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...Dedicated to ensuring quality long-term care for all Americans
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The Long-Term Care Graduate Seminar

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The following is a transcription of the two-hour program presented dozens of times to highly positive reviews during the Center for Long-Term Care Reform's 2008 National Long-Term Care Consciousness Tour.

We offer this transcript in response to the many requests from audience members.

Each program began with a presentation about the "LTC Tour" including a slide show of the "Silver Bullet of Long-Term Care" at numerous state capitals. See the slideshow at http://www.youtube.com/watch?v=aDmXS_gpVNA&feature=channel_page.

When there were long-term care insurance agents in the audience, I began the program in the following way. Otherwise it began with "The Elephant, The Blind Men and Long-Term Care."

Introduction

Has anyone in the audience ever sold a long-term care insurance policy?

[Hands rise.]

Good, quite a few of you.

Well, now, I'm confused. Why do you need more training on long-term care insurance sales?

I mean, after all, we know 70 percent of all people over the age of 65 are going to need some long-term care. We know 20 percent will require five years or more.

[Source: Peter Kemper, Harriet L. Komisar, and Lisa Alecxih, "Long-Term Care Over an Uncertain Future: What Can Current Retirees Expect?," *Inquiry*, Vol. 42, Winter 2005/2006, pps. 335-350, www.inquiryjournal.org.]

We know long-term care is a very expensive prospect, whether it's provided in a nursing home, in assisted living, or in a person's own home.

I assume you do not get in front of people with the offer of private long-term care insurance as a solution to this problem unless and until you've qualified them, both medically and financially. Surely, you wouldn't want to waste their time or yours.

So, here's my problem. You know they need it. You know they can afford it. You've answered all their objections. So I assume this is a slam-dunk sale, right? Do you ever still have the experience of offering this product to qualified people who need it, and they don't buy?

Let the record show that there was a titter of amusement at that statement.

Well, then, I don't understand. What do they tell you to get you to leave without a signed contract?

Audience: "It costs too much."

Moses: "Right, I'd rather spend dollar-dollars later than nickel-dollars now." Makes no sense. What else?

Audience: "My kids will take care of me."

Moses: "Sure, I'm just fine with my daughter or daughter-in-law having to quit her job or take early retirement so she can change my diapers someday." Anything else?

Audience: "Denial, I'll never go to one of those places."

Moses: "Yeah, I'll never go to one of those places. I'd shoot myself first. That's usually the guy right? Macho man. Here's the truth. At age 85, there's a 47 percent probability you'll already have Alzheimer's Disease. Two-thirds of all residents in long-term care facilities are cognitively impaired. The reality, Mr. Jones, is that when it comes time to use it, you won't remember why you bought the gun!

"Or, when you have the stroke, you'll be on a cruise ship, where they don't let you take firearms aboard."

Now, the reason I begin the program in this way is to show you that the excuses people give to get you to leave without a signed long-term care insurance contract have very little to do with the real reasons they don't buy. Something else is going on under the surface.

But, what? That's what today's program is about. I estimate that 80 percent of the American public who could, should and would buy long-term care insurance never even rises to the level of concern about the issue to ask "who pays?"

In fact, I'd say the American public has no idea who pays for long-term care. They don't know if it's Medicaid, Medicare, or Santa Claus. Nor do they care.

Furthermore, even if they do wonder who pays for long-term care, they have a pretty good idea that somebody must pay. After all, you don't see Alzheimer's patients dying in the gutter.

In other words, for most people, the issue of long-term care probably doesn't even reach the level of full consciousness in their minds. So you never see them.

And for the 20 percent of the potential LTCI market that you do get in front of, usually because they've been through a crisis with a family member recently, you only sell a third to a half for the same reason. They just don't believe they're as at risk as you're saying.

Today's Program

My goals in today's program are threefold:

First, I want to show you why the public remains asleep about the risk and cost of long-term care.

Second, I want to show you why everything is about to change.

And third, I want to explain how you can help more people protect themselves against the real LTC risk and cost in the meantime.

Here's the danger:

If your clients are looking through the rear-view mirror at the issue of long-term care, what they are probably seeing is how Mom and Dad or Grandpa and Grandma got nursing home care funded by Medicaid.

If you can help them look through the windshield, however, what they're going to see is a brick wall of fiscal reality approaching at 100 miles an hour.

The way long-term care has been funded in the past is about to change dramatically. Individuals and families will be much more personally responsible for their own care in the future than they have been in the past. Understanding why long-term care is the way it is today is critical to preparing for how long term care will be funded in the future.

I'm going to approach today's topic from three different angles.

First, we'll look at the big picture, the long-term care service delivery and financing system in terms of its full complexity.

Second, we'll trace the history of long-term care service delivery and financing in order to understand how the system became so dysfunctional.

And third, we'll analyze the current system in order to explain what has to change and how and when it will change.

The Elephant, the Blind Men, and Long-Term Care

There is an old East Indian allegory about an elephant and some blind men. It goes like this. Six blind men approached an elephant. Depending on what part of the elephant they touched, each thought he was grasping something entirely different.

One blind man touched the trunk and assumed it was a hose. Another blind man touched the tail and thought it was a rope. A third blind man patted the flank of the elephant and assumed it was the side of a barn.

The point of this story is that with any complex entity, until you understand each of its facets and all of their interrelationships, you really don't know with what you're dealing.

It seems to me that the old story of the elephant and the blind men is a perfect analogy for the complex issue of long-term care. If you're looking at long-term care only from the perspective of long-term care insurance, you're not really seeing the whole picture.

The same holds true for all the other blind men of long-term care. I mean by that, there are several interest groups or stakeholders concerned about long-term care. They each view the elephant of long-term care very differently, and very provincially.

Let me show you what I mean. If I asked you to name one of the blind men of long-term care, one of the key interest groups in the issue of long-term care, what would you say?

Audience: **"The government?"**

Moses: Exactly. The government pays for the vast majority of all expensive long-term care in the United States. Medicaid and Medicare are the heaviest funders of nursing home care and home health care. Medicaid, especially, is the 800-pound gorilla of long-term care financing.

Medicaid funds most nursing home care, and a good portion of home health care in the United States. But Medicaid is bankrupting the states. It accounts for 22 percent to 25 percent of state budgets and long-term care is a third to a half of the average state's Medicaid expenditures. Medicaid long-term care costs are breaking the bank.

Despite these huge expenditures, Medicaid can't afford to pay adequately for long-term care. That's true already, and will be more true in the future, when the baby boomers retire and ultimately need long-term care themselves. Medicaid reimburses nursing

homes less than the cost of providing the care: $4.6 billion annually and $14.17 per Bed Day less than cost.

[Source: "A Report on Shortfalls in Medicaid Funding for Nursing Home Care," November 2009, http://www.ahcancal.org/research_data/funding/Documents/2009%20Medicaid%20Shortfall%20Report.pdf]

How do nursing homes survive under those circumstances? I'll explain that later in the program. I'll also explain why it can't continue.

So, when the government looks at the elephant of long-term care, it sees a gigantic fiscal black hole. Government can't afford to fund the long-term care it pays for today, much less in the future. Yet government continues to pay for most long-term care not only for the poor, but for the middle class and affluent as well.

What might be another blind man of long-term care?

Audience: **"The public, consumers, people who need long-term care."**

Moses: Absolutely, somebody has to receive the care, right? So what does the public see when it looks at the elephant of long-term care?

The public's response to long-term care is "what, me worry?" Most people have no idea who pays for long-term care. They're in denial. Hence the cliché among long-term care insurance agents: "Denial is not a river in Egypt."

But here's the problem: if long-term care is such a huge risk and cost, how can the public remain in denial? What enables their denial?

Do you think it could have something to do with the fact that since 1965, the United States government and state governments have paid for most long-term care provided in nursing homes or through home health care?

There is another blind man of long-term care, closely related to the public, but different enough for us to identify it separately.

The third blind man of long-term care is the **"senior advocates."** Now, when I ask about organizations that represent seniors and advocate on their behalf, what comes to your mind?

Audience: **"AARP."**

Moses: Right, but also the Alzheimer's Association, the National Council on the Aging, the American Society on Aging and many, many others.

What role do these groups play? Are they strong advocates for personal responsibility and private financing to supplement public financing of long-term care? Are they wonderful sources of medically and financially qualified leads for private long-term care insurance producers?

The answer to these questions is "no." Instead of warning their members that long-term care will require more personal responsibility in the future and urging them to save, invest or insure for the risk, these groups often pooh-pooh LTC insurance, saying most people are too young, too old, too rich or too poor to buy it. They are principally focused on attracting more financing for long-term care from the government. But as we've already established, the government has no extra money for LTC programs. It's a hopeless task to squeeze more blood out of that turnip.

