted entirely, then the family is completely destitute and eligible for a newly reformed and financially reinvigorated Medicaid program, i.e., welfare.

This approach, call it *LTC Choice*, has many advantages over the current situation. Middle-class seniors regain their dignity: it is not welfare if you pay it back. Vulnerable elderly people get red-carpet access to top-quality care: there is never a shortage of preferred long-term care beds or services for full-paying customers. Consumers return to the market place: someone else may pay the monthly bill, but it all comes out of the family's estate in the long run, so buyers will be wary of price and quality. Providers receive the full market price for their services: home care companies, assisted living facilities, nursing homes, and even hitherto unforeseen purveyors of housing and care will compete avidly to offer the best possible services for the lowest possible fee. Government and the taxpayers save money: the only up front cost, which is

LTC Choice: A Simple, Cost-Free Solution to the Long-Term Care Financing Puzzle

more than compensated by savings in the old Medicaid colossus, is a loan guarantee program to attract private lenders to fund the fully collateralized system.

The biggest advantage to *LTC Choice*, however, is the change in consumer behavior it will engender. Families will know with strict certainty that they cannot ignore the substantial risk of long-term care. The choices will become stark for 40- and 50-year-olds. Plan now and buy insurance while you are young and healthy and good coverage is inexpensive. Or, take your chances, hope for the best, accept a dollar for dollar loss to your estate if you ever have to rely on the public program, and explicitly assume the risk that you may ultimately lose everything, including your home equity, and become dependent on welfare.

Confronted with genuine risk like this, more people will choose to insure privately than in the past. Fortunately, good insurance policies that cover home care, assisted living, and nursing-home care are already easily available and affordable to most non-elderly people. Those who cannot afford coverage, such as many older people, may seek private home equity conversion to generate a sufficient cash flow to pay their premiums. Heirs, especially adult children who will stand to lose their inheritances entirely otherwise, are likely to encourage their elders to purchase insurance coverage and may also help to pay the premiums. Instead of rewarding people for ignoring the risk, avoiding the premiums, and taking advantage of the public dole as the current system does, this approach rewards responsibility and exacts a gradual and predictable penalty for irresponsibility.¹⁰

¹⁰ One sure way to derail the privatization of long-term care financing and destroy its promise is to make publicly-financed long-term care even more attractive to consumers than it already is. The damage done by easily accessible Medicaid nursing-home benefits has been mitigated by the fact that most people do not want to go to nursing homes. If grand plans now under discussion to pool Medicaid and Medicare monies and provide home- and community-based services for dual eligibles are implemented without a strongly enforced means test and mandatory estate recovery, dire consequences will follow. Expanded public financing for more desirable kinds of care will not merely exacerbate the "woodwork factor" of induced demand as

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Obviously, for *LTC Choice* to succeed, it cannot be abused and manipulated as Medicaid has been. We will have to assure that the public understands the high probability of needing long-term care and that individuals and families, not the government, are primarily responsible for this huge potential expense. Therefore, before they are too old, frail or sick to save or insure for their own protection, the federal government should deliver comprehensive information on long-term care to aging Americans and require them to make a tough choice about how they intend to protect themselves from this risk. The tough choice is whether or not they will insure privately or rely on the *LTC Choice* program. If they insure privately, or earmark sufficient assets permanently for long-term care, their problem is solved. If they choose to rely on the government-backed *LTC Choice* program, they must report annually on their income and assets in order to secure their estates as collateral and to eliminate the problem of artificial self-improvement which has plagued the Medicaid program. Of course, every American will always be free to dispose of personal wealth as he or she sees fit. The *LTC Choice* program merely requires that no one who expects to receive public assistance in the future may spend, divest, divert or shelter wealth that could have been used to pay for long-term care.

