Presented by the

CENTER FOR
LONG-TERM CARE
FINANCING

Dedicated to ensuring
quality long-term care
for all Americans

What We Don't Know About Medicaid and Long-Term Care is Hurting Washington State

Presented by the

Center for Long-Term Care Financing

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

to the

Washington Health Care Association's
"Long-Term Care College for State Legislators"

December 7, 2004

Stephen A. Moses, President
Amy Marohn-McDougall, Executive Director
Damon V. Moses, Administrative Coordinator
2212 Queen Anne Avenue North, #110
Seattle, Washington 98109

Phone: 206-283-7036
Fax: 206-283-6536
Email: smoses@centerltc.org
amy@centerltc.org
info@centerltc.org
Web: http://www.centerltc.org

The Center for Long-Term Care Financing is a 501 (c) (3) charitable non-profit organization

What We Don't Know About Medicaid and Long-Term Care is Hurting Washington State

"Hell is paved with good intentions."
Samuel Johnson

"Insanity: doing the same thing over and over again and expecting different results."
Albert Einstein

"What you don't know can hurt you."
Anonymous

Introduction

Jeff Marshall, President and CEO of Eagle Healthcare, retained the Center for Long-Term Care Financing to conduct a limited review of long-term care service delivery and financing in Washington state. The goal of this review was to raise important questions that should be studied and answered in a more comprehensive study to be recommended for funding by the State. The following report provides a tree-top-level analysis of long-term care in Washington and proposes some tough questions that need to be asked and answered as soon as possible.

Eagle Healthcare is a Kenmore, Washington long-term care provider that operates 14 nursing homes, 12 of which are in Washington state. The Center for Long-Term Care Financing is a 501(c)(3) charitable, nonprofit, nonpartisan think tank and public policy organization located in Seattle. For details, see www.centerltc.org.

The author of this report is Stephen A. Moses, President of the Center for Long-Term Care Financing. Moses has conducted numerous national and state-level studies of long-term care as an 18-year career employee of the federal government (Health Care Financing Administration and the US Department of Health and Human Services Office of Inspector General), as Director of Research for LTC, Inc. (9 years), and as President of the Center for Long-Term Care Financing, which he founded in 1998.

To make the basic argument as easy to follow as possible, this report is written in thumb-nail outline. For documentation and further development of key points, please refer to the "end notes."

Executive Summary

What Do We Know?	**What Do We Need to Learn?**
Americans and Washingtonians are living longer, but dying slower, often in need of expensive long-term care. Most professional long-term care in Washington, as in the rest of the country, is paid for through Medicaid, a means-tested	Can Washington's Medicaid-financed long-term care system survive the coming onslaught of baby-boomers as the biggest generation retires, approaches

What Do We Know?	What Do We Need to Learn?
public assistance program, that is already severely strained financially. Private financing of long-term care in Washington, whether through personal spend down, Medicaid estate recovery, home equity conversion, or private insurance, is very small compared to public financing of nursing home and home care services. The State of Washington has a national reputation for providing and funding long-term care in the home and community-based settings most elders prefer to institutional care settings. The cost of Medicaid, especially its long-term care component, is a large, growing, and extremely worrisome component of the state budget. Concerns about access to and quality of all levels of long-term care are serious and growing in Washington already. The impending nationwide demographic crisis resulting from the aging of the baby-boom generation threatens to implode Washington's exemplary but financially fragile long-term care system. The kind, extent and quality of long-term care available to Washingtonians is at risk of being controlled by difficult, perhaps draconian budget decisions instead of by the needs and preferences of people who need care.	senescence, and begins to withdraw from instead of contributing to public coffers? Why does Washington's long-term care system face access, quality, and financing problems and what can be done to fix these problems? Should legislators and policy-makers be searching for ways to ease the burden on government programs by attracting more private financing sources to long-term care? What is the savings potential for Washington's Medicaid program of diverting more people to private financing alternatives? Could Washington provide more services and better reimbursement if fewer citizens became dependent on Medicaid for their long-term care?

Aging Demographics

What Do We Know?	What Do We Need to Learn?
With 617,330 residents over the age of 65, Washington has a smaller elderly population (10%) than the United States as a whole (12%).[1] But this will change. Between 2000 and 2020, Washington state's population of 65-75 year olds is expected to grow 120.2% compared to a 72.3% increase nationally. Among 75-84 year olds, the increase in Washington will be 45.8% compared to 25.5% in the country as a whole. But here's the kicker. The proportion of citizens 85 years of age or older, the population cohort most likely to need long-term care, is	Can Washington's long-term care service delivery and financing system sustain the extra demands that will be placed on it by a rapidly aging population? Since everyone who will be 85 in 30 years is alive today, precisely how can Washington's current long-term care system be adapted to accommodate the predictable

What Do We Know?	What Do We Need to Learn?
projected to increase 67.7% in Washington compared to 48.9% nationwide.[2] Clearly, the demographic challenge to Washington's ability to provide long-term care will become tougher in the future, both absolutely and in comparison to the rest of the United States.	increase in long-term care dependents? If adapting the current long-term care system to future demands is not feasible, what alternative service delivery and financing approaches should be considered?

Fiscal Pressures

What Do We Know?	What Do We Need to Learn?
Nearly 10% of seniors have chronic conditions that necessitate long-term care, so increases in the number of older citizens will mean heavier demands and higher costs in the future.[3] State budgets are already reeling from a nationwide budget crisis.[4] Medicaid is a major driver of state expenditures.[5] Washington is no exception. Here, Medicaid is 22.2% of state spending as compared to 21.4% on average for all states in Fiscal Year 2003. This is the highest percentage of all six "far west" states.[6] Long-term care is a huge part of the Medicaid financing crunch. Medicaid nursing home expenditures in Washington rose from $544.2 million in FY1998 to $657.1 in FY2003, an increase of 20.7 % in five years.[7] Medicaid home care expenditures in Washington skyrocketed from $273.3 million in 1996 (29.8% of total LTC expenditures of $917.0 million) to $753.5 million in 2002 (47.3% of total LTC expenditures of $1,592.8 million) a 275.7 % increase in six years.[8] Education and health care programs have already borne painful budget cuts in Washington.[9] Tough trade-offs are inevitable: "Since Medicaid is a federal entitlement and education is discretionary, Medicaid will trump education going forward," Raymond Scheppach, executive	Is Washington's tax base large enough and willing to sustain the large extra costs likely to be imposed by Medicaid, especially its long-term care component, in the future? Will taxpayers bear the exceptionally high costs of Medicaid home and community-based services while continuing to support nursing home care when needed? Is it desirable or politically feasible to allow the ebb and flow of government budgets to control who has access to what long-term care services in which venues? To what extent could private long-term care financing alternatives, such as private insurance and home equity conversion, relieve the burden on public programs? What kinds of changes in public policy, such as Medicaid eligi-

What Do We Know?	What Do We Need to Learn?
director of the National Governors Association (NGA), said in response to the report."[10] Future cuts are likely in Washington.[11] Yet, Washingtonians are already heavily taxed and have rebelled before.[12]	bility controls, tax incentives, and education, might influence the public to take responsibility and plan for long-term care risk and costs?