There's also a subcategory of the senior-advocacy blind man of long-term care. That's the elderlaw bar, including the Medicaid estate planning attorneys who help affluent people self-impoverish to become eligible for Medicaid. We'll talk more about these people and how they do what they do later in the program. For now, it's important to recognize that the more people depend on scarce government financing of long-term care, the harder it is for the government to provide quality care to people truly in need.

So, how about another blind man of long-term care? What's another group critical to providing long-term care?

Audience: **"Nursing homes?"**

Moses: Correct, but home care providers and assisted living facilities also. Were talking about the providers of long-term care. Here it's important to distinguish between providers who receive most of their funding from government versus providers who receive most of their funding from private sources.

Nursing homes and home health care agencies are largely funded by Medicaid and Medicare. Consequently, the tremendously powerful trade associations representing nursing homes and home care agencies are principally focused on getting the government to provide more reimbursement to them. Most of their revenue has always come from government. So that's where they focus their lobbying and public policy advocacy efforts. They don't spend much time or money on encouraging responsible long-term care planning for the future.

I think you will agree that LTC providers are rarely good sources of qualified leads for private long-term care insurance. These organizations are struggling to survive next week, next month, next quarter. That's why they are not particularly concerned about who's going to pay the bills 15 or 20 years from now when someone who buys a long-term care insurance policy today might finally go on claim.

Assisted living facilities, on the other hand, are in a completely different position. Their funding comes 90 percent from private sources, mostly out-of-pocket expenditures by

residents and their families. So, you would think that assisted living facilities would be focused on increasing private financing of their services, including through private long-term care insurance. But they're not.

Why? Assisted living facilities are also struggling financially. They too can't wait 20 years for more private payers. In the meantime, they are tempted to take more Medicaid money, even at rates less than the cost of providing the care, because any reimbursement is better than none for an empty bed.

Thus, assisted living facilities are hurt in two ways. Medicaid subsidized nursing home care draws away potential assisted living residents and assisted living facilities are tempted to accept prohibitively low-reimbursement Medicaid residents as a way to fill beds. I've published in assisted living trade journals in the past warning that industry against the mistake of taking the same Primrose Path as nursing homes toward more and more dependency on public financing.

A fifth blind man of long-term care is the financiers. These are the people who provide the debt and equity capital to build, operate, and maintain long-term care facilities. The LTC financiers represent Wall Street. They represent investors. If they can make more money in a sector of the economy other than long-term care, that is where they will invest their investors' capital. Capital always migrates to its highest and best use.

The financiers have been burned by long-term care in the past. In the late '80s and early '90s, they invested heavily in assisted living facilities. They assumed that nursing home care was highly undesirable and that the public was spending down into impoverishment for nursing home care, so that if assisted living facilities (ALFs) were built, the new service modality would be much more attractive to consumers. They invested heavily in these beautiful Victorian mansions, but found the new ALFs could not fill fast enough to be profitable and provide the expected investment returns. Wall Street, once burned, remains twice cautious.

Several years ago, I attended a conference of the National Investment Center, NIC, an educational and trade association for LTC financiers. The first evening I found myself in a giant Washington, DC hotel auditorium. There were blinking neon lights in the shape of cocktail glasses. The room was full of distinguished gentleman in three-piece suits. I thought I'd hit the mother lode. "Follow the money," they say. "Show me the money." That's the key to understanding any industry, I thought. If I can just show these people how vulnerable long-term care is to public financing and what a great potential private financing through long-term care insurance would have, they should get on board.

Boy, was I wrong. I found out they only look at specific projects. "Do the demographics justify building a facility in this particular location at this particular time?" is the only question they ask. They gave no level of concern to the fact that public financing of long-term care is collapsing and private financing of long-term care is not increasing. In fact long-term care insurance is of no concern to them at all. LTC insurance paid $8.5

billion in claims in 2008 (AALTCI, 2008), but that's within a market of over $201 billion a year (CLTCR, 2010). Long-term care insurance isn't even a flyspeck on the windshield of the larger long-term care marketplace. And it won't be a significant factor to these investment advisors in the future, because too few people are purchasing long-term care insurance for the product to play an important role in funding long-term care in the foreseeable future.

Nevertheless, investors in long-term care are taking a larger interest lately. I've been invited to consult with many Wall Street people on the wisdom of investing in long-term care service delivery and financing. But the bottom line right now is that investors can make more money in other sectors of the economy than in long-term care. Consequently, we have a dearth of debt and equity capital to fund long-term care.

This is a serious problem, because America's nursing home infrastructure is antiquated. The average nursing home in the United States is 37 years old. The average life expectancy of a nursing home is only 40 years. The Age Wave is about to crest and crash on long-term care service delivery in the United States. Yet, we have an institutional bias in the system, an excessive dependency on nursing home care. We have an underdeveloped home and community-based services infrastructure. And we lack the investment capital to deal with these shortages.

Well, there is one more blind man of long-term care, can you tell me what it might be?

Audience: **"Long-term care insurance?"**

Moses: Correct. I always put the long-term care insurance industry under the elephant's tail. [Laughter] You'll see why.

What does the long-term care insurance industry see when it looks at the elephant of long-term care? Well, 30 years ago the LTCI industry looked at long-term care and said:

"Wow! What an opportunity! 77 million baby boomers are getting older. Everyone knows that most people have to spend down their life savings before they get any help from the government. Then all they get is nursing home care, which nobody wants. So, if we just offer an insurance product to help them spread that risk and purchase the care they want, it's bound to be popular and very profitable."

Is that how it turned out? Not by a long shot. Although actuaries who were around at the beginning have told me they expected 75 percent of all Americans to be protected for long-term care by now, the actual market penetration for private long-term care insurance is less than 10 percent today.

Long-term care insurers got into the business with stars in their eyes. Companies, brokers and agents entered the industry with high expectations. They made a few revolutions and headed out the other side of the revolving door. Turns out long-term care

insurance is much harder to sell than was originally thought. A key goal of today's program is to explain why that is and what has to change to fix it.

Those are the six blind men of long-term care. We've now taken the elephant of long-term care apart. Here's what we found.

The government funds most long-term care but can't afford to do so in the future.

The public is asleep about the risk of long-term care because the government has paid for most of it since 1965. So the public is about to get a rude awakening as government is forced to withdraw slowly from widespread LTC funding.

Senior advocacy organizations, instead of working to wake the public up to the need for long-term care planning, have put all their lobbying energy and resources into promoting more government financing of long-term care. But that's a dead end.

And ironically, at least for the time being, the easiest money of all to be made in long-term care is made by Medicaid planning attorneys who wave a magic legal wand and make the financial liability for long-term care disappear for their affluent clients--after the insurable event has occurred!

Long-term care providers are hooked on "LTC crack." They invest all of their energy, resources and money into squeezing more revenue out of the government. But again, that's beating a dead horse, drilling a dry hole.

Nursing homes remain a powerful lobby because they get and have gotten so much government financing for so long. Home and community-based services providers have little clout, because the government co-opted a private market for their services by paying mostly for nursing home care for over four decades.

Long-term care financiers are few and far between, because they can make more money for their investors in other sectors of the economy. Hence, we have a dearth of debt and equity capital to build, operate and maintain long-term care facilities in the United States at the very time the demand for long-term care is about to explode.

And finally, long-term care insurance remains a stunted market, because the government has paid for most long-term care since 1965, the public is asleep about the risk, and the long-term care providers are hooked on public funding.

Get the picture? What a mess! When you look at the whole elephant of long-term care, take it apart and put it back together again as we just have, what you see is a very complicated interrelationship between a lot of interconnected parts resulting in a totally dysfunctional whole.

How in the world did our country's long-term care service delivery and financing system get into such a dangerous mess? That's where we're going next with today's program.

History of LTC and Why it Matters for Financial Advisors and LTCI Producers

I want to change gears now and take another approach to the LTC issue. We have established so far that the elephant of long-term care is a very complicated animal. It's comprised of many competing interest groups, each and all of which have something to gain from continuation of the status quo.

We've established that the United States has a welfare-financed, nursing home based long-term care system in the wealthiest country in the world where nobody wants to go to a nursing home. And yet most people are asleep about the risk and cost of long-term care. Until we understand how this status quo came to be and why, we can hardly expect to identify the right corrective actions.

So I want to turn now to the history of long-term care service delivery and financing. How did we get into the mess we're in?

Something really important happened in 1965. Two new government programs were established. Do you know what they were?

Right, Medicare and Medicaid.

Medicare, of course, was designed to provide acute health care to the elderly. But Congress decided that something really needed to be done for low income people as well. So they added Medicaid as kind of an afterthought to Medicare. Then, as an afterthought to that afterthought, Congress decided that something should also be done for aging Americans who need long-term care. So they added nursing home care to Medicaid for people over the age of 65.

In the beginning, there were no transfer of assets restrictions interfering with eligibility for Medicaid long-term care. There was no estate recovery mandate requiring people with sheltered wealth to pay back the cost of their care. If you were over the age of 65, it was easy to get the government to pay for nursing home care.