The best time to present these hard realities of long-term care to the public is as early as possible, but no later than when they sign up for Social Security and Medicare. At this time of life, seniors and their families are most sensitive to the financial and health security challenges of aging. Most of them remain relatively secure financially and insurable. When it sends

other writers have warned, it will make Medicaid estate planning more attractive to consumers and more lucrative to elder law practitioners. It will inhibit the market for privately-financed home care services, home care, assisted living, and geriatric care management. And it will decimate demand for private long-term care insurance. Public benefits have always been and will always remain starved for financing. Our only hope to achieve a fully financed, universally available, comprehensive long-term care service delivery system is to draw as heavily as possible on private financing and depend on public resources only to cover the interstices of need left unfilled by the private market.

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information on Medicare and Social Security to aging Americans, the federal government should also provide advice and guidance on the risks and costs of long-term care, on low-cost home- and community-based services options, on home equity conversion, on private long-term care insurance and on the *LTC Choice* alternative once it is enacted.

LTC Choice: A Simple, Cost-Free Solution to the Long-Term Care Financing Puzzle

Conclusion

Do we have the courage of our convictions?

Long-term care for a rapidly aging population presents an enormous challenge to the United States. Our country must meet this challenge while simultaneously confronting similar strains on Social Security and Medicare. To preserve our prosperity and protect our elderly, we will need to reassert the traditional values of freedom, independence, and individual responsibility that brought economic greatness to America in the first place. A simple public policy, with which most of our countrymen will agree, would suffice to achieve this goal if unstintingly observed:

We have very limited dollars available for public assistance. We must take care of the truly poor and disadvantaged first. The middle class and well-to-do should pay privately for long-term care to the extent they are able without suffering financial devastation. Prosperous people who rely on public assistance for long-term care should reimburse the taxpayers before giving away their wealth to heirs. Seniors and their heirs who wish to avoid such recovery from their estates should plan ahead, purchase private long-term care insurance, and pay privately for the care of their choice when the time comes.

LTC Choice is a viable, simple, and cost-free means to implement this policy and solve the long-term care financing puzzle once and for all. We need only the vision to see the way, the courage to embrace the change, and the will to follow the course.

Stephen A. Moses

Biographical Profile



Stephen Moses is President of the Center for Long-Term Care Financing in Seattle, Washington. The Center promotes universal access to top-quality long-term care by encouraging private financing and discouraging welfare financing of long-term care for most Americans. Previously, Mr. Moses was Director of Research for LTC, Inc., a Medicaid state representative for the Health Care Financing Administration and a senior analyst for the Inspector General of the U.S. Department of Health and Human Services.

Mr. Moses is widely recognized as an expert and an innovator in the field of long-term care. *McKnight's Long-Term Care NEWS* named him "one of the 100 most influential people in long-term care." *Nursing Homes* magazine reported "there is probably no more articulate spokesperson for privately financed long-term care than Stephen Moses."

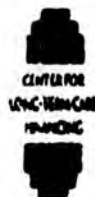
Steve Moses has directed numerous national studies for the federal government, state governments, and private organizations on Medicaid nursing home eligibility, asset transfers, estate recoveries and private long-term care financing. He specializes in problems associated with "Medicaid estate planning," i.e., the practice of artificially impoverishing affluent people to qualify them for public assistance.

Moses is credited with having "forged the framework" for the Omnibus Budget Reconciliation Act of 1993, which attempted to bring Medicaid eligibility loopholes under control. He helps state Medicaid programs curtail Medicaid estate planning and encourage private insurance as an alternative to public welfare financing of long-term care for the middle class.

Mr. Moses' articles appear often in distinguished publications like *The Gerontologist*, *The Journal of Accountancy*, *Contemporary Long-Term Care*, *Best's Review*, *National Underwriter* and *LTC News & Comment*. He is the author of "Health and Long-Term Care Insurance," a chapter in Clark Boardman Callaghan's legal treatise, *Advising the Elderly Client*. He has testified before half of America's state legislatures and he frequently addresses professional conferences in the fields of law, aging and insurance.