Service Delivery Strategy

What Do We Know?	What Do We Need to Learn?
Washington's Medicaid program invests heavily in nursing homes.[13] Empirical evidence strongly suggests that Medicaid nursing home reimbursement rates in the U.S. do not cover provider costs.[14] In Washington state, an average nursing facility per diem rate in 2001 of $110.65, resulted in an estimated nursing facility shortfall of $84.5 million below actual costs.[15] Compared to the average private-pay per diem rate in Washington of $175 in 2001, Medicaid reimbursement was only 66.3%.[16] Low Medicaid reimbursement rates may contribute to nursing home access and quality problems.[17] "The government's own data expose a direct correlation between inadequate Medicaid reimbursement, low staffing levels, excessive regulation and the harm caused to Nursing Home residents. . . . Nursing Homes, for-profit and not-for-profit alike, cannot provide quality care without adequate Medicaid reimbursement."[18] Liability insurance premiums for long-term care facilities have skyrocketed in Washington despite the fact that state facilities have suffered few large litigation settlements.[19] Washington's Medicaid program has a national reputation for deinstitutionalizing long-term care recipients and providing a wide range of highly desirable home and community-based (HCBS) alternatives.[20]	Has the state of Washington undercut nursing homes' ability to provide quality long-term care for high acuity patients by paying too little through Medicaid? Does Washington's complicated Medicaid nursing home reimbursement system contain perverse incentives that discourage improvements and force "cost shifting" to private payers? Will inadequate Medicaid reimbursement ultimately end in nursing home closures or litigation? Has heavy public financing of home and community-based care through Medicaid constricted the market for privately financed home care and assisted living? How serious is the nursing home liability and liability insurance crisis in Washington and what are the ramifications for public and private LTC patients? Does the state of Washington's virtual monopsony[25] in the market for long-term care discourage long-term care

What Do We Know?	What Do We Need to Learn?
"For example, in SFY [State Fiscal Year] 2002, Washington spent $414.4 million on HCBS (47.8 percent) and $489.4 million on nursing facilities (52.2 percent). Although the spending was fairly evenly split between these services, nearly three times as many aged and physically disabled clients were served in home and community-based settings (a caseload of about 32,200 clients) as were served in nursing facilities (13,140 clients)."[21] Although the cost effectiveness of Washington's emphasis on home and community-based services has been taken for granted, most empirical research suggests that HCBS unit costs may be less than nursing home care, but total long-term care expenditures tend to be higher.[22] Washington's strategy of encouraging Medicaid financed home and community-based services while discouraging nursing home use is risky. It unleashes the "woodwork factor,"[23] encourages Medicaid estate planning,[24] and discourages private financing alternatives like insurance and home equity conversion.	planning through savings, investment and insurance? Does every stakeholder in the long-term care financing issue understand the ramifications of depending primarily on public financing over the next few decades? Could nursing homes, assisted living facilities, home care agencies, insurers, financial institutions, senior advocates and advisors find common interest in expanding private long-term care financing alternatives? Conversely, would targeting Medicaid more toward the needy by tightening eligibility and estate recovery rules discourage vulnerable seniors from seeking needed care?

Medicaid Eligibility and Long-Term Care

What Do We Know?	What Do We Need to Learn?
Medicaid pays for most nursing home residents in Washington state. It covers 62.9% of all nursing home patients; 64.3% of patients in for-profit facilities; although only 54.1% in non-profit facilities.[26] Medicaid dominates the market for home and community-based care in Washington with the vast majority of such services provided by non-profit organizations.[27] Assisted living facilities remain predominantly for profit and private pay in Washington, but Medicaid is gradually paying for more assisted living through waiver programs.[28] Despite the conventional wisdom that Medicaid eligibility requires total impoverishment, the truth is that most people	What effect does Medicaid's predominance in the long-term care marketplace have on the public's sense of urgency regarding the need to plan for long-term care? Does the relatively easy availability of Medicaid long-term care benefits chill the market for private financing alternatives that might otherwise relieve the fiscal burden on the state and taxpayers?

What Do We Know?	What Do We Need to Learn?
qualify (based on income) to have their long-term care paid for by Medicaid without significantly spending down their assets.[29] Washington's COPES waiver program will pay for HCBS for people with incomes over double the poverty level. Singles with monthly incomes under $1,692 qualify, while married couples can have up to $3,384.[30] United States Department of Health and Human Services 2004 Poverty Guidelines place the poverty level at $9,310 ($775 per month) for a single person and $12,490 ($1,041) for a couple.[31] Likewise, Washingtonians qualify for Medicaid-financed nursing home care if their incomes are "less than the following total: the Medicaid rate for nursing home care plus your regular monthly medical expenses." In the example given on the "Washington LawHelp" website, a person with under $4,535 of monthly income would qualify for Medicaid long-term and acute care benefits.[32] Although Medicaid rules allow no more than $2,000 of non-exempt liquid assets, people can qualify for COPES or nursing home care while retaining a "home, household goods and personal effects, some real estate sales contracts, a car, life insurance with a face value of $1,500 or less, most burial plots and prepaid burial plans, and certain other property and items used for self-support."[33] It is not commonly recognized, but Medicaid also exempts one business including the capital and cash flow of unlimited value.[34] Married couples are allowed to retain even more income and assets under federally mandated "spousal impoverishment" provisions that protect up to $2,319 per month of income and half the joint assets not to exceed $92,760 for the non-Medicaid, "community spouse."[35] The federal government encourages people to seek assistance with Medicare premiums and deductibles from the state Medicaid program while retaining substantial assets. A recent mailing from the Social Security Administration and the Centers for Medicare and Medicaid Services advised Washington seniors that "You may be able to get help with your Medicare costs from your State. . . . This can be worth almost $800 a year." The letter explained they could qualify and still	Precisely how much money is diverted from private financing of long-term care by Medicaid's exemption of the home, a business, a car, household goods, personal effects, etc.? How widespread is Medicaid estate planning and how much more wealth does it divert from private long-term care financing than would be the case if artificial self-impoverishment were not an option? Is Washington's Medicaid program doing everything it can do under federal law to target program benefits to the genuinely needy and encourage others to prepare to pay privately for long-term care? What would a detailed review of a valid random sample of Medicaid long-term care eligibility cases reveal about the level of income and assets available to Medicaid recipients to pay for their own care? Are there waivers that Washington should request from the Centers for Medicare and Medicaid Services that would allow the state to control and target long-term care expenditures more effectively?[43] What have other states done to control Medicaid estate planning and to encourage attorneys, financial planners, accountants and other senior advisers to suggest private long-term care