The public isn't stupid. They figured: "You mean, if we want to take care of Grandma at home, we'll have to pay for it 100 percent out of our own pockets? But if we put her in a nursing home, the government will not only pay for her care but send in surveyors to make sure she receives quality care? That's a no-brainer."

The nursing home industry isn't stupid, either. They said. "You mean the government is going to put a giant pot of money out in the middle of the country, somewhere around Kansas or Nebraska, and all we have to do is build nursing homes, offer the beds to people who want long-term care, and the government will pay? Terrific. Bring it on."

Medicaid Nursing Home Costs Explode

P.J. O'Rourke, the political satirist, likes to say "If you think health care is expensive now, just wait until it's free."

For all intents and purposes, the government made nursing home care free in 1965.

That had the effect of crowding out a market for privately financed home and community-based care. Why pay out of pocket for home care services, adult day care, respite care or assisted living, when the government provides nursing home care?

For the same reason, a market for long-term care insurance to pay for home care and nursing home care was slow to develop and remains stunted to this day.

By the mid-1970s, I was working for the Health Resources Administration in Rockville, Maryland. That's part of the U.S. Public Health Service. I saw what happened next, up close and personal.

Predictably, the cost of Medicaid financed nursing home care exploded. The public filled new nursing home beds as fast as the nursing home industry could build them. "Roemer's Law" said: "A built bed is a filled bed."

[See http://en.wikipedia.org/wiki/Roemer's_law]

The government looked at the exploding cost of nursing home care and concluded that something had to be done. But instead of addressing the cause--that is, the fact that government had made nursing home care free or radically subsidized resulting in higher construction, utilization and expenditures--they attacked the symptom, the increasing costs.

The government figured "they can't charge us for a bed that doesn't exist." So, state governments began to require nursing homes to get permission before they build new facilities. Nursing home companies had to obtain a "certificate of need" or CON before building new skilled nursing facilities.

Now, this arrangement was fine with the nursing home industry. For anyone already in that business, the Certificate of Need only meant that they now had a government-enforced monopoly. They might not be able to build more nursing homes, but neither could their potential competition. Since the nursing homes' growth was restricted by this limit on supply, however, the industry simply started charging more for the beds they already had.

That was predictable. In any economic system, when supply goes down or is artificially restrained from going up, price tends to increase. You don't need a PhD in economics to figure that out, but the government didn't see the consequences coming.

The cost of Medicaid financed nursing home care continued to explode. Once again, the government knew it had to take action. And once again, it failed to address the cause--

i.e., free government financed nursing home care--and went instead after the symptom--skyrocketing costs caused by increasing charges to Medicaid by the nursing home industry.

So the government told the nursing home industry they could no longer charge whatever they wanted to charge for nursing home care. Medicaid capped its reimbursement rates. This was the origin of the differential between the very low Medicaid reimbursement rates for long-term care and the relatively high private pay rates. Today, Medicaid pays only about two-thirds of the private-pay rate for nursing home care. Private payers have to pay half again as much as Medicaid reimburses for people in the same nursing home, sometimes in the same room as the private payers.

Quality Collapses

With supply AND price capped, what do you think happened to demand? Of course, demand went through the roof. In the mid-1980s, nursing homes were 95 percent occupied. At the same time, hospitals were only 55 percent to 60 percent full. If a nursing home was willing to accept Medicaid's low reimbursement rates, it could fill all of its beds . . . no matter what kind of care it offered. Consequently, quality of care collapsed in principally Medicaid-financed nursing homes.

Once again, Congress took note. Even though quality plummeted, costs continued to explode. True to form, however, government attacked the symptom (poor quality) instead of the cause (public financing). So Congress went to the nursing home industry and said, in paraphrase:

"This is America. We cannot tolerate poor quality of care in our nursing homes. You must improve the care. You must hire more nurse's aides; you must train them better; you must pay them more. Make sure you dot every I and cross every T according to stricter regulations. And if you don't, we will hit you with fines and other penalties."

That was OBRA '87, the Omnibus Budget Reconciliation Act of 1987. In 2007, we celebrated the 20th anniversary of that law. Thankfully, it worked, and quality of care in America's nursing homes is top notch today. [Audience snickers.] Well, not exactly. If anything, the problems are worse than ever today.

But when OBRA '87 passed, the nursing home industry wasn't displeased. They said, in essence, "We're not in this business just to make a lot of money. We want to provide loving and compassionate care. We love the idea that you want us to hire more people, train them better and provide higher-quality care. Only one question though, how much more are you going to reimburse us under Medicaid to make this possible?"

And the government responded "Money? We don't have any of that. We just demand that you do all these new things."

Nursing Homes Sue Medicaid

Well, now the nursing home industry was caught between the rock of inadequate reimbursement and the hard place of mandatory quality. If they tried to attract more private payers at the higher private-pay rate, they were accused of discriminating against Medicaid recipients. If they tried to cut costs, they were accused of providing poor care. It was a hopeless situation. So the nursing home industry turned to the courts.

Under the "Boren amendment," which was part of OBRA '81, the nursing home trade associations in many states began suing their state Medicaid programs for higher reimbursement under Medicaid. The Boren amendment said in essence: "State Medicaid nursing home programs must provide sufficient reimbursement for an effective facility to provide decent care." That's a paraphrase, but pretty close.

[For the precise language, see Joshua M. Wiener and David G. Stevenson, "Repeal of the 'Boren Amendment': Implications for Quality of Care in Nursing Homes," at http://www.urban.org/publications/308020.html.]

Who do you think won most of those lawsuits? There's an old saying that "you can't fight City Hall," so you might think the State Medicaid programs prevailed. But the truth is, the state nursing home associations won most of those Boren suits. They forced Medicaid to increase reimbursements for nursing home care.

So, what do you think the government did next? You guessed it. Congress repealed the Boren Amendment in the Balanced Budget Act of 1997. Since then, there has been no floor under Medicaid reimbursement for nursing home care. Nevertheless, long-term care costs continue to increase and quality remains questionable.

Medicaid LTC Eligibility Bracket Creep

While all this was going on, another situation developed. Most people who needed long-term care were receiving it in nursing homes because an alternative market for home and community-based care had been crowded out by free nursing home care. So people were finding themselves in nursing homes, often in semiprivate rooms, paying privately, but sharing a room with a person on Medicaid.

The people paying privately, or their representatives, noticed that the person on Medicaid may have had more money than the person paying privately throughout most of their lives. Because of Medicaid's reduction in the reimbursement rate it was willing to pay nursing homes, private payers came to be paying half again as much on average as Medicaid was paying for Medicaid recipients. That's called "cost shifting." Naturally, this created a temptation on the part of the private payers to find a way to qualify for Medicaid. If they could get onto the program, it would pay not only for their nursing home care, but for other, ancillary services that Medicaid often pays for but Medicare doesn't, such as foot care, eye care, dental care and residual pharmaceuticals after Part D.

By the early 1980s, there developed a sub-practice of law, called "Medicaid estate planning" designed to help middle-class and affluent people self-impoverish in order to become eligible for Medicaid. I call this process of extending Medicaid eligibility to more and more prosperous people "eligibility bracket creep." As Medicaid LTC eligibility expanded, it created even more financial pressure on Medicaid and reduced the number and percentage of people in nursing homes who were paying at the higher private pay rate. Thus, eligibility bracket creep exacerbated all the problems we've discussed so far regarding access to and quality of care.

Congress Acts to Discourage Medicaid Abuse

Beginning in 1982, Congress tried to get control of Medicaid LTC eligibility. The first major measure in this direction was the Tax Equity and Fiscal Responsibility Act of 1982, or TEFRA '82. TEFRA authorized state Medicaid programs for the first time to (1) penalize asset transfers done for the purpose of qualifying for Medicaid, (2) place liens on real property in order to hold that property in a recipient's possession during their period of Medicaid eligibility, and (3) to recover the cost of their care from the estates of deceased recipients.

The critical thing to understand about TEFRA '82 is that it was entirely voluntary. States could implement these new programs or not at their own discretion. In 1983, I was the Medicaid State Representative for the state of Oregon in the Seattle Regional Office of the Health Care Financing Administration (the predecessor organization of the current Centers for Medicare and Medicaid Services or CMS). It was my job to make sure that the federal laws and regulations governing Medicaid long-term care were properly implemented by the state government. The federal government partially funds and oversees Medicaid. State governments partially fund and administer the program. So the Medicaid State Rep's job was to be the linchpin between the federal and state Medicaid programs.

In Oregon, I came across this interesting program called "Medicaid estate recoveries." It purported to recover five percent of the cost of Oregon's nursing home program, or about $5 million a year. That was back then. It's more like $20 million a year now.

Imagine my confusion when I discovered this program. By that time I had already worked a total of ten years in federal welfare programs. I thought I knew how they worked. When you're poor . . . when you're destitute . . . when you have nothing left . . . you can apply for public assistance, and the government helps you with cash or, in Medicaid's case, with medical or long-term care services. That's how it was with the old Aid to Families with Dependent Children Program. I thought it was the same with Medicaid.