Steve Moses' recommendations are quoted regularly in the national media including the "CBS Evening News," PBS's "Frontline" and "The Financial Advisors," CNN, *The New York Times*, *Newsweek*, *USA Today*, *Forbes*, *The New Republic*, *Smart Money*, *National Journal*, and Jane Bryant Quinn's syndicated column. He appears in a public television documentary entitled "The Aging of America: The Dilemma of Long-Term Care." His talk radio appearances on health care reform are unique, provocative, and are increasingly in demand.

Mr. Moses' latest project was to write a chapter for a new anthology entitled *Toward Healthy Aging*, edited by best-selling author Ken Dychtwald of *Age Wave* renown.



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David M. Rosenfeld Biographical Profile



David Rosenfeld is Vice President and Chief Counsel for the Center for Long-Term Care Financing. The Center promotes universal access to top-quality long-term care by encouraging private financing and discouraging welfare financing of long-term care for most Americans. Mr. Rosenfeld publishes and speaks throughout the United States on public versus private financing of long-term care and related issues.

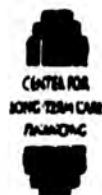
Mr. Rosenfeld recently presented "*Medicaid Estate Planning: Moral Relativity and the Shell Game*" at several national conferences and debated a nationally recognized Medicaid planning attorney. He is authoring a provocative article on protecting seniors from financial abuse in a prominent academic journal.

He has published or been quoted in *Kiplinger's Personal Finance Magazine*, *LTC News & Comment*, *Bureau of National Affairs Health Care Fraud Report*, *American Bar Association Journal*, and others.

Mr. Rosenfeld is a graduate of Case Western Reserve University School of Law (JD) and CWRU's Mandel School of Applied Social Sciences (MSW). He co-founded the Center for Long-Term Care Financing after serving as the Counsel for Public Policy with LTC, Incorporated. Previously, Mr. Rosenfeld practiced law with two Seattle firms where he specialized in insurance defense litigation, and clerked for United States District Court Judge Paul R. Matia and Ohio Attorney General Lee Fisher. His experience also includes a tenure with the United States Senate Judiciary Committee.

Mr. Rosenfeld's educational and professional background has enhanced his ability to build meaningful relationships with key constituencies in the long-term care community. He has developed an innovative interdisciplinary learning program called "*All-Aboard*" to bring together senior service professionals for the benefit of mutual clients.

Mr. Rosenfeld is a member of the American Bar Association's Center for Professional Responsibility, the ABA's Ethics 2000 Advisory Council, and several state and local professional associations.



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ADOPTED BY EXECUTIVE (EX) COMMITTEE MARCH 18, 1997
TO BE CONSIDERED BY THE NAIC PLENARY IN JUNE, 1997

**1997 INSERT TO THE NAIC
SHOPPER'S GUIDE TO LONG-TERM CARE INSURANCE**

**NEW TAX CHANGES AFFECTING LONG-TERM CARE
INSURANCE PREMIUMS AND BENEFITS**

Congress passed a new law in 1996 called the Health Insurance Portability and Accountability Act. Starting in the 1997 tax year, this law may let you deduct all or part of the premium for a long-term care (LTC) insurance policy. Your LTC premium can be added to your other deductible medical expenses. To claim a tax deduction, all of your medical expenses must be more than 7.5% of your adjusted gross income.

Not all long-term care contracts are tax qualified. Policies must meet certain federal standards before you can deduct the premium. These policies are called *tax qualified* or *qualified long-term care insurance contracts*. Benefits you receive from a qualified LTC policy are generally not taxable as income. Benefits received from a policy that is not a qualified LTC policy may be taxable as income.

The Health Insurance Portability and Accountability Act makes changes to the Internal Revenue Code. The Department of Treasury is responsible for developing regulations giving direction as to how the law should be applied. **These regulations have not yet been completed. It is important to understand that uncertainty exists.** Companies will use their own interpretation of some policy provisions (such as when benefits are triggered) until the Department of the Treasury issues regulations.