What Do We Know?	What Do We Need to Learn?
retain "the home where you live, your home furnishings, a car, burial plots and $1,500 in a burial account . . .. If you think you might be able to get this help with your Medicare costs, or if you are not sure, call your medical assistance (Medicaid) office or your social service or welfare office."[36] Medicaid estate planners are lawyers and other financial advisors who help people impoverish themselves purposefully to qualify for Medicaid while sheltering or transferring their wealth. Medicaid planning clients in Seattle have on average a home owned free and clear worth $250,000 to $400,000 plus $150,000 to $200,000 in additional assets and relatively small incomes comprised of Social Security and modest pensions totaling $2,000 to $2,500 per month.[37] The most common Medicaid planning techniques in Washington include interspousal quitclaim deeds; revoking community property agreements; revising the community spouse's will to incorporate a trust for the institutionalized spouse; asset transfer strategies; annuities; gifting; conversion of nonexempt assets to exempt resources; transfers outside the three-year look-back period; and special needs trusts. Note that the average Medicaid planning client qualifies fairly easily for nursing home benefits. The home and all contiguous property are exempt regardless of value. Income of $2,500 a month or more is no obstacle because it falls well under the usual Medicaid nursing home rate. Extra assets of up to $200,000 present a problem, but that is what the techniques of Medicaid planning (such as annuities, half-a-loaf,[38] gifting, etc.) are supposed to handle. Medicaid eligibility workers in Nebraska estimate conservatively that 20 percent of long-term care cases in that state transfer assets without penalty which would result in a loss of $49 million across the caseload that might otherwise have been spent privately for care. Washington's Medicaid long-term care program is a little more than double the size of Nebraska's.[39] Many Medicaid planners are responsible professionals. Others profiteer egregiously on Medicaid. Numerous examples of both can be found with a simple internet search for "Medicaid estate planning in Washington." One can read "Medicaid Planning: Is There a Way to Protect My Assets if My Spouse or I Need Nursing Home Care?" at	financing alternatives while their clients are still young, healthy, and affluent enough to afford and qualify medically for them? What kinds of concerns and recommendations would a field review of Medicaid eligibility practices in rural, suburban, and urban welfare offices uncover? For example: interview supervisors and eligibility workers; review eligibility policies and procedures; compile examples of Medicaid estate planning practices; explore the potential impact of possible alternative solutions on affected field staff; and obtain ideas and recommendations from front line workers. How do other states combat Medicaid estate planning? Are there initiatives Washington should and could take to discourage abuse? What works elsewhere? How would key long-term care stakeholders respond to the idea of saving and improving Medicaid by targeting it more effectively to the needy and encouraging others to save, invest or insure for long-term care? For example, what would we learn by interviewing senior and consumer advocates; Governor's staff; key legislators and staff; proprietary and non-proprietary nursing home, assisted living and home health providers; long-term

What Do We Know?	What Do We Need to Learn?
http://www.isenbleck.com/medicaid.htm but you'll have to attend one of Jay D. Kaiser's seminars for seniors to learn how to "protect your money from Medicaid's greedy henchmen."[40] Medicaid eligibility policy staff estimate that 80% of Washington's long-term care caseload of 17,000 or 18,000 recipients shelter $5,000 on average for prepaid burials alone.[41] If this estimate is accurate, approximately $70,000,000 has been diverted in Washington at any given time from private long-term care expenditures to publicly financed care, thus relieving heirs of the financial responsibility to provide for their parents' funerals.[42] Bottom line, qualifying for Medicaid's long-term care benefits in Washington does not require poverty level income nor catastrophic asset spend down. All that is required to obtain Medicaid-financed nursing home care and (at a somewhat more restrictive level) home care and assisted living is a **cash flow** problem.	care insurers; elder law attorneys and Medicaid planners; taxpayer representatives; the Chamber of Commerce and other business interests; Medicaid management, line and legal staff; and any other group with a vested interest in long-term care? How can we hope to know the answers to questions like these until we ask the questions systematically and document the answers with interviews, questionnaires, case record reviews, and other research?

Private Financing Alternatives for Long-Term Care

What Do We Know?	What Do We Need to Learn?
The main private financing alternatives for long-term care that could relieve fiscal pressure on Medicaid are personal asset spend down, Medicaid estate recovery, private long-term care insurance, and home equity conversion. Not surprisingly, personal asset spend down for long-term care is severely limited by the fact that Medicaid exempts substantial assets as explained above. Why liquidate one's personal wealth to pay for long-term care when Medicaid allows most of it to be retained while receiving publicly financed care? To mitigate the numbing effect of Medicaid's asset exemptions on consumers without forcing people into destitution, Congress and President Clinton mandated Medicaid estate recovery in the Omnibus Budget Reconciliation Act of 1993 (OBRA '93). The idea was to let families keep their homes and other exempt assets while receiving care from Medicaid, but to recover the cost of their care out of their estates after they die. OBRA '93 included many exceptions and safeguards to soften estate recovery requirements and protect surviving spouses and	How much could Washington's Medicaid program save by encouraging more private financing of long-term care? What kinds of measures could Washington take to encourage more private financing of long-term care and preserve more public resources for the long-term care of people most in need? Should Washington join the states of Minnesota, Connecticut and Massachusetts in petitioning the Centers for Medicare and Medicaid Services for a waiver to eliminate or discourage certain Medicaid planning techniques?