So how could it be that people who are poor and destitute enough to qualify for Medicaid would spend years in a nursing home at enormous expense to the state and federal governments, and then, after they die, a little state like Oregon recovers nowadays $20 million out of their estates? Where did all that money come from?

That question really fascinated me. So, in 1983 I conducted a study, the objective of which was to ask and answer the question "What if every state in the country recovered from estates at the same rate as Oregon?"

I quickly realized that to do this study, I would have to understand how Medicaid eligibility works. In other words, how could people with substantial income and assets qualify for Medicaid in the first place?

What I learned is that income is rarely an obstacle to qualifying for Medicaid. I also found that assets, ostensibly limited to only $2000, were rarely an obstacle to qualifying for Medicaid. That's because unlimited assets could be held in exempt form. We'll discuss Medicaid income and asset eligibility in detail later in this program.

Until 2006, for example, there was no limit on the amount of home equity that could be exempted. One home and all contiguous property, regardless of value, was disregarded. It was no wonder, therefore, that people could qualify for Medicaid, receive free or subsidized nursing home care and other medical services indefinitely, and still have substantial assets in their estates.

The report I prepared for the Health Care Financing Administration in 1985, titled "The Medicaid Estate Recoveries Study," is available at http://www.centerltc.com/mer_study.pdf. What I found was that most states had not aggressively implemented TEFRA '82. Most states had implemented some form of the transfer-of-assets restriction, but back then it was limited to a two-year look-back and no more than a two-year penalty. Only two states had implemented TEFRA liens. And while 15 or 16 states had implemented estate recoveries, most had not done so in such a way as to maximize estate recoveries. My state of Oregon was an exception in that regard.

After I drafted this report, I forwarded it to a number of people interested in long-term care financing, including several scholars and federal agencies like the General Accounting Office (GAO is now known as the Government Accountability Office) and the Office of Inspector General (OIG) of the Department of Health and Human Services (DHHS). Although HCFA discouraged my work and refused to publish it, the DHHS Inspector General loved it and hired me out of the Health Care Financing Administration to conduct a more comprehensive national study and write a report titled "Medicaid Estate Recoveries." That report is still available to read on the OIG's website at http://oig.hhs.gov/oei/reports/oai-09-86-00078.pdf. GAO also followed up with a national study on which I consulted. Read that report at http://archive.gao.gov/d15t6/138099.pdf.

My report for the OIG explained how people with substantial income and assets could qualify routinely for Medicaid. It estimated that nearly $600 million could be recovered from estates, if every state in the country performed at the same level as Oregon. The report warned that as long as people with substantial income and assets could qualify

easily for Medicaid, there would be very little market for private LTC financing alternatives; Medicaid nursing home expenditures would continue to explode; no privately financed home and community-based services infrastructure would develop; quality of care would continue to decline due to Medicaid's notoriously low reimbursement rates; and, if something weren't done about these problems, within 25 years the cresting of the Age Wave would crush the existing long-term care financing system.

Here we are 25 years later and everything I predicted in that early OIG study has come true or is about to!

COBRA '85, MCCA '88, OBRA '93, HIPAA '96, BBA '97 and DRA '05

In 1985, in the **Consolidated Omnibus Budget Reconciliation Act** of that year, Congress took the next step to rein in abuse of Medicaid LTC. COBRA '85 put a stop to "Medicaid qualifying trusts." MQTs had become the technique of choice for elderlaw attorneys to impoverish their affluent senior clients and qualify them for Medicaid nursing home care. COBRA '85 changed the rules, but did not grandfather in people who already had Medicaid qualifying trusts. Many individuals and families were hurt. A lot of elderlaw attorneys were embarrassed professionally. But that didn't stop them from finding new ways to focus on qualifying affluent clients for Medicaid financed long-term care.

The **Medicare Catastrophic Coverage Act of 1988** (MCCA '88) was the next step in this process. MCCA '88 was mostly about Medicare, but it did have some provisions that affected Medicaid long-term care eligibility. The most important change was, for the first time, to require state Medicaid programs to penalize asset transfers for less than fair market value done for the purpose of qualifying for Medicaid long-term care benefits. MCCA '88 required state Medicaid programs to look back 30 months for inappropriate asset transfers. It established an ineligibility penalty equal to the amount of assets transferred for less than fair market value for the purpose of qualifying for Medicaid divided by the average cost of a nursing home in the state. For example, give away $100,000 to qualify for Medicaid in a state where nursing home care averaged $5,000 per month and you'd be ineligible for 20 months *from the date of the transfer*. The italicized point will be very important later. MCCA '88 also established a limit of 30 months as the maximum penalty for asset transfers. In other words, if you gave away $1 million within 30 months of applying for Medicaid, your transfer of assets penalty would still be only 30 months.

In 1993, the **Omnibus Budget Reconciliation Act** of that year implemented most of the recommendations from my 1988 "Medicaid Estate Recovery" report for the Office of Inspector General [http://oig.hhs.gov/oei/reports/oai-09-86-00078.pdf]. OBRA '93 extended the look-back period for asset transfers to a full three years (36 months) for most improper transfers and to five years for transfers into or out of a trust. The law also eliminated the limit on the eligibility penalty. Now, if you gave away $1 million within

three years of applying for Medicaid, you would be permanently ineligible for all intents and purposes.

OBRA '93 also eliminated the Medicaid planning gimmick of "pyramid divestment." Before OBRA '93, the elderlaw bar had figured out that because transfer of assets eligibility penalties were allowed to run concurrently, they could jettison lots of money very quickly for their affluent clients while minimizing any transfer of assets penalty. On their websites, they published schedules that showed exactly how much to give away each month to take full advantage of this loophole. They could actually spend you down from $1 million to nothing in a period of about a year. This was possible because, for example, instead of giving away all the money in one month and incurring the maximum penalty, you could give away smaller amounts each month and, because the penalties ran concurrently from the date of the first transfer, you'd be out of money and eligible for Medicaid in only a fraction of the time originally intended by Congress. This so-called pyramid divestment was no longer allowed after 1993. But the elderlaw bar was very creative and opened many new "loopholes" to replace this one.

A Political Earthquake

Something big happened in American politics in 1994. Anybody recall what it was? Remember the "Contract with America," Newt Gingrich? The Republicans took over both houses of Congress.

Who was president at the time? Right, Bill Clinton.

Clinton was well known for something in particular. [Audience snickers.]

"Not that!"

I'm referring to President Clinton's frequent statement that he would "change welfare as we know it." And he did. He added a work requirement to the welfare (Aid to Families with Dependent Children or AFDC) rules and reduced the welfare rolls by two-thirds, a tremendous success.

The new Republican Congress and President Clinton were alarmed by the exploding Medicaid long-term care costs. They were frustrated that none of the government's efforts since 1982, which were intended to control the abuse of Medicaid long-term care resources, had worked. So they decided to stop the overuse of Medicaid once and for all. In 1996, in the Health Insurance Portability and Accountability Act (HIPAA '96 or the Kennedy/Kassebaum Act), they made it a crime to transfer assets for less than fair market value for the purpose of qualifying for Medicaid. To do so, according to HIPAA '96 would be punishable by a fine of up to $10,000 and a jail term of as much as a year.

Now, remember the senior advocates? They were one of the blind men of long-term care we talked about. The senior advocates and their organizations looked at this new rule with alarm and decided to fight it. They called HIPAA '96 the "throw granny in jail law."

Okay, this was one measure to control Medicaid abuse that even I didn't favor. It seemed to me like a stupid, ham-handed way to deal with the problem, which is actually fairly simple to fix.

But when Congress repealed the throw granny in jail law in the Balanced Budget Act of 1997 (BBA '97) and replaced it with the "throw granny's lawyer in jail law," that made a lot more sense to me. Why penalize the victim, when you should be going after the culprit? For awhile, the Medicaid planners' big conventions, held at luxury resorts twice a year, were more like funerals than professional meetings. (I used to attend those sessions to keep an eye on the Medicaid planners and report their egregious methods to the media until they blackballed me by closing their conventions to non-attorneys.)

Unfortunately, the "throw-granny's-lawyer-in-jail law," which threatened a year in jail and/or a $10,000 fine for recommending (in exchange for a fee) that a client transfer assets to qualify for Medicaid, was unconstitutional. Janet Reno, who was Bill Clinton's Attorney General at the time, looked at the law and concluded it would be unenforceable. How could you hold an attorney legally culpable for recommending a practice that was legal again after the "throw-granny-in-jail law" was repealed?

So, there we were in the late 1990s, 15 years after Congress had taken the first steps in TEFRA '82 to control the abuse of Medicaid, right back where we'd started. Costs continued to explode. More and more people were qualifying for Medicaid-financed long-term care. Private payers were disappearing. Quality of care continued to decline. The public remained asleep about long-term care risk and cost. Neither private insurance nor home equity conversion contributed significantly to LTC costs. And the Age Wave was a decade and a half closer to wiping out the LTC safety net.