How will I know if the premium for my long-term care insurance policy qualifies for a tax deduction?

- LTC policies issued before January 1, 1997 are automatically qualified.
- LTC policies issued on or after January 1, 1997 must be qualified (meet federal standards) before you can deduct the premium. These standards are discussed below.

The maximum amount you can add to your other deductible medical expenses is based on your age at the end of each tax year.

Age	Limit on Deduction
40 years old or less	\$200
41 to 50 years old	\$375
51 to 60 years old	\$750
61 to 70 years old	\$2000
71 years old or older	\$2500

*See your personal tax advisor for information
On how these changes could affect you.*

LTC Insurance for Retirees

CHAIR
HOUSE HEALTH, EDUCATION
& SOCIAL SERVICES COMMITTEE

VICE-CHAIR
HOUSE JUDICIARY COMMITTEE

MEMBER
LEGISLATIVE BUDGET & AUDIT COMMITTEE
HOUSE SPECIAL COMMITTEE ON OIL & GAS
SELECT COMMITTEE ON LEGISLATIVE ETHICS

Alaska State Legislature



REPRESENTATIVE CON BUNDE

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October 15, 1998

Mr. Dennis Murray
Heritage Place
232 Rockwell
Soldotna, AK 99669

Dear Mr. Murray;

Sheila Peterson of Sen. Gary Wilken's office asked me to gather some information for you about the long-term care (LTC) insurance program offered to retirees from the state of Alaska's.

I spoke with Lisa Tourtellot, Benefits Supervisor, Alaska Department of Administration, Division of Retirement and Benefits (907) 465-4460, and hope the information she shared with me will provide answers to questions about the plan.

First off, the specific provisions of the program (enrollment, premiums, covered expenses etc.) are outlined on the attached pages from the state Retiree Group Insurance Information Booklet from May, 1998).

The LTC policy is relatively popular with Alaska retirees, about 50 percent of whom take advantage of their single opportunity to enroll upon retirement. Of the 18,839 state retirees covered by medical insurance as of June, 1998, 8,309 had signed up for LTC insurance. Almost half of those, or 3,479, had also enrolled their spouses.

By way of background, Alaska began offering LTC insurance to retirees (PERS, STERS, elected officials, judicial employees) in 1987. At this time, Alaska was one of first public entities to offer such insurance, and it was a popular option. Some retirees were denied enrollment in first year because they did not meet certain health standards, while others declined to enroll because of the cost.

In the years since, many other such insurance plans have become available, and Alaska's may no longer be the best deal. Accordingly, the Retirement Board is considering a major overhaul over the next six months, including raising the benefit level (currently \$125 per day for services received inside Alaska, and \$75 per day for services Outside.)

Dennis Murray
October 15, 1998
Page 2

Benefit levels notwithstanding, Alaska's LTC insurance comes fairly close to meeting informal national standards. One difference is that Alaska's policy includes home assistance, while most other plans sell it as a separate rider.

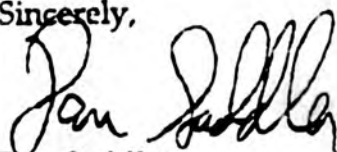
Premiums are based on age of retiree at retirement, and do not rise with age.

<55 years old \$16.10/month
>85 years old \$412/month
most average \$21-55/month.

I have not yet received an answer on the question of how much the state pays out in services compared to how much it receives in premiums, but expect to hear back from Ms. Tourtellot soon.

I hope this information is helpful, though I am afraid it may be a little short on answers to some deeper policy questions you may be seeking to answer. Please contact me if I can be of any further assistance.