What Do We Know?	What Do We Need to Learn?
other exempt relatives. Most states did not pursue estate recoveries aggressively because of the political sensitivity of "picking the bones of the elderly" as the program is sometimes described by its opponents. Nevertheless, some states have been more successful than others in collecting nontax revenues from deceased recipients' estates to supplement their Medicaid budgets. For example, Washington recovered $7.5 million out of a total Medicaid long-term care budget of $927.3 million in 2002 (.81% ranking the state 22nd in the country) whereas contiguous Oregon recovered $13.7 million out of $233.9 million (5.87% ranking the state 2nd in the country.)[44] Oregon reports collecting $14 for every $1 invested in Medicaid estate recovery. The comparable figure for Washington's program is $8.28 per $1 invested in recovery. If Washington collected the same proportion of total long-term care expenditures from recipients' estates as Oregon does, Washington would have an extra $46.9 million per year to relieve the fiscal burden of Medicaid. An important factor impeding the revenue potential of estate recoveries is that Medicaid planners routinely help their clients avoid this requirement. For example, see Columbia Legal Services advice on what can "be done to avoid estate recovery?" on its website at www.lawhelp.org/WA .[45] Although Medicaid estate recovery is highly cost-effective, it pales in comparison to the potential savings from empowering people to pay privately for long-term care and stay off Medicaid in the first place. Two private-market financial products help people pay for long-term care and avoid or delay Medicaid dependency: long-term care insurance and home equity conversion loans. Private long-term care insurance market penetration is higher in Washington than in most other states. Between 10% and 14% of Washingtonians over the age of 50 have purchased the product. Only MT, ND, SD, NE and IA have higher LTC insurance (LTCi) market penetrations.[46] Nevertheless, LTCi agents in Washington, representing both the group and individual markets, report flat to declining sales and say a relatively small percentage of insurance agents specialize	Why is Washington's Medicaid estate recovery program less successful than Oregon's? Does it need more staff, stronger state legislation, better systems, etc.? How exactly do states that are more successful in estate recoveries achieve their success? Does Washington need stronger authorizing legislation to support estate recoveries? Has Washington taken advantage of the authority granted in the Omnibus Budget Reconciliation Act of 1993 to expand the definition of "estate" beyond the traditional meaning of the probate estate to include assets that pass in joint tenancy with right of survivorship? Should Washington seek ways to close loopholes that permit avoidance of estate recovery liability? Why don't more people buy long-term care insurance in Washington? Does the state need to offer education or incentives to encourage citizens to plan for long-term care and purchase private insurance? Why are long-term care insurance sales flat or declining in Washington? Is there a connection between the disappointing LTCi market in Washington and the easy access

What Do We Know?	What Do We Need to Learn?
in the product. Unlike many states, Washington offers no tax or other incentives to encourage the purchase of private long-term care insurance. Regulations by state insurance commissions intended to protect consumers sometimes impede the marketability of long-term care insurance and therefore increase the financial burden on Medicaid and undermine consumers' long-term best interests. However, Washington's Office of the Insurance Commissioner provides extensive material on the product including consumer guides on its website.[47] The other major private-market product that could enhance Washingtonians' ability to pay for their own long-term care is home equity conversion (HEC). HEC which is usually accomplished by means of a formal (through a federally insured financial institution) or an informal (through a family member or friend) reverse mortgage. Formal reverse mortgages allow people at least 62 years of age to withdraw otherwise illiquid equity from their homes in the form of monthly income or lump sums without repayment until they move, sell or pass away with full reinsurance protection by the federal government.[48] According to the National Council on the Aging (NCOA), 48% of America's 13.2 million households age 62 and older could get $72,128 on average from reverse mortgages. "In total, an estimated $953 billion could be available from reverse mortgages for immediate long-term care needs and to promote aging in place."[49] Even ignoring the fact that Washington's home values are greater than the national average,[50] simply applying the NCOA's estimates to Washington state gives a staggering potential of revenue that aging Washingtonians could realize from reverse mortgages: **$21.4 billion for 296,318 families**.[51] Says NCOA: "These funds can go a long way to pay for help at home and for retrofitting the home to make it safer and more comfortable. They could also use it to purchase long-term care insurance if they qualify."[52] Of course, such funds could also help pay for assisted living or nursing home care for an ill spouse while the well spouse remained in the family home.	here to free, publicly financed long-term care? Do insurance regulations enforced by the Washington Insurance Commission impede the marketability of private LTC insurance in any way? Why is home equity conversion used so infrequently to finance long-term care and to supplement seniors' income so they can afford private LTC insurance? Does the fact that Medicaid exempts the home and all contiguous property regardless of value discourage homeowners from tapping the equity in their homes to pay privately for their long-term care? What percentage of people receiving Medicaid-financed long-term care in Washington still own their homes? How many people receiving Medicaid long-term care used to own homes but no longer do? What happened to those homes and their value and could they have been used to pay for long-term care? What could Washington do to encourage home equity conversion as a means to relieve the fiscal burden of long-term care on Medicaid? To what extent are middle class people on Medicaid consuming state tax revenues needed to fund other public needs such as

What Do We Know?	What Do We Need to Learn?
Hard data is difficult to obtain but we estimate that over 2,662 HECM loans had closed in Washington state (or 9.2 per 1000 elderly homeowners) by the middle of federal fiscal year 2004, ranking Washington 8th in the country for HEC market penetration.[53] Out of a potential market of over 290,000, however, Washington has barely scratched the surface of HEC potential. Two Seattle home equity conversion lenders interviewed for this study indicated that HEC mortgage loans are increasing in popularity but that people rarely take them out to help finance long-term care. Rather, the main drivers of HECM demand are the need for supplemental income to replace income lost because of low interest rates and to pay for pharmaceutical prescriptions and home maintenance.	education, highways, and prisons? Can Medicaid afford to be "inheritance insurance" for the baby boom generation? Are there ways to divert the middle class to other financing mechanisms while making Medicaid benefits more readily available to the poor than ever before?

Summary and Conclusions

What Do We Know?	What Do We Need to Learn?
Nationally syndicated financial columnist Jane Bryant Quinn summarized the problem eloquently, if bluntly, in the *Seattle Post-Intelligencer*:[54] "As the population ages, Medicaid spending on nursing homes could easily lurch out of control. That is, unless it's limited to the people who really need it. "Medicaid is supposedly for the poor. But increasingly, it's being exploited by the well-to-do. Instead of buying nursing home insurance or using their personal savings, they're getting the government to cover their bills. . . . "I suspect that some of the well-off people who weasel their way onto Medicaid are vigorous supporters of big income-tax cuts. But where do they think the money for Medicaid comes from? Chocolate bars? . . . "That turns Medicaid into an 'inheritance insurance plan for the middle class,' says Stephen Moses of the Center for Long-Term Care Financing in [Seattle]. Parents go on welfare so they can leave their money to their kids. . . . "Bottom line -- Medicaid is in serious trouble. The government isn't spending enough for quality care. The more people with money exploit the system, by not paying for themselves, the	What effect are Washington's Medicaid laws, regulations and policies having on the public's sense of responsibility to plan for LTC? What can the state do to encourage early planning for long-term care that results in more citizens being able to pay privately for their care? How much could WA save by dropping Medicaid long-term care census 10% and increasing private pay census commensurately? How much will Medicaid lose if Medicaid census continues to increase by 10%? One of our interviewees summed it up this way: "The State of Washington has done admirable work in creating community options. But the community-based services are severely

What Do We Know?	What Do We Need to Learn?
worse the care is going to be for everyone." (Jane Bryant Quinn has written several articles like this one over the years and several other recommending the careful purchase of private long-term care insurance.) Put in a somewhat kinder and gentler way, Washington's generous and well-intentioned long-term care service delivery and financing system may lead to insupportable unintended consequences. Ironically, the better job state programs do of providing free or subsidized long-term care for middle-class Washingtonians, the less likely state citizens are to plan ahead so they can pay for their own long-term care some day. Although Washington has been able heretofore to make great strides in long-term care, evidence is mounting that continued support of the existing government system is infeasible over the long run, especially as the baby boom generation ages. Already, services have been cut, eligibility reduced, and reimbursements restricted. But the Age Wave has not yet begun to crest, much less crash. According to the Health Policy Analysis Program (HPAP) at the University of Washington: "New eligibility verification policies for the Washington State Medicaid program have resulted in 20,615 people - primarily children - losing coverage from April through December 2003. Most of the people cut from Medicaid have low enough income to qualify, but no longer participate due to 'the hassle factor' and other issues . . .. Providers report administrative delays in obtaining Medicaid reimbursement and note that charity care has increased by as much as 100 percent over the past year."[55] Unless something is done, meat-axe cuts in Medicaid may become the rule rather than the exception. Legislators, policy makers and citizens who truly care will study the issues raised in this report and implement corrective actions before it is too late.	underfunded." Could private financing help to save and improve the public program by relieving its cost? Is it any wonder so few people pay privately for LTC when: "If someone is eligible for Medicaid, it is a really generous, comprehensive package: total cost of medication with no copay, any related medical expenses beyond Medicare, guaranteed nursing home care, optional programs like adult day health, waiver programs, assisted living, boarding homes, payment for home care, built-in payment for meals on wheels, nutrition, and other limited extras." Another interviewee said: "Fifteen years ago, a top state official told a conference audience that they would not need long-term care insurance because 'Medicaid would be putting on a big effort to cover everyone.'" Medicaid did. The strains are showing. The future is doubtful. The key question is: how can Washington stanch the Medicaid hemorrhage, change the perverse incentives in public policy that discourage responsible long-term care planning, preserve a social safety net for the truly needy, and empower everyone else to pay their own way?

List of Interviewees

Jerry Capretta, Branch Manager, Reverse Mortgage Specialist, Wells Fargo Bank, Seattle. Interviewed regarding the home equity conversion market in Washington.

Bernard Dean, Senior Fiscal Analyst, House Appropriations Committee, Office of Program Research, Washington State Legislature, Olympia. Interviewed regarding sources of data on Medicaid and LTC spending in Washington State.

Dan Dowler, Lead Program Manager for Home and Community Programs, Aging and Disability Services Administration, Department of Social and Health Services (DSHS), Olympia

William L.E. Dussault, Elder Law Attorney, William L.E. Dussault PS, Inc., Seattle. Interviewed regarding the practice of elder law and Medicaid estate planning in Washington.

Nora Gibson, Executive Director of Elder Health Northwest, Seattle. Interviewed regarding Medicaid-financed and private pay home and community-based services in Washington.

Dan Halpin, Compliance Analyst II, Office of Insurance Commissioner, State of Washington. Interviewed regarding Washington state rules and regulations governing private long-term care insurance products.

Mary Beth Ingram, Regional Representative for Region V, Medical Assistance Administration, DSHS. Interviewed regarding Medicaid LTC eligibility policy.

Tom Kelly, Author, Syndicated Columnist and Talk-Show Host. Interviewed regarding the home equity conversion market in Washington.

Jeff Marshall, President, Eagle Health Care. Interviewed regarding the long-term care service delivery and financing system in Washington.

Christine McCullugh, President, LTC Solutions, Group Long-Term Care Insurance Specialist. Interviewed regarding the market for private long-term care insurance and its potential as a source of LTC financing.

Lee McCutcheon, Loan Officer and Reverse Mortgage Specialist, Seattle Mortgage. Interviewed regarding the home equity conversion market in Washington.

Jacob Menashe, Elder Law Attorney, Isenhour Bleck Law Firm, Seattle, Washington. Interviewed regarding the practice of elder law and Medicaid estate planning in Washington.

Don Mercer, Chief, Office of Financial Recovery, Financial Services Administration, DSHS. Interviewed regarding Washington's Medicaid Estate Recovery Program.

Eileen Murphy, Associate Director of the Information and Assistance Project at Senior Services in Seattle, Washington. Interviewed regarding the availability of home and community-based services funded by Medicaid in Washington.

Mary Lou Percival, Financial Program Manager, Aging and Disability Services Administration, DSHS. Interviewed regarding Medicaid long-term care eligibility policy.

Lynn Prunhuber, Senior Deputy Prosecuting Attorney, Fraud Division of King County Prosecutor's Office, Seattle, Washington. Interviewed regarding physical and financial abuse of the elderly in Washington and the relationship, if any, between elder abuse and inadequate financing of long-term care.

Gerald Reilly, MGA, Public Policy Consultant, Olympia, Washington. Interviewed regarding key players, policy makers, and legislators, on the long-term care political scene in Washington.

Jim Roe, President, Washington Health Care Association. Interviewed regarding the long-term care service delivery and financing system in Washington.

Jim Scadlock, Senior Vice President of Operations West, Life Care Centers of America. Interviewed regarding the long-term care service delivery and financing system in Washington.

Liz Taylor, Founder, Aging Deliberately, Seattle, Washington. Interviewed regarding the view of senior advocates toward the long-term care service delivery and financing system in Washington.

John Wane, President, American Independent Marketing, Yakima, Washington. Interviewed regarding the market for private long-term care insurance and its potential as a source of LTC financing.

End Notes

[1] Source: Kaiser Family Foundation's www.statehealthfacts.org for Washington, Demographics and the Economy, "Washington: Population Distribution by Age, state data 2002-2003, U.S. 2003."

[2] Steven R. Gregory and Mary Jo Gibson, "Across the States 2002: Profiles in Long-Term Care, Washington," AARP Public Policy Institute, 2002, http://research.aarp.org/health/d17794_2002_ats_wa.pdf

[3] "Nationally, 9.5 percent of adults age 65 and older have physical, mental, or emotional conditions lasting six months or more that make it difficult to perform basic activities of daily life, such as dressing, bathing, or getting around inside the home. People of all ages have disabilities, but disabilities are more common among older people. Thus, growth in the number of older people, which is expected in every state, is likely to mean an increase in the number of people with disabilities, even if disability rates do not change." (Laura Summer, et al., "Measuring the Years: State Aging Trends & Indicators: Data Book," National Governors Association, Washington, DC, 2004, http://www.nga.org/cda/files/04DATABOOK05.PDF)

[4] "Having closed large budget deficits for three consecutive years through spending cuts and tax increases (as well as a variety of budget gimmicks), many states are facing continuing budget problems in fiscal year 2005 and beyond. The duration of the fiscal crisis means states are being forced to take increasingly painful steps, such as cutting back on important services on which many low- and middle-income families rely - cutting child care and health care programs, raising college tuitions, and the like." (Center on Budget and Policy Priorities, "A Brief Update on State Fiscal Conditions and the Effects of Federal Policies on State Budgets," September 13, 2004, http://www.cbpp.org/9-13-04sfp.htm , p. 6.)

[5] "The cost of Medicaid continues to grow faster than any other portion of state spending, overtaking primary education for the first time and forcing reductions in welfare and other assistance, according to a report released Tuesday [October 12, 2004] by the nation's governors and budget officers." (Robert Tanner, "Report: Medicaid Costs Vie With Education," *Seattle Post-Intelligencer*, October 12, 2004, http://seattlepi.nwsource.com/printer/ap.asp?category=1155&slug=States%20Spending)

[6] National Association of State Budget Officers, "2003 State Expenditure Report," October 2004, Table 5, p. 10, http://www.nasbo.org/Publications/PDFs/2003ExpendReport.pdf

[7] CMS 64 data analyzed and provided by Brian Burwell of Thompson Medstat for the Centers for Medicare and Medicaid Services, May 25, 2004.

[8] Laura Summer, *et al*., "Measuring the Years: State Aging Trends & Indicators," "Chart 5: A shift to more community-based care is anticipated (p. 1 of 2)," National Governors Association, Washington, DC, 2004, http://www.nga.org/center/databook04/ .

[9] "Essentially [Washington's] budget gap [for the 2003-2005 biennium] was closed through reductions in spending on education, reductions in state employee compensation, and in health care spending greater than those that had been contemplated in earlier years." (John Holahan, "State Responses to Budget Crises in 2004: Washington," The Urban Institute, February 2004, http://www.urban.org/uploadedpdf/410956_WA_budget_crisis.pdf , p. 2.)

[10] Source: National Governors' Association issue brief at http://www.nga.org/common/issueBriefDetailPrint/1,1434,7422,00.html .

[11] "While the Governor and the Legislature are not facing as severe a shortage of revenue as in 2003 (a shortfall of over $1 billion for the 2005-2007 biennium), the state's economic recovery will not bring in enough additional revenues to fully fund all existing services since client caseloads and the costs of medical care for clients are projected to increase." (Department of Social and Health Services, "Priorities of Government, Priorities of DSHS," September 17, 2004, http://www1.dshs.wa.gov/pdf/ea/budgetlkho.pdf)

[12] "Taxpayers in the state of Washington carry the highest tax burden in the Northwest, even though citizen tax-reduction initiatives have taken effect.. . . . At current taxation levels, Washington's tax revenues are expected to increase by $1.7 billion for the 2005 - 2007 budget compared to the current budget . . .." (Source: National Center for Policy Analysis, *Daily Policy Digest*, Monday, October 18, 2004, http://www.ncpa.org citing Jason Mercier, "Washington Still Tops Northwest in State and Local Tax Burden," *Policy Highlighter*, Evergreen Freedom Foundation, Vol. 14, No. 21, October 1, 2004, , http://www.effwa.org/highlighters/v14_n21.php .)

[13] "In Washington's Medicaid program, the State now sponsors over 13,000 residents in 253 nursing facilities. On average, Washington nursing facilities receive 52 percent of their revenue from Medicaid, which paid for 4,794,033 bed-days in SFY 2001. At any given point in time, over 55 percent of the State's 23,665 licensed nursing home beds are filled by Washington citizens whose care is sponsored by the State's Medicaid program." (The Lewin Group, Inc., "October 2002 Medicaid Cost Containment: Report No. 3," prepared for The Washington State Legislature, January 2003, p. 23.)

[14] BDO Seidman, LLP, Accountants and Consultants, "A Report on Shortfalls in Medicaid Funding for Nursing Home Care Prepared for The American Health Care Association," December 2003, http://www.ahca.org/brief/seidmanstudy0312.pdf , p. 1.

[15] "The State Long Term Health Care Sector 2003: Nursing Homes, ICFs/MR, and Government Funding," Health Services Research and Evaluation, American Health Care Association, February 26, 2004, http://ahcaweb.org/research/statestatsrpt_2003040226_final.pdf .

[16] Steven R. Gregory and Mary Jo Gibson, "Across the States 2002: Profiles in Long-Term Care, Washington," AARP Public Policy Institute, 2002, http://research.aarp.org/health/d17794_2002_ats_wa.pdf

[17] "Our findings have shown that a dependence on Medicaid affects the nursing home's staffing, case-mix, occupancy, and risk of termination from public reimbursement programs. This, in turn, affects the quality of the facility as reflected in the cited health-related deficiencies as well as

quality measures aggregated from resident-level data." (Vincent Mor, *et al*., "Driven to Tiers: Socioeconomic and Racial Disparities in the Quality of Nursing Home Care," *The Milbank Quarterly*, Vol. 82, No. 2, June 2004, http://www.milbank.org/quarterly/8202feat.html .)

[18] Robert Abrams, "Government Dilemma: How The Government's Own Data Exposes a Direct Correlation Between Inadequate Medicaid Reimbursement, Low Staffing Levels, Excessive Regulation and The Harm Caused to Nursing Home Residents," MyZiva.net, September 19, 2003, http://www.myziva.net/about/pressrel/myzivanetreport.pdf , p. 19.

[19] "The average long term care GL/PL [General Liability / Professional Liability] cost per annual occupied skilled nursing bed has increased from $310 in 1992 to $2,290 in 2003. National costs are now seven times higher than they were in the early 1990's. On a cost of care basis this means $6.27 per day needs to be set aside per long term care resident to cover the cost of patient care litigation. . . ." (Source: Aon Risk Consultants, Inc., "Long Term Care General Liability and Professional Liability--2004 Actuarial Analysis, June 2004, http://www.ahca.org/brief/aon_ltcanalysis2004.pdf , p. 4.)

[20] "During the 1990s, Washington expanded home and community-based services (HCBS) and downsized institutions. The state's allocation of Medicaid long-term care expenditures went from 78 percent institutional, 22 percent HCBS in 1994 to 52 percent institutional and 48 percent HCBS in FY 2001. The nursing facility occupancy rate in the state in 1999 was 81.3 percent, and only 3.2 percent of the age 65 and older population resided in nursing homes that year compared to the national average of 4.3 percent. The number of people receiving long-term care services in the community is more than double the number of people in nursing homes." (Source: U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, Office of Disability, Aging, and Long-Term Care Policy, "State Long-Term Care: Recent Developments and Policy Directions, Appendix A: State Summaries, 2001," http://aspe.os.dhhs.gov/daltcp/reports/statltcA.htm#WA)

[21] The Lewin Group, Inc., "October 2002 Medicaid Cost Containment: Report No. 3," prepared for The Washington State Legislature, January 2003, p. 25.

[22] "An increasingly large number of studies, including the results of a national channeling demonstration program, have shown that noninstitutional services typically do not substitute for nursing home care, but, rather, represent additional services most often to new populations." (John F. Holahan and Joel W. Cohen, *Medicaid: The Trade-off Between Cost Containment and Access to Care*, The Urban Institute Press, Washington, D.C., 1986., p. 106.)

"Evaluations of community care programs...tend to show not only that expansion of community care has little effect on nursing home use, but that it raises, rather than lowers, total expenditures." (Alice M. Rivlin and Joshua M. Wiener, *Caring for the Disabled Elderly: Who Will Pay?*, The Brookings Institution, Washington, D.C., 1988, p. 190.)

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

(Kenneth G. Manton, "The Dynamics of Population Aging: Demography and Policy Analysis," *The Milbank Quarterly*, Vol. 69, No. 2, 1991, pps. 309-338, p. 322.)

"Increased financing for HCB services may be desirable but will not significantly influence nursing home expenditures. The underlying assumption is that the delivery system is correct, but funding is inadequate.... We must seek to justify HCB on grounds other than cost effectiveness or clinical efficacy: the debate should focus on how much community care we are willing to purchase as a society, rather than how much money we can save by purchasing these services." (Diane Dion Hallfors, "State Policy Issues in Long-Term Care for Frail Elders," Center for Vulnerable Populations, Institute for Health Policy, Brandeis University, March 30, 1993, p. 8.)

[23] For every person in a nursing home in America today, there are two or three others of equal or greater disability, half of whom are incontinent, bed-bound or both. These people are managing at home with the help of friends and relatives, but they come "out of the woodwork" to take advantage of publicly financed services when Medicaid offers home care, which they want, instead of nursing home care, which they prefer to avoid.

[24] Medicaid estate planning is artificial self-impoverishment to qualify for Medicaid. Some attorneys and financial advisors specialize in arcane legal techniques to qualify prosperous people for Medicaid while avoiding the program's spend down requirements. Less savvy, usually less affluent seniors, who lack professional legal advice, may simply give away assets and run afoul of Medicaid's transfer of assets penalties.

[25] A monopsony is a market with a single buyer, as compared to a monopoly which has a single seller. The potentially perverse economic effects of a monopsony are comparable to those of a monopoly.

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

Payor Mix by Class of Ownership, State of Washington June 2004

Obs	Ownership Control	Medicare Census	Medicare Percent	Medicaid Census	Medicaid Percent	Other Census	Other Percent	Total Census
1	TOTAL	2,505	12.64%	12,454	62.86%	4,853	24.50%	19,812
2	FOR-PROFIT	2,039	14.33%	9,142	64.25%	3,047	21.42%	14,228
3	GOVERNMENT	60	5.20%	917	79.46%	177	15.34%	1,154
4	NON-PROFIT	406	9.17%	2,395	54.06%	1,629	36.77%	4,430

Source: CMS OSCAR data arrayed by Cowles Research Group

[27] Although we did not find comparable data to break down source of funding for home and community-based care as for nursing home care, interviewees told us that Medicaid is the predominant payor and that few for-profit companies offer these services.

[28] Assisted living companies are tempted to follow the path of nursing homes toward more Medicaid reimbursement. By accepting Medicaid residents, they can fill beds that would otherwise remain empty because of a dearth of private payers. Even at Medicaid's low reimbursement rates, a filled bed is more desirable than an empty bed. But assisted living companies fear that accepting Medicaid residents may lead to a downward spiral of lower reimbursements, tighter regulation, and more Medicaid utilization.

[29] For a fuller explanation of Medicaid long-term care eligibility than we have room to provide here, see "The Realist's Guide to Medicaid and Long-Term Care" at http://www.centerltc.org/realistsguide.pdf . (Stephen A. Moses, "The Realist's Guide to Medicaid and Long-Term Care," Center for Long-Term Care Financing, Seattle, Washington, 2004.)

[30] Columbia Legal Services, "Questions and Answers on the Copes Program," http://www.lawhelp.org/documents/1541615102EN.pdf?stateabbrev=/WA/ , p. 2.

[31] *Federal Register*, Vol. 69, No. 30, February 13, 2004, pps. 7336-7338, http://aspe.os.dhhs.gov/poverty/04poverty.shtml .

[32] Columbia Legal Services, "Questions and Answers on Medicaid for Nursing Home Residents," October 2004, http://www.lawhelp.org/documents/1538915170EN.pdf?stateabbrev=/WA/ , p. 1.

[33] Columbia Legal Services, "Questions and Answers on the Copes Program," http://www.lawhelp.org/documents/1541615102EN.pdf?stateabbrev=/WA/ , p. 6 and "Questions and Answers on Medicaid for Nursing Home Residents," October 2004, http://www.lawhelp.org/documents/1538915170EN.pdf?stateabbrev=/WA/ , p. 4.

[34] "Recently, resource limitations for persons desiring Medicaid eligibility have been expanded to favor the small business owner, farmer or rancher. A current amendment to the Social Security Act allows for exemption of all income producing property used in a trade or business. This new amendment applies to 'SSI states' such as Washington who use the SSI or Supplemental Security Income resource eligibility rules for Medicaid eligibility. . . . Examples of businesses that are likely to be excluded under this provision include a family farm or ranch. The entire ranch property, livestock, and farm or ranch buildings and equipment are excluded under this provision regardless of their aggregate value. . . . There is no limit on the amount of liquid resources used in the business that can be excluded." (*Elder Law News*, September 1999, published by the law offices of Barry M. Meyers, P.S. in Bellingham and Mount Vernon, Washington, p. 1)

[35] Under certain circumstances in Washington, the community spouse's resource allowance (CSRA) may be as low as $40,000 because of state legislation passed in 2003.

[36] Source: SSA-L440 form letter titled "Help With Medical Costs is Available," signed by the Commissioner of the Social Security Administration and the Administrator of the Centers for Medicare and Medicaid Services, and posted October 1, 2004.

[37] We derived these averages based on interviews with two prominent Seattle elder law attorneys. Elder law attorneys perform a wide range of services beyond Medicaid planning to protect the legal rights of their aging clients. Regarding Medicaid, they argue that they have a professional responsibility to disclose all options for financing long-term care to their clients. If the client chooses to pursue Medicaid eligibility, their job is to get the client everything he or she is entitled to under the law.

[38] "Half-a-loaf" refers to the strategy of giving away half the assets and spending down the remainder during a transfer of assets penalty period thus reduced by half from what it would have been if all the assets had been transferred at once.

[39] See "The Heartland Model for Long-Term Care Reform: A Case Study in Nebraska," Center for Long-Term Care Financing, Seattle, Washington, 2003, p. 24.

[40] Isenhour Bleck is a responsible Seattle elder law firm. Jay D. Kaiser was ordered to "cease and desist" providing "financial and investment advice to senior citizens and others primarily relating to income tax reduction, asset protection, and long-term care planning" without being "a Federally nor a State licensed investment adviser." (State of Washington Department if Financial Institutions Securities Division, Summary Order to Cease and Desist and Notice of Intent to Impose Fines and Order Affirmative Relief, Case No. 01 - 04 - 122, The State of Washington to: Jay D. Kaiser, Senior Advisor, Inc., May 16, 2002.)

[41] This estimate comports with similar educated guesses made by eligibility staff in other states' Medicaid programs as reported in studies we have conducted.

[42] Funeral companies and their trade associations are often strong advocates of this Medicaid planning technique.

[43] For example, Minnesota, Connecticut, and Massachusetts have requested waivers from the Centers for Medicare and Medicaid Services to allow their Medicaid programs to eliminate the "half-a-loaf" divestment strategy and extend the transfer of assets look-back beyond the current three- and five-year limits.

[44] Source: "FY 2002 CMS 64 Medicaid Expenditures - Collections." This table, supplied by Hunter McKay of the United States Department of Health and Human Services, is believed to be the best estimate the Center for Medicare and Medicaid Services has of total state and national Medicaid estate recoveries. Don Mercer, Chief of the Office of Financial Recovery in the Financial Services Administration of the Department of Social and Health Services estimated Washington's estate recoveries for the last state fiscal year to be $13,972,327, up substantially from previous years.

[45] The exact URL is http://www.lawhelp.org/documents/1542715172.pdf?stateabbrev=/WA/ .

[46] Susan Coronel, "Long-Term Care Insurance in 2002," America's Health Insurance Plans, Washington, DC, June 2004, Figure 9: State-by-State Long-Term Care Insurance Market Penetration.

[47] See http://www.insurance.wa.gov/publications/inspublications_longterm.asp.

[48] A good source of information on home equity conversion is the National Reverse Mortgage Lenders Association at http://www.reversemortgage.org/default.aspx .

[49] National Council on the Aging Press Release and Fact Sheet, "Use Your Home to Stay at Home(tm): Program Study Shows That Reverse Mortgages Can Help Many with Long-Term Care Expenses," April 15, 2004, http://www.ncoa.org/content.cfm?sectionID=105&detail=576#release .

[50] The median value of 72,238,000 owner-occupied homes in the United States is $140,201 according to the U.S. Census Bureau. See "Table 3-14. Value, Purchase Price, and Source of Down Payment--Owner Occupied Units" in the "American Housing Survey for the United States: 2003" issued September 2004 at http://www.census.gov/prod/2004pubs/H150-03.pdf . The median price for homes in Washington as of the first quarter of 2004 was $210,600 up 8.3% in the past year. (Source: "Median Home Prices, State of Washington and Counties, Time Trend," Washington Center for Real Estate Research, http://www.cbe.wsu.edu/~wcrer/MARKET.ASP .)

[51] Derivation: 48% of 617,330 Washington households over the age of 65 gives 296,318 potential reverse mortgage households times the national average reverse mortgage revenue potential of $72,128 gives $21,372,853,555.20.

[52] National Council on the Aging Press Release and Fact Sheet, "Use Your Home to Stay at Home(tm): Program Study Shows That Reverse Mortgages Can Help Many with Long-Term Care Expenses," April 15, 2004, http://www.ncoa.org/content.cfm?sectionID=105&detail=576#release .

[53] This estimate is patched together from several different sources and omits the years 2000 to 2002 for which we were able to find no data. Thus, the true figure is probably somewhat higher than our estimate. Also, the reverse mortgage market is rapidly increasing nationwide: "Reverse mortgage lenders originated double the number of federally-insured reverse mortgages in the most recent federal fiscal year, ending September 30, compared to the prior year . . .. Data from the U.S. Department of Housing and Urban Development show that lenders closed a record 37,829 Home Equity Conversion Mortgages in FY 2004, compared to 18,097 in FY '03." (Source: National Reverse Mortgage Lenders Association *Mid-Month Report* for October 2004.)

[54] Jane Bryant Quinn, "Personal Finance: Growing Numbers of the Well-Off Are Exploiting Medicaid," Seattle Post-Intelligencer, Tuesday, May 29, 2001, http://seattlepi.nwsource.com/money/25008_quin29.shtml .

[55] Health Policy Analysis Program Press Release, "New Policies Cut More Than 20,000 People from Washington Medicaid," April 6, 2004, http://depts.washington.edu/hpap/pdf_reports/Medicaidcost_release.pdf .