From Boom to Bust

Now, what was the economy like in the late 1990s? Good or bad?

Right, those were boom years. The Internet bubble. The new economy. Everyone's 401(k) was on its way to becoming an 802(k). In my experience, when the economy is good, when tax receipts are up, and when welfare rolls are down, it is extremely hard to get the attention of politicians and public officials to the issues of controlling Medicaid costs and encouraging personal responsibility and long-term care planning.

But, exactly the opposite is true when the economy goes into the tank. When welfare rolls are up and tax receipts are down, state legislatures, governors and other public officials become much more amenable to reason and evidence about the need to control Medicaid long-term care expenditures. After September 11, 2001, as the economy went rapidly into recession, state officials became far more sensitive to the need to spend Medicaid's scarce resources effectively and efficiently.

When governors could not make their budget ends meet and because, unlike the federal government, they are constitutionally required to work within their budgets, we were able

to get their attention. In 2005, I was funded by the American Health Care Association, the big proprietary nursing home and assisted living trade association, to spend half time for six months in Washington, DC. My objective was to explain to all of the "blind men of long-term care," the key stakeholders in the LTC issue, the need to control Medicaid long-term care expenses and encourage private financing alternatives for long-term care.

I testified before Congress on April 27, 2005; I gave briefings on Capitol Hill; I met with all the key interest groups, including long-term care providers, LTC insurers, the National Governors Association, the National Reverse Mortgage Lenders Association and dozens of others. In fact, I sought out and met with anyone and everyone who had any role in or concern about long-term care financing . . . and would listen.

My co-founder of the Center for Long-Term Care Reform, an attorney by the name of David Rosenfeld, after leaving the Center in 2001, ultimately became the Chief Health Counsel to the House Energy and Commerce Committee, the germane committee for Medicaid in the United States House of Representatives. David wrote much of the Deficit Reduction Act of 2005 and guided it through the shoals of political opposition.

On February 8, 2006, President Bush signed the DRA '05. It had passed by a single vote. Vice president Cheney had to be transported back from the Middle East to cast the deciding vote in the Senate. As soon as the law was signed, senior advocacy organizations and Medicaid planning attorneys filed lawsuits against it. All of this litigation was thrown out of court.

The DRA '05 took some giant steps in the direction of controlling Medicaid eligibility. For the first time ever, it put a limit on the amount of assets that could be exempted in a home and contiguous property. The limit was placed at $500,000 or up to $750,000 at the option of a state legislature. That is a step in the right direction. By the time the Deficit Reduction Act passed, however, the recession that made it possible had ended. When state governments were under severe budgetary constraint, the National Governors Association had actually come out in writing for a limit on the Medicaid home equity exemption of $50,000. We got half a million and that's significant, but it isn't enough to solve the problem.

An LTC Tour Anecdote

Let me tell you an anecdote from our 2008 National Long-Term Care Consciousness Tour that helps make the point about Medicaid's home equity exemption.

When I was in Washington, DC with the Silver Bullet of Long-Term Care, I received an e-mail from the Prime Minister's office of the United Kingdom. They wanted to know if it would be all right to send over a delegation to speak with me, and others, about long-term care financing. It seems Great Britain is unable to pay for its socialized acute care health system, much less for long-term care. They would love to have a private long-term care insurance market to help defray the public cost of funding long-term care.

But when they looked at the United States, where it is commonly understood that no one qualifies for help with their long-term care costs until they have spent down into total impoverishment, they wondered: "If Americans can't sell long-term care insurance in their dog-eat-dog, capitalist system, how could we ever hope to develop a long-term care insurance market in a socialized health care system like England's?" (My paraphrase.)

I invited the U.K. delegation of two experts on aging to join me in the Silver Bullet at a very nice RV park on the outskirts of DC. I picked them up in the truck at the end of the D.C. Metro Green line, and drove them to the Airstream trailer. It was a hot and humid day, so we had the air conditioning on. The three of us sat in that little 16-foot trailer for three hours talking about long-term care financing.

I learned something very interesting. In the United Kingdom, all you can shelter in home equity while getting the government to help with your long-term care costs is $42,000. We are 10 to 15 times more generous with our scarce public resources for long-term care in the United States as they are in their socialized health care system.

More on the DRA

The Deficit Reduction Act of 2005 also extended the look-back period for asset transfers from three years to five years for all transfers. That sounds impressive until you realize that the look-back period on asset transfers in Germany, another European socialized health care system, is ten years! Transfer assets for less than fair market value within ten years of applying for public assistance to help with your long-term care costs in Germany, and you run the risk of their pursuing recovery from the people, probably your relatives, to whom you gave the money.

One of the most important changes the DRA '05 made was to eliminate the single most prevalent Medicaid estate planning gimmick at the time. That was the so-called "half-a-loaf" strategy. Instead of giving away $100,000 and incurring a 20 month transfer of assets penalty, people would give away $50,000, incur half the penalty, *i.e.*, 10 months, hide the rest of the money and become eligible after the penalty ran its course, without ever spending any of their own money for long-term care. The Deficit Reduction Act ended this practice by starting the eligibility penalty at the date someone would have otherwise become eligible for Medicaid if the rule hadn't changed. Previously, the penalty began at the date of the transfer, a practice which enabled the half-a-loaf strategy. Now, the penalty begins (usually) at the date of Medicaid application.

Ironically, this was a DRA provision to which the nursing home lobby was in opposition. They worried that people who had transferred assets would end up on their doorstep destitute, unable to pay their own way for long-term care, but also ineligible for Medicaid. In other words, nursing homes figured they'd end up with a lot more "charity" cases. I explained to them at the time that this would not happen, at least not in significant numbers, because the new rule eliminated the practicality of giving away half of one's assets to become eligible for Medicaid more quickly. In the future, no attorney in his or her right mind would recommend that people transfer assets in the same old way

to qualify for Medicaid, because that strategy would no longer work and would leave the lawyers vulnerable to malpractice suits. To date, I have heard no evidence that the worry of the nursing home industry has been realized. By eliminating the half-a-loaf strategy, people who would have used that trick are now having to spend their money for long-term care or they divest or shelter it in some other way.

The Home Care Panacea

There was one other important development we should discuss that was going on simultaneously. For many years, at least since the early 1980s, academics and government officials have been enamored with the idea that Medicaid's long-term care financing crisis could be relieved by paying for less nursing home care, which is so expensive, and paying for more home and community-based care, which is ostensibly less expensive AND the venue of care that most people prefer. The idea is that taking care of people in their own homes or in the community must be cheaper than maintaining them in a nursing home. Data often cited at the individual level seem to show that home care is cheaper than nursing home care. The error is in projecting such individual savings to the society as a whole.

None of the research shows that home and community-based care saves money compared to nursing home care overall. Community-based care usually only delays institutional care. Between them, expanded home care plus eventual nursing home care end up costing more in the long run than nursing home care alone. There are many reasons for this. One reason is the economy of scale that comes from taking care of a larger number of people in an institutional setting. Another reason is that people who are enabled to remain at home and maintain their independence and control, tend to be happier. They live longer and die slower, ending up in a nursing home sooner or later anyway. Not a single state has reduced the overall cost of nursing home and home health care by diverting more people to home care. The combined costs continue to rise everywhere, year after year. This is not to say we shouldn't find a way to fund home and community-based care. It only means that to think funding home care instead of nursing home care will save money is ridiculous.

For every person in a nursing home in America today, there are two or three of equal or greater disability, half of whom are bedbound, incontinent or both, who remain at home. They are able to stay home because their families, mostly daughters and daughters-in-law, struggle heroically to keep them out of a nursing home. When government starts providing long-term care that they want (home care) instead of long-term care that they don't want (nursing home care), people come out of the woodwork to take advantage of it. That drives up Medicaid LTC expenditures.

Furthermore, if all it gets you is into a nursing home, you might be reluctant to seek the advice of an attorney to self-impoverish in order to qualify for Medicaid. But when Medicaid planning will get you access to home care services, adult day care, respite care, and even assisted living, you will be much more likely to seek out the elderlaw attorney.

Medicaid financed home and community-based care encourages the practice of Medicaid estate planning.

And Medicaid financed home and community-based care is deadly to the marketability of private long-term care financing alternatives, such as reverse mortgages or long-term care insurance. The big benefit of being able to pay privately for long-term care is the ability to command red-carpet access to top-quality long-term care at the most appropriate level and in the private marketplace. To the extent the government conveys to the American public that you can achieve the same benefits financed by Medicaid, Medicaid will continue to explode in costs and reverse mortgages to fund long-term care in the short-term and LTC insurance to fund long-term care in the long run will remain stunted.