Sincerely,



Dan Saddler
Staff to Representative Con Bunde

Enc. Retiree Group Insurance Information pages

LONG-TERM CARE PLAN HIGHLIGHTS

- Requires a deductible period of 90 days of covered long-term care before benefits begin.
- Pays for covered expenses after the deductible period up to a lifetime maximum benefit of \$200,000.
- Pays a maximum daily benefit for a nursing care facility of \$125 within Alaska and \$75 outside Alaska, after the deductible period.
- Pays a maximum daily benefit for a home convalescent care facility of \$75 within Alaska and \$40 outside Alaska, after the deductible period, up to a lifetime maximum of \$50,000.

COVERED LONG-TERM CARE EXPENSES

Benefits are available for covered expenses for conditions that require long-term care.

Covered expenses are those expenses incurred for medically necessary care received in connection with a Covered Program of Care (see page 76) when:

- initial certification by the facility or individual responsible for the supervision of nursing or other services and the attending physician confirms the need for services as prescribed and specified as appropriate in the Covered Program of Care; and

- recertification requests confirm the ongoing need for services as prescribed and specified in the Covered Program of Care.

Long-term care benefits are available for medically necessary services and supplies which, as determined by the claims administrator, are needed to diagnose, care for, or treat a physical or medical long-term care condition. Care is considered medically necessary when it involves:

- skilled or intermediate nursing care, or
- home convalescent care,

AND it provides:

- nursing services,
- nursing supervision,
- occupational therapy services,
- physical therapy services, or
- speech therapy services.

Services must be appropriate and essential for the treatment or maintenance of the disease or injury or for essential personal care services that are necessary as a result of a covered disease or injury. "Essential personal care services" means the physical dependence of an individual who requires continual human assistance in at least two of the following activities of daily living: eating, dressing, toileting, transferring, and walking. Long-term care provides coverage for custodial care when it is received in connection with a Covered Program of Care. The benefit amount is based on where services are received.

The patient's attending physician must order the needed care. The care received must not be at the insistence of, or for the convenience of, the patient or the patient's family.

A physician is a person who is licensed to practice medicine (M.D.) in the state where services are rendered and is practicing within the scope of that license.

HOW LONG-TERM CARE BENEFITS ARE PAID

Benefit Period

A benefit period begins on the first day of a Covered Program of Care and ends 30 days after the Covered Program of Care is no longer necessary.

Deductible

You must first meet the deductible period of 90 days of covered long-term care. Only one deductible period applies during any one benefit period. At the end of any benefit period, any subsequent Covered Program of Care will be subject to the deductible period before any benefits are paid.

Coinsurance

After you meet the deductible, the Plan pays 100% of the usual, customary and reasonable charges for covered long-term care services. See specific daily maximums in the Nursing Care Facility and Home Convalescent Care Facility sections that follow.

Usual, Customary and Reasonable Charges

Payment is based on usual, customary and reasonable charges (see pages 8-9) for covered services. Charges or fees in excess of usual, customary and reasonable, as determined by the claims administrator, are your responsibility to pay.

Lifetime Maximum Benefit

The maximum lifetime benefit for each person for all covered long-term care expenses is \$200,000.

Covered Program of Care

A Covered Program of Care is a written program of care that an attending physician prescribes for medically necessary care and treatment in a nursing care facility or a home convalescent unit. This treatment must include one or more of the following services:

- registered nursing;
- licensed practical nursing;
- home health aides (provided through a home health care agency);
- physical therapy;
- occupational therapy; or
- speech therapy.

The claims administrator determines whether the Covered Program of Care is the most appropriate course of action. This determination will be made after receiving evidence furnished by your doctor.

Pre-existing Conditions Limitation

No benefits are payable for any care provided or begun during the first 12 months of coverage which is as a result of a pre-existing condition. Pre-existing conditions are conditions for which you received diagnosis, tests, or treatment (including

taking medication) during the three consecutive months before the most recent day you became covered under this plan.

Nursing Care Facility Benefits

If you or your covered spouse incurs covered expenses for skilled or intermediate nursing care while confined in a nursing care facility, the Plan will pay a benefit for each day of care after the deductible period (90 days).

Maximum Daily Benefit

The maximum daily benefit for a nursing care facility is \$125 within Alaska, and \$75 outside Alaska. The Plan will pay an amount equal to the lesser of the usual, reasonable, and customary charges for the covered expenses or the maximum daily benefit.

Facility Definition

A nursing care facility is an institution or part of an institution that:

- is licensed to provide inpatient care for persons convalescing from injury or disease, skilled nursing care or intermediate nursing care by an R.N. or L.P.N. under the direction of an R.N.; or physical restoration services to help patients reach a degree of bodily functioning that permits self-care in essential daily living activities;
- provides services for its patients and under the full-time supervision of a physician or R.N.;
- provides nursing services by licensed nurses (seven days a week on the day shift), under the direction of a full-time R.N.;

- maintains a complete medical record on each patient;
- has an effective utilization review plan;
- is not, other than incidentally, a place for rest, custodial or educational care or care of the aged, or a place for care of people with mental disorders, chemical dependency, or mental retardation.

Excluded Nursing Care Facility Benefits

No benefits are payable for:

- expenses or services which are covered under the group health plan; or
- the cost of food or preparation of meals if separate from the cost of the room

Home Convalescent Care Benefits

If you or your covered spouse incurs covered expenses for home convalescent care while confined in a home convalescent unit, the plan will pay a benefit for each day of care after the deductible period (90 days).

Maximum Daily Benefit

The maximum daily benefit for a home convalescent unit is \$75 within Alaska, and \$40 outside Alaska. The Plan will pay a benefit equal to the lesser of the usual, reasonable and customary charge for the covered expenses or the maximum daily benefit.

Lifetime Maximum Benefit

The maximum lifetime benefit for home convalescent care for each covered person is \$50,000.

Definitions

Home convalescent care must be:

- provided through a home health care agency and performed by a registered graduate nurse (R.N.), licensed practical nurse (L.P.N.), or home health aide; or
- performed in an adult day care center, or
- performed by a licensed, certified, or registered occupational therapist, speech therapist, or physical therapist.

A home convalescent unit is:

- your home or any other private home;
- a home for the retired or the aged;
- an institution which provides residential care; or
- an adult day care center.

It is not a hospital, sanitarium, or nursing care facility.

A home health care agency is an agency or organization that meets all the following requirements:

- It is mainly engaged in and, if required, is licensed to provide skilled nursing services and other therapeutic services.
- It has policies set up by a professional group associated with it. This group must have a physician and at least one R.N. to govern the services provided.
- It keeps a complete medical record on each patient.
- It has a full-time administrator.

An adult day care center is an organization that provides a program of adult day care that meets all the following requirements:

- It is established and operated as an adult day care center in accordance with any applicable laws.
- Its staff includes:
 - a full-time director;
 - one or more R.N.s in attendance during operating hours for at least four hours a day;
 - enough full-time staff members to maintain a client-to-staff ratio of eight to one or better;
 - a dietician;
 - a licensed physical therapist; and
 - a licensed speech therapist.
- It operates at least five days a week for a daily minimum of six hours and a daily maximum of twelve hours.
- It maintains a written record of medical services given to each client.
- It has established procedures for obtaining appropriate aid if a medical emergency occurs.

Excluded Home Convalescent Care Benefits

No benefits are payable for:

- expenses or services which are covered under the group health plan; or
- the cost of food or preparation of meals.

Skilled Nursing Care

Skilled nursing care is care furnished under a physician's orders which:

- requires the skills of technical or professional personnel; and
- is provided daily (five days a week for restoration services) either directly by or under the supervision of licensed, certified medical professionals. Care must be part of a Covered Program of Care.

Intermediate Nursing Care

Intermediate nursing care is care furnished under a physician's orders which combines a medically oriented program of simple treatment plans under the supervision of licensed, certified, or registered medical professionals, with emphasis on:

- physical activity;
- intellectual stimulation; and
- social motivation.

LONG-TERM CARE EXPENSES NOT COVERED

Limitations and Exclusions

The following services are not covered and no benefits are payable:

- A covered program of care which starts within 12 months after a person's effective date and is caused by a

pre-existing condition. Any condition which was diagnosed or treated within the 90-day period before the individual's effective date is considered a pre-existing condition.

- A loss caused by declared or undeclared war or any such act.
- A loss caused by mental disease or disorder without demonstrative organic disease, excluding Alzheimers.
- A loss caused by a suicide attempt or an intentionally self-inflicted injury.
- A confinement in a government institution, unless an individual is legally obligated to pay a charge.
- Services received or expenses incurred on any day that an individual is confined to a hospital.
- Services or expenses which are covered by a State of Alaska group medical plan.
- Services received or expenses incurred outside the United States.
- Services provided by a person who usually resides in the covered individual's home or is a member of the covered individual's family, or when the person performing the service normally does not charge for the service.
- Services received for which the covered individual is not legally obligated to pay.
- Services received which are covered under Medicare.
- Services received that are not medically necessary.
- Services received that the claims administrator determines are not usual, reasonable and customary.

LONG-TERM CARE GENERAL PROVISIONS

In addition to the general provisions described on page 85, the following provisions apply to the Long-Term Care Plan.

This Plan covers only losses resulting from nonoccupational, accidental bodily injuries and nonoccupational diseases.

Nonoccupational Disease

A disease is considered nonoccupational only if it does not arise out of any work for pay or profit and does not result from any work-related disease. However, if a covered individual provides proof to the claims administrator that a person covered under workers' compensation (or other similar laws) is not covered for a particular disease under that law, that disease will be considered nonoccupational, regardless of its cause.

Nonoccupational Injury

An injury is nonoccupational only if it is an accidental bodily injury. It cannot arise out of or in the course of any work for pay or profit or in any way result from an injury that does. However, if a covered individual provides proof to the claims administrator that a person covered under workers' compensation (or other similar laws) is not covered for a particular disease under that law, that injury will be considered nonoccupational, regardless of its cause.

Lifetime Maximum Benefit

No more than \$200,000—the lifetime maximum benefit—will be payable during the lifetime of any individual.

Benefits After Coverage Termination

If coverage terminates because the group policy is discontinued, the Plan will continue to provide benefits for individuals who are under a Covered Program of Care on the date of the discontinuance. This coverage will continue only until the earlier of:

- the date the individual is no longer under a continuous and uninterrupted Covered Program of Care;
- the date of an individual's death; or
- the date that any applicable maximum is exhausted.

Applicable Law and Venue

This policy, issued and delivered in the State of Alaska, is governed by the laws of the State of Alaska. Any and all suits or legal proceedings of any kind that are brought against the State must be filed in the First Judicial District, Juneau, Alaska, within three years from the deadline for filing a claim.

The claims administrator will not attempt to reduce or deny a benefit payable for loss on the grounds that a disease or condition existed before coverage became effective if the loss occurs more than two years from the date coverage began. This provision will not apply to conditions specifically named as excluded from coverage on the date of the loss.

Right of Examination

The claims administrator has the right and opportunity to examine, at its own expense, an individual who is the basis of any claim as often as it may reasonably require during the pending claim, or while benefits are being paid.

Other Provisions

The following additional provisions apply to your coverage:

- You cannot receive multiple coverage under this Plan. Spouses insured as retirees cannot be eligible dependents.
- If, under this Plan, a misstatement of facts affecting your coverage occurs, the actual facts will be used to determine the coverage in force.

State of Alaska Retiree

Long Term Care Plan

Covers care which is medically necessary to diagnose or treat a long term care condition or to provide at least two essential personal care services such as eating, dressing, transferring, and walking.

Deductible	90 days of covered services
Lifetime Maximum	\$200,000 per person
Coinsurance	100% up to daily maximums
Nursing Home Daily Maximum	\$125 in Alaska/ \$75 outside Alaska
Home Convalescent Care Daily Maximum	\$75 in Alaska/\$40 outside Alaska
Home Convalescent Care Lifetime Maximum	\$50,000 per person
Pre-existing Conditions Limitation	Nothing paid for services started in first 12 months of coverage due to pre-existing condition
Coordination of Benefits	Does not coordinate with other plans
Premiums	Based on age at enrollment

Age at enrollment	Monthly Premiums
Under 50	\$ 16.10
50-54	\$ 21.45
55-59	\$ 26.80
60-64	\$ 48.25
65-69	\$ 80.45
70-74	\$128.70
75-79	\$193.05
80-84	\$294.95
85 & over	\$412.90

This is just a brief summary - full details are included in the Retiree Group Insurance Information Booklet.

Comments

ALASKA STATE LEGISLATURE



REPRESENTATIVE ALLEN KEMPLER

October 8, 1998

TO: Senator Gary Wilken
Rep. Con Bunde
Long Term Care Task Force

FM: Rep. Allen Kempler *AKC*

RE: Gero-Psychiatric Specialist

Gary and Con,

Recently I met a gero-psychiatric specialist who discussed how useful this type of expert could be within our senior services systems. This specialist could help keep elders out of hospitals and help reduce medication costs through better diagnoses. Keeping elders in the least expensive, least restrictive environments as long as possible with a focus on prevention would be one goal for such a position.

I would propose that the Task Force consider such a specialist as one way to help with long term care.

If I can provide more information, please let me know.

SESSION
STATE CAPITOL
JUNEAU, ALASKA 99801-1182
(907) 465-2435
(907) 465-6615 FAX
1-800-550-2435

INTERIM
716 W. 4TH AVENUE
ANCHORAGE, ALASKA 99501
(907) 258-8190

Comment Card



Long-Term Care Task Force Alaska State Legislature

A 12-member task force of legislators, state officials and private citizens recently began the task of reviewing Alaska's system of providing long-term care.

This review process is the first step in developing an equitable plan for providing long-term care for all Alaskans. By filling out this comment card, your input on this important topic will be provided to the Alaska State Legislature.

If you require more time or more space to make your comments, you are welcome to send them directly to Senator Gary Wilken, LTC Task Force Co-chairman, at the address provided on the other side of this card.

Name: Liz Lucas

Address: 2880 Fritz Cove Rd.
Juneau, AK. 99801

Please provide your comments on:

- how to improve current long-term care services;
- possible funding options for long-term care;
- projected future care demands and how to address the need;
- other issues relating to long-term care services.
- Easy access to various health agencies in community. "One stop shopping." One call gives them the help they need. There should be a follow-up call to see if they are satisfied.
- Quality care and reasonable cost is imperative.
- Large emphasis on prevention! Across state, in communities, legislature. Stress savings.
- Encourage geriatric training for nurses and all levels of home and health care providers.

Print in width of lines concerning health care.

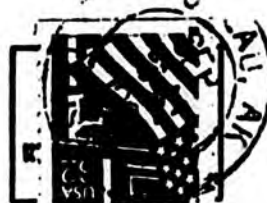
There is a Tribal work experience in Barrow (Contact Margaret Glastetter) that intrigued me. If a patient is confined to the house, a person is hired to take care of this person. The tribe pays \$7 - the family pays \$7 - total, \$14 per hr. Shared economic load. Could this concept be carried out in other places across the state?

WIC program - could it be modified to meet the needs of seniors?

Please fold on dotted line, tape the Comment Card closed and mail.

Thank you for participating in the review of Long-Term Care services.

Senator Gary Wilken, Co-chairman
Long-Term Care Task Force
State Capitol Building, Room 510
Juneau, AK 99801-1182



Elizabeth E. Lucas
2880 Fritz Cove Rd
Juneau, AK 99801