The Brave New World of Long-Term Care

presented by Stephen A. Moses
to the Notre Dame Law School Symposium on Aging
Notre Dame, IN: November 9, 2006

Thank you for inviting me to Notre Dame Law School. It is an honor to address you and to share the podium with such distinguished co-presenters.

My background includes 18 years as a career U.S. government employee working a decade with Medicaid and long-term care issues for the HCFA and the DHHS Office of Inspector General.

I'm currently president of the Center for Long-Term Care Reform, a private think tank and public policy advocacy organization dedicated to ensuring quality long-term care for all Americans.

I chose "The Brave New World of Long-Term Care" as my topic today. But let me start by describing the "Pusillanimous Old World of Long-Term Care," that is, the status quo.

America has a welfare-financed, institution-based long-term care system in wealthiest country in the world where no one wants to go to a nursing home.

Long-term care in the United States is characterized by access and quality problems, dismally low reimbursement levels, discrimination against public benefits recipients, institutional bias, loss of independence, welfare stigma, and imminent insolvency.

Most Americans don't worry about long-term care until they need it. Consequently, few save, invest or insure for the risk and they usually end up on public assistance.

How in the world did we get into this mess?

Well, it's pretty simple. Government started paying for nursing home care in 1965 through Medicaid and Medicare. Its good intentions had unanticipated and extremely unfortunate consequences.

Because nursing home care was free, institutionalization predominated. Home and community-based care languished for decades.

Since the government paid for nursing home care, no one bought private insurance against the long-term care risk.

Costs exploded of course as they always do when a benefit is free to consumers.

To control costs, Medicaid tried to contain expenses by paying too little for care thus causing access and quality problems.

When that didn't control costs, government tried to restrict access to Medicaid by making eligibility harder to get, by requiring recovery from recipients' estates, and even by making it a crime to transfer assets to qualify or penalizing financial advisors for rendering advice to do so for a fee.

Those measures failed because Medicaid eligibility rules are generous to begin with and so elastic that they are easily stretched to cover even affluent people.

How can that be when Medicaid long-term care eligibility requires impoverishment?

Simple, it doesn't. There is no limit on how much income people can have as long as their medical expenses, including private nursing home care, are high enough.

There is no limit on assets either as long as they are held in exempt form such as a home, business, automobile, prepaid burial expenses, term life insurance, home furnishings and other personal belongings, etc.

Bottom line, most elderly people who have a nursing-home level of care need, qualify for Medicaid. Lawyers and other advisors who specialize in artificially impoverishing people can easily qualify people far above these already generous levels.

Medicaid eligibility is a very complicated topic. I do not have time to explain in detail today. But I invite you to read my monograph titled "Aging America's Achilles' Heel: Medicaid Long-Term Care" at www.centerltc.com.

After over 40 years of publicly financed long-term care, consumers are anesthetized to the high risk and catastrophic costs because government pays for the vast majority of all long-term care in the United States.

Amy Finkelstein and Jeffrey Brown of the National Bureau of Economic Research (http://www.nber.org/) have confirmed this fact in two papers. They found that two-thirds to 90 percent of the potential market for private LTC insurance has been crowded out by Medicaid.

The key point is that Medicaid and Medicare took on too much of the burden of long-term care financing, distorted the market so as to impede development of a

home and community-based care infrastructure and to discourage private insurance to pay for it.

Both programs are both now spiraling toward financial collapse.

The good news is that if we stop doing what we've always done, we'll get a different result. After all, isn't that the very definition of "sanity."

If the current problems of long-term care have been caused by excessive dependency on public financing, the solution is clear:

Target Medicaid to the truly needy and others will plan early to save, invest or insure for long-term care.

That is finally starting to happen. The Deficit Reduction Act of 2005 took several baby steps in that direction.

Before the DRA, anyone could shelter unlimited assets in a home and contiguous property. Now there is a cap on home equity of $500,000 (or $750,000 at state discretion).

With the average home equity in America only $86,000, that's only a start. But keep in mind, Britain, with its socialized health care system, only allows people $36,000 of home equity while receiving publicly financed long-term care.

The DRA extends the look-back period for asset transfers done to qualify for Medicaid to five years. This is also just a start as the average period of time from onset to death in Alzheimer's Disease is eight years. Medicaid planners are already urging people to begin much earlier to plan for public welfare.

In Germany, another European socialized system, the look-back period for asset transfers is 10 years, double ours. Ironically, America's long-term care system is far more generously available than are some of the ostensibly socialized systems in Europe.

The DRA changed the penalty period for asset transfers done to qualify for Medicaid to eliminate the half-a-loaf strategy, the single commonest technique used to impoverish people artificially for Medicaid.

Critics have claimed that imposing the asset transfer penalty later than before will cause people in need of care to be denied access, but that won't happen. Why? Because we've eliminated the main reason to transfer assets in the first place.

But even if someone does accidentally end up penalized for transferring assets, in need of care, but penniless and ineligible for Medicaid, the DRA strengthened the provisions for undue hardship waivers to protect such people.

The DRA also blocked several other abuses previously used to divert people to Medicaid who should have paid their own way for long-term care.

There are more restrictions on the use of annuities to convert countable, disqualifying assets into non-disqualifying income. The income first rule has replaced the asset first option, thus preventing huge extra asset exemptions for community spouses.

I've described these and other provisions in the Deficit Reduction Act bearing on Medicaid eligibility in testimony before Congress, which you can find and read at www.centerltc.com.

Finally, the DRA did two other critical things related to long-term care. LTC Partnerships may now be expanded to all states. That's nice but not decisive. The Partnerships allow people who buy LTC insurance to exempt extra assets from Medicaid spend down.

So, if there is no real spend down requirement as in the past, the Partnerships have, and indeed they have had in the four states that tried them already, little effect.

The last key thing the DRA did was to unleash Medicaid to pay for more home and community based services instead of nursing home care. States will no longer have to obtain waivers to cover HCBS; they can do so under their regular Medicaid state plans.

This is a double-edged sword, however, unless states also control the hemorrhage in Medicaid eligibility. HCBS and assisted living are popular services that everyone wants. When private LTC insurance started paying for them, costs and premiums exploded. Government is about to learn the same bitter lesson.

The Deficit Reduction Act with its constraints on Medicaid long-term care eligibility and its encouragement of personal responsibility through private insurance and home equity conversion is definitely the direction in which we must move.

When we target Medicaid's scarce resources to the genuinely needy, they'll get better care across a wider spectrum of services.

When more people pay privately for long-term care, they'll command red-carpet access to top-quality care at the most appropriate level of care.

When people with money have to pay for their own long-term care, they will buy LTC insurance and use their home equity, which means those businesses will boom, provide more jobs and pay more taxes.

When long-term care providers have more private payers, nursing homes, assisted living facilities, and all other caregivers will be more financially solvent. Debt and equity capital, desperately need to finance the construction and operation of long-term care facilities will return to the marketplace.

Finally, what's wrong with other proposals commonly offered to solve this problem?

Many seek to solve the problems of long-term care service delivery and financing with compulsion. They want to force people to pay for LTC insurance or load up Medicare with a long-term care benefit. That won't work and it hasn't worked.

If excessive public financing has caused the problems we have now, then trying to solve them by adding more government financing would be like trying to put out a fire by dousing it with gasoline.

Social Security and Medicare have unfunded liabilities totaling $86 trillion at latest count. To fix them, we'd have to double payroll taxes or halve their benefits. Neither is politically popular.

The more likely outcome is that these programs will be means-tested. In other words, they will be turned into welfare programs. In time they'll lose political support in the same way Medicaid already has.

Adding long-term care to Medicare, therefore, would be like adding deck chairs to the Titanic after the incident with the iceberg.

Here's the irony: our problems in long-term care are self-inflicted by well-intentioned but perversely counterproductive public policy.

The good news is that the problems are easy to fix.

We can do it responsibly through public policy or we can just stand by and let the existing social insurance and welfare house of cards collapse.

The Brave New World of Long-Term Care is here. My advice to you as individuals, families and citizens is to take responsibility for your own long-term care. Plan early and save, invest or insure.

Maybe you can't solve the public policy problem alone but you can protect yourselves and your families.

Doing so is an important contribution. After all, as a wag once said: "The best way to help the poor is not to become one of them."

Politically, my advice to you is to support targeting Medicaid to the poor in order to save the fraying safety net and supplement long-term care with private financing sources.

Do you wonder how the new Democratic majority in Congress will lean?

Remember: some of the most stringent controls on Medicaid long-term care eligibility in the past came under Democratic Presidents and Congresses.

Besides, for Democrats, this is a "fairness" issue. Why use scarce public resources to indemnify well-to-do heirs of affluent seniors? They're probably all Republicans anyway!

That's all I can say in 15 minutes. If you're interested in more, check out http://www.centerltc.com/. Feel free to call or email me anytime. I've got plenty of business cards here so you can find me.

Thanks for your attention.