Summing Up

So far in this class, we've analyzed the big picture of long-term care service delivery and financing by means of the analogy of the elephant, the blind men and long-term care. We showed that America has a welfare-financed, nursing home-based long-term care system in the wealthiest country in the world where no one wants to go to a nursing home, but nevertheless, most people fail to plan responsibly for long-term care. They remain in denial about this risk and cost.

Next, we traced the history of long-term care service delivery and financing in order to explain how we got into this mess in the first place. We showed how Medicaid began financing nursing home care in 1965, which crowded out markets for privately financed home and community-based care and private insurance to pay for long-term care. We saw how the cost of Medicaid LTC, predictably, exploded and that the government responded first by capping the supply of nursing home beds with certificate of need, and then by capping the price, thus creating excessive demand for Medicaid financed nursing home care. With an artificially shrunk bed supply and artificially low reimbursement rates, nursing homes could fill up, no matter what quality of care they offered. So, quality plummeted, but measures to demand higher quality failed because there was no additional money to pay for them.

By then, nursing homes were virtually the only venue of care available. People who were paying privately half again as much as Medicaid paid were eager to become eligible for Medicaid. After all, the government pressured nursing homes to provide equal care to everyone whether Medicaid or the resident paid. That led to an explosion in eligibility, what I earlier called eligibility bracket creep, which the government has been trying since 1982 to control and discourage. Finally, efforts to ameliorate the symptom of excessive nursing home expenditures by providing home and community-based care to more people only exacerbated the cost problems while further desensitizing the public to LTC risk and cost by leading them to believe Medicaid would pay for desirable long-term care services.

So, that's how America's dysfunctional long-term care service delivery and financing system came to be.

I want to change focus now and approach the long-term care issue from a different angle. Let's apply a conceptual analysis to the problem.

The Welfare Paradigm

I'd like to describe for you what I believe to be the most common description of the long-term care service delivery and financing marketplace. I call it the "welfare paradigm." It goes like this:

"In America today, we're living longer and dying slower. It's a very expensive prospect. Most people spend down into total impoverishment quickly. Congress once said the average family spends themselves into total destitution for long-term care in an average of only 13 weeks! Once people are completely destitute, they qualify for Medicaid, and Medicaid is already under water financially. With the onslaught of the baby boom generation, Medicaid will be totally overwhelmed. Woe is me, what can we possibly do about this massive problem?"

Does that sound familiar? This is how I see the problem described in all the popular newspaper and magazine articles I read. It's certainly the way the long-term care problem is described in training classes provided by long-term care insurance carriers. Even scholars who ought to know better articulate the same platitudes. But is it correct?

Let's think about consumer behavior and see if it follows reasonably from the welfare paradigm. If people are spending down into total impoverishment all across the country; if long-term care is wiping out one of every 10 people financially; wouldn't you expect individuals and families to be worried about this? Are they? No, the public is in "Denial." That just doesn't make any sense if the cost and risk of needing long-term care is so great.

If people are spending their own money for LTC down to total impoverishment, where would you expect them to seek care? Would they go straight to a nursing home, the least desirable and most expensive venue of care? Or would they seek the least institutional, most desirable kinds of services such as chore services, home care, adult day care, respite care, or assisted living if they need an increased level of care. Wouldn't they pursue all these options before going to a nursing home? You'd think so. But, is that what they do? No, in the United States the principal venue of long-term care is the nursing home. We have an underdeveloped home community-based services infrastructure. It just makes no sense if you assume that people are spending their own money for long-term care.

What is the single biggest financial resource older people possess? Right, their homes. Somewhere around 83 percent of seniors own their homes and roughly 74 percent own them free and clear. There is $4.2 trillion worth of home equity held by people over the age of 62 in the United States. Is there a financial product that enables older people to take the equity out of their home in small or large amounts without having to leave their

home and without having to make monthly payments? Of course, it's called a reverse mortgage.

Are reverse mortgages used extensively to fund long-term care? No, almost never. I've done dozens of state level studies of long-term care financing. (You can find several of them at http://www.centerltc.com/reports.htm.) I always interview reverse mortgage lenders for these studies. To the person, they tell me almost no one takes out a reverse mortgage in order to fund long-term care. If the welfare paradigm is true, it makes no sense that people fail to draw on their single biggest asset to enable them to purchase the most desirable level and kind and quality of care . . . and stay in their own home.

Finally, the way we protect ourselves for most catastrophic risks in America is through private insurance. We all have health insurance, automobile insurance, and fire insurance, *etc*., but too few of us have long-term care insurance. The market penetration for private long-term care insurance is under ten percent. If the welfare paradigm accurately describes the long-term care marketplace, it simply makes no sense that so few people buy private insurance to protect against the high risk and cost of long-term care.

In other words, if the welfare paradigm is correct, consumer behavior doesn't follow at all. It's a total disconnect. I don't know how to explain it. Either consumers are totally irrational or long-term care insurance agents are completely incompetent. I don't think either of those explanations work either.

Most consumers are not financially incompetent. They know the value of money. This is especially true of people who accumulated enough wealth to need to protect it with a private insurance policy. Generally, they accumulated their wealth because they know how to use private sector financial planning tools. So I don't think we can blame consumers.

How about long-term care insurance agents? Are they incompetent? I don't think so. I've worked with these people for 25 years. In my experience, it takes a very special person to succeed as a long-term care insurance agent. In fact, I have my own certification for successful long-term care insurance producers. I call them AMGs. That stands for altruistic, masochistic geniuses, because that's what it takes to sell a product the government's been giving away since 1965.

I decided a long time ago that the welfare paradigm does not explain consumer behavior adequately. So, I went back to the drawing board and came up with another explanation. I call this the "entitlement paradigm."

The Entitlement Paradigm

I'm going to describe it to you now, but I want to ask you to do something for me. Suspend your disbelief at first. Pretend like you're going into a play or a movie. Just let it wash over you and think about whether the entitlement paradigm is a better explanation

of consumer behavior than the welfare paradigm. Later, I'll give you the evidence that supports the entitlement paradigm and refutes the welfare paradigm.

The entitlement paradigm goes like this: "In America today, we're living longer; we're dying slower; and it's a very expensive proposition. You may die with your boots on, in which case you're home free . . . sort of. But if you get one of the chronic illnesses of old age--Alzheimer's, Parkinson's, or if you have a stroke--and you need expensive long-term care, somebody else pays." Never mind who pays, for now.

If the entitlement paradigm is true, if you can ignore the risk of long-term care, avoid the premiums for private insurance, wait and see if you get sick and if you ever need expensive care, somebody else pays . . . would you expect consumers to be worried about the risk of long-term care? Of course not. If the entitlement paradigm is true, it makes perfect sense for the public to be in denial about LTC risk and cost. Why bother to ask "who pays?" if somebody does?

Where would you expect people to go to get their care? If nursing home care is free, but consumers have to pay out of their own pockets for any other kind of long-term care, where would you expect them to go? If the entitlement paradigm is true, it makes perfect sense that the venue of care which government has made free or radically subsidized--nursing home care--is the dominant venue for care. Institutional bias and the absence of a home and community-based services infrastructure follow logically from the entitlement paradigm hypothesis.

How about home equity conversion? Would you expect people to take the equity out of their home through a reverse mortgage to fund LTC when Medicaid exempts the home and all contiguous property up to, at a minimum, one-half million dollars? Probably not. The lack of a market for reverse mortgages to fund long-term care also makes perfect sense if the entitlement paradigm is correct.

Finally, long-term care insurance. You can't sell apples on one side of the street when they're giving them away on the other. Now, you and I know that the apples they're giving away on the other side of the street are full of worms. But most Americans don't realize that yet. They don't find out until a loved one begins a long-term care crisis. And that's why we have a vestige of a market for long-term care insurance today. The front cusp of the baby boom generation, people in their late 50s or early 60s, are going through long-term care crises with their parents nowadays. Those are the people buying long-term care insurance to the extent anyone is. If we wait 18 years for the entire baby boom generation to go through this process, we'll have a strong market for long-term care insurance. But by then, the publicly financed long-term care system will have collapsed long ago.

Evidence for the Entitlement Paradigm and Against the Welfare Paradigm

So, what is the evidence for the entitlement paradigm and against the welfare paradigm? There are really three kinds. If the entitlement paradigm is a better explanation of the

long-term care system than the welfare paradigm, I should be able to explain (1) how people with substantial income and assets qualify for Medicaid, (2) how most long-term care in this country is funded without using personal assets, and (3) why Medicaid asset spend-down is much less common than commonly understood.

Let's examine Medicaid asset spend-down first. In the middle 1980s, it was commonly believed that most people--50 percent to 75 percent--who entered nursing homes were private pay at admission and, because of the enormous cost of their care, quickly spent down into impoverishment before becoming eligible for Medicaid. I always said back then that it made no sense to spend down for long-term care. Medicaid rules don't require it. People would only spend down if they were ignorant of the eligibility rules, failed to get the advice of a Medicaid planning attorney, or had a moral compunction against taking advantage of the welfare program.

In the late 1980s and early 1990s, roughly three dozen so-called "Medicaid spend down studies" were conducted. These studies found that despite the conventional wisdom that most people enter nursing homes private pay, the truth was that only ten percent to 25 percent entered private pay and converted to Medicaid. Seventy-five percent to 80 percent of all new nursing home admissions were Medicaid eligible from the start.

Furthermore, these Medicaid spend down studies did not distinguish between people who spent down the old-fashioned way, by writing big checks every month to the nursing home until they became eligible for Medicaid, and people who spent down the new-fangled way, by writing one check to a Medicaid planning attorney and becoming instantaneously eligible for Medicaid.

The motivation behind the Medicaid spend down studies was to prove the conventional wisdom that people all across the country were spending down into total impoverishment for long-term care. The goal was to produce convincing evidence to support a government takeover of long-term care financing. Remember, those were the days when Hillary Clinton was developing and promoting a government-controlled health-care system to include long-term care as well as acute care. To their consternation, the researchers who conducted the Medicaid spend down studies discovered exactly the opposite of what they set out to prove. Their findings ratified the entitlement paradigm and supported my position.

Medicaid Eligibility for Long-Term Care

So, there is no empirical evidence of widespread catastrophic spend down for long-term care. But if people are ending up on Medicaid who have substantial income and assets, how can that possibly be? Isn't Medicaid a means-tested public assistance program? Medicaid is welfare, isn't it? The answer is "Yes, but."

Let's examine Medicaid eligibility for long-term care. First it's important to understand that to qualify for Medicaid long-term care, people must have a nursing home level of medical need. But, that's not what I want to focus on today. We will examine instead the

financial criteria to qualify for Medicaid. These are two: income eligibility and asset eligibility.

Let's take income eligibility first. The conventional wisdom--what most articles in the media say and what most people are taught by the insurance carriers--is that Medicaid long-term care eligibility requires low income. It's common to read that your income must be "below the poverty level" before you can qualify for Medicaid to fund your long-term care. You'll see statements like that not only in the popular media, but in peer-reviewed journal articles written by "experts" who ought to know better.

The idea that Medicaid nursing home eligibility requires extremely low income is preposterous. No such requirement exists. The rule of thumb is that anywhere in the United States, if your income is below the cost of a nursing home, you're eligible for Medicaid to fund your nursing home care. In 15 states, the so-called "income cap states," you may have to obtain a "Miller income trust," which allows you to divert excess income away from disqualification. But in the other states, the 35 so-called "medically needy states," the rules are even more generous. In addition to deducting the cost of your nursing home care from your income, medically needy states also subtract the coinsurance and deductibles for Medicare, coinsurance and deductibles for a Medicare supplemental insurance policy, and all of the medical expenses seniors have that Medicare doesn't pay for, such as foot care, eye care, dental care, and residual pharmaceutical costs after Medicare part D.

Thus, Medicaid nursing home eligibility does not require low income by any stretch of the imagination. That's not to say that income is not an issue. You do have to have a cash flow problem, that is to say, not enough income to cover all of your medical expenses. But, what does nursing home care cost in your state? Usually, it's $5,000 to $7000 per month. Is that low income? Of course not. But if your income is below that level, you will be eligible to have Medicaid fund your long-term care as long as you're willing to go to a nursing home.

Income eligibility restrictions for the very-limited home and community-based care that Medicaid may pay for under "waivers" is sometimes stricter. This is another reason why Medicaid financing leads to the institutional bias in America's long-term care system.

Income Eligibility for Married Couples

Ever since the Medicare Catastrophic Coverage Act of 1988, married couples have been able to preserve much more income and assets than individual recipients can. Let's digress for a moment to explain this.

Before MCCA '88, Medicaid long-term care financing had a serious problem called "spousal impoverishment." Medicaid then and now requires that people in nursing homes on Medicaid contribute their income toward their cost of care--all but a small "personal needs allowance" of $30-$50 usually. In most cases, the man would be the first to go to a nursing home, and most of the family income would be in his name, especially

in this older generation. Grandpa would go to the nursing home, most of his income would have to be used to offset the cost of his care to Medicaid, and Grandma would be left at home with, back then, only about $350 a month in income. She might be left so short of cash as to be eating cat food.

In 1988, Congress stepped in and resolved this problem by guaranteeing community spouses of institutionalized Medicaid recipients up to $1,500 a month of income and half the couple's joint assets not to exceed $60,000. This "spousal impoverishment" protection was set to increase with inflation each year. As of 2009 and 2010 community spouses are protected up to $2,739 per month in income and $109,560 in assets. Medicaid's spousal impoverishment protections may be below today's middle class income and asset standards, but that's why they're called "spousal impoverishment" protections. The purpose of Medicaid has never been to replace personal savings, investments or insurance for long-term care, nor has it been to protect middle-class inheritances from the risk of parents' needing long-term care.

Medicaid Asset Eligibility

Let's consider asset eligibility for Medicaid long-term care now. Almost everything you read on the subject says that people must spend down for long-term care until they get to the impoverished level of $2,000 in total assets. First of all, that $2,000 level is cash, negotiable securities, or anything that can be easily converted to cash. Is it true that you must spend down your savings *for long-term care* to get to that $2,000 level before you become eligible?

No, no, no. No one cares how you spend the money to get to that level as long as you don't give it away without compensation. All you have to do is obtain fair market value for the assets you spend. Elder law journal articles suggest such things as taking a world cruise or throwing a party of "Ziegfield Follies proportion" to get down to the $2,000 level. So, eat, drink and be merry, for tomorrow your nursing home care will be free, thanks to Medicaid.

In addition to the $2,000 of cash or negotiable securities which you're allowed to keep and receive Medicaid financed nursing home care, you can also retain a home and all contiguous property up to at least half a million dollars in equity. Some states, including California, New York and Idaho, have opted to allow their citizens to retain three quarters of a million dollars in home equity while receiving Medicaid financed nursing home care. People who live in the states that have kept the more responsible $500,000 limit should realize they're paying up to half the cost of Medicaid in states that have decided to be much more generous. That's because federal taxes support 57 percent of the cost of Medicaid on average nationally. What's worse, New York, for example, not only allows people to retain $750,000 in home equity while receiving Medicaid financed nursing home care, the state's Medicaid program also pays for unlimited 24-hour-a-day home care with no transfer of assets restriction. Your tax dollars at work!

Besides the home equity exemption, Medicaid exempts one business including the capital and cash flow of unlimited value. Some years ago in Indiana, the real estate industry and the elderlaw bar got into cahoots. If someone wanted Medicaid to fund nursing home care, but they had $200,000 to $300,000 too much in assets, their real estate agent would buy a rental house for them and their Medicaid planning attorney would write that off as a business for the client while taking a nice big legal fee for himself. A new rental house would not throw off enough income to make the person ineligible for Medicaid. Income, as we explained already, is rarely an obstacle to qualifying for Medicaid nursing home care. A rental house is a business, so it would be exempt. The client gets instantaneous self-impoverishment and eligibility for Medicaid, not only for the nursing home care, but in many cases for ancillary services that Medicaid pays for and Medicare doesn't.

Medicaid exempts one automobile of unlimited value as long as it is used in some way for the benefit of the Medicaid recipient. So take Grandma for a ride in the country once in a while. That counts. And because the automobile is exempt, it obviously does not affect a person's Medicaid eligibility if it's given away. You can have one automobile. So giving it away doesn't affect your eligibility. Thus, you can give away one Mercedes, buy another, give it away and so on until you get down to that $2,000 asset limit. The elderlaw bar calls this the "two Mercedes rule."

[See "LTC Bullet: SSI Expands Medicaid's 'Renoir' and 'Two Mercedes' Loopholes" at http://www.centerltc.com/bullets/archives2005/542.htm.]

Medicaid exempts prepaid funeral plans in unlimited amounts, not only for the Medicaid recipient, but for everyone in the Medicaid recipient's immediate family. In a study I did some years ago in New Jersey, I found a case that sheltered $35,000 in a prepaid funeral plan in order to qualify Grandma for long-term care. So if you ever wanted your very own pyramid, ladies and gentlemen, this is your chance.

Medicaid exempts one term life insurance policy of unlimited value for purposes of determining nursing home eligibility. Now, why would a 90-year-old buy a million dollar term life policy? The premium would be roughly the same as the benefit. Well, the answer is very simple. Instantaneous self-impoverishment. You make $1 million go away, but it is not a transfer of assets for less than fair market value to qualify for Medicaid because you get full value from the life insurance benefit. There is no cash value so it doesn't affect your asset eligibility for Medicaid. When you die, the benefit passes directly to your heirs without going through a probated estate. So you have evaded the Medicaid estate recovery mandate.

[You can find hyperlinks to the federal laws and regulations governing the Medicaid exemptions summarized above in the footnotes of "Aging America's Achilles' Heel: Medicaid Long-Term Care," a monograph I wrote for the Cato Institute, at http://www.cato.org/pubs/pas/pa549.pdf.]

Medicaid Estate Planning

Obviously, the basic eligibility rules for Medicaid financed nursing home care are very generous. What we've covered so far is nothing more than the fundamental rules that anyone who applies for Medicaid will be advised about by the eligibility workers at their local welfare office. Over and above these already extremely generous eligibility rules, however, there are special sophisticated legal techniques available to people with hundreds of thousands of dollars who want to get the government to pay for their long-term care. These sophisticated techniques include special annuities, trusts, life care contracts, reverse half-a-loaf strategies, and many, many others.

We will not take time to delve into these special legal techniques, because they affect only a small percentage of all Medicaid cases. The Government Accountability Office found that only one percent of nursing home cases involve asset transfers to qualify for Medicaid. Asset transfers probably only cost the Medicaid program $1 billion a year, the GAO said. My reaction to this is "Wow! That's terrible." Besides, asset transfers are only a relatively minor one of the hundreds of Medicaid planning techniques in widespread use, so the true total may be much higher. But still, it probably isn't much in the greater scheme of things. After all, people have to have hundreds of thousands of dollars over the basic Medicaid eligibility requirements before it's cost-effective to hire an attorney at $200-$500 billable hours to impoverish themselves. Obviously, not many older people have that kind of money. The travesty is that so many people who do have that kind of money take advantage of Medicaid, which is supposed to be a safety net for the truly poor.

There is a rule of thumb for the cost in attorneys' fees to self-impoverish after the long-term care insurable event has already occurred and become eligible for Medicaid. It costs about the same as one month in a nursing home private pay. OK, so it's cheaper for an older couple to qualify for Medicaid after they need care than the cost of annual premiums for LTC insurance they may never need! No wonder so few people buy LTC insurance.

But, many people ask me: "Why would anyone want to go to one of those awful Medicaid nursing homes?" Even if they're no longer insurable, wouldn't they prefer to spend their own money rather than go to a "welfare home." There is an answer for those questions, and it reveals the tragic irresponsibility of the Medicaid estate planning bar.

Key Money

Medicaid planning attorneys routinely tell their clients, who are usually the adult children or heirs of the impaired elderly and not the vulnerable elderly themselves, that they shouldn't worry about their parents ending up in the notoriously poor-quality Medicaid nursing homes. They tell them something like this:

"Don't worry about the horror stories you've heard about Medicaid nursing homes. We know which are the best homes. We're pillars of the community and highly respected. We'll make sure that your loved ones get into the relatively few nursing homes that don't have very many Medicaid recipients. Because they have mostly high paying private

residents or Medicare patients, their cash flow is much greater than nursing homes that have to depend primarily on Medicaid. Generally, their staff don't even know who's on Medicaid and who is paying privately."

How do we get your Mom or Dad into one of the nice places? Easy. When we get rid of your folks half a million to one million dollars in order to qualify them for Medicaid, we'll hold out $50,000 or $60,000 in 'key money' so they can pay privately for a period of time. Because nursing homes are reimbursed less than the cost of providing the care by Medicaid, they have to do all they can to attract private payers who pay half again as much as Medicaid. If you're a private payer, the best nursing homes roll out the red carpet to attract you. Once you're in, however, they can't kick you out just because your source of payment changes. State and federal law prohibits them from doing so. So your Mom or Dad gets into the nicest nursing home; they pay privately for a few months or a year; and then, we flip a switch and convert them to Medicaid.

The use of "key money" allows affluent people to transfer the financial liability for long-term care to the taxpayers and to the nursing home owner who then gets less than the cost of providing the care. But the biggest victims of this legal scam are the poor who have to depend on Medicaid for their care. They don't have key money to buy their way into the nice places. The tragic inequity in the system is that the nicest beds in the best nursing homes become occupied by people who would have, could have, and should have either paid their own way or planned responsibly to save, invest or insure for long-term care.

Because of "key money" abuse, the poor end up in 100 percent Medicaid nursing homes. These are the kinds of places that *20/20* goes into with their mini-cameras to show people lying in their own waste with bedsores down to the bone. I don't like to bring the program down to this level, but it's important that you understand just how tragically critical all of this information is. The next time you hear Medicaid planning attorneys justifying what they do as no different than tax planning, think about the effect that affluent people taking the best beds in the nicest nursing homes has on the ability of poor people to get access to decent care.

Who Pays for Long-Term Care?

The third form of evidence for the entitlement paradigm and against the welfare paradigm that I'll share is to explain how most expensive long-term care in our country is funded without requiring the use of anyone's personal assets.

For details and hard numbers, please refer to "LTC Bullet: So What if the Government Pays for Most Long-Term Care" at http://www.centerltc.com/bullets/latest/855.htm. Every year when the Centers for Medicare and Medicaid Services make available the latest expenditure data for nursing home and home care, I publish a "LTC Bullet" titled "So What if the Government Pays for Most Long-Term Care?" Check out the LTC Bullets archives at www.centerltc.com each year in January to find that publication for any year of interest.

We only have time in today's program to hit some of the key points. Bottom line, we can account for 85 percent to 90 percent of the entire cost of nursing home care and home health care in the United States without touching a penny of anyone's assets.

For example, eight of every nine dollars spent for home care in the United States comes either directly from Medicaid, Medicare or private insurance or from the spend-through of Social Security income by people already on Medicaid. Only one dollar out of nine remains that could possibly come from out-of-pocket expenditures, and some of that remainder is actually income other than Social Security. Most people spend their income for long-term care first before they tap into their assets.

I'll go into a little more detail on nursing home care. New numbers on both nursing home care and home care came out of CMS in January 2010. We updated these numbers in a new "LTC Bullet: Who Cares if the Government Pays for Most Long-Term Care."

Approximately 41 percent of the entire cost of nursing home care nationally comes from Medicaid. One's initial reaction to that figure may be to think the remainder must be coming out of people's savings to fund their long-term care. Not so. Another 19 percent comes from Medicare. Out-of-pocket expenditures are reported by CMS to be 27 percent.

But these numbers are extremely misleading. For example, look at the 27 percent that CMS reports as out-of-pocket expenditures. First of all, that 27 percent figure itself is roughly half what it used to be 35 years ago (52 percent). Furthermore, half of the current 27 percent, or 13.5 percent of the entire cost of nursing home care nationally, is nothing more than the spend-through of Social Security income by people who are already on Medicaid!

What's more, the seven percent that CMS calls "Private Health Insurance" is really a made-up figure. Most people see that number and assume it stands for private long-term care insurance. It doesn't. CMS derives it by starting with the total spent for nursing home care annually, subtracting all the sources of funds they're aware of, and calling whatever remains "private health insurance." Some of it may be LTCI, but it also includes health insurance, major medical and Medi-Gap payments. Besides, it's a specious number in the first place.

The 60 percent of nursing home costs that come directly from Medicaid or Medicare have to be added to the 13.5 percent of out-of-pocket costs that are really Social Security income spend-through. Already we've accounted for almost three-fourths of the entire cost of nursing home care nationally without touching any assets. Something more comes from private health insurance. Other forms of income besides Social Security are most likely spent for nursing home care before assets. The result is that it's very easy to get to 85 percent to 90 percent of the entire cost of nursing home care nationally without touching anyone's assets.

This is an extremely important observation. It is easy to understand how Medicaid crowds out so much of the market for long-term care insurance when you realize that most assets are not at risk to fund long-term care and that long-term care insurance is usually marketed as asset protection.

Another LTC Tour Anecdote

When the Silver Bullet of LTC and I were in the Midwest, we made a stop at the University of Illinois in Urbana-Champaign. I wanted to speak there with the University's Karnes Professor of Finance, Dr. Jeffrey Brown. Jeff Brown and his colleague Amy Finkelstein, currently at MIT, conducted some amazing research on Medicaid and long-term care insurance. They concluded that Medicaid crowds out two-thirds to 90 percent of the entire potential market for private long-term care insurance. Don't take my word for it. Search for their names on the National Bureau of Economic Research's website at www.nber.org. You'll find several of their articles including the one that makes that amazing claim.

As incredible as it seems to most people, their conclusion was no surprise to me. For reasons explained already in this program, it's obvious Medicaid interferes with the marketability of private LTC insurance. What confused me in reading Brown and Finkelstein, however, was their explanation of the crowd-out phenomenon. It didn't convince me. I wanted to explain to them what I've already told you today about how easy it is for people with substantial income and assets to qualify for Medicaid nursing home benefits. That's why I stopped in for a visit with Dr. Brown. It was a very rewarding hour. He invited me to participate in their future research on this topic. For now, however, just put that startling fact--that Medicaid crowds out two-thirds to 90 percent of the market for LTCi--in the back of your mind. We'll refer to it several times in what follows.

Summary

So far in this program, we looked at the big picture of long-term care by examining the elephant, the blind men, and long-term care. We showed how the various stakeholders in long-term care try to make the status quo work for themselves. They focus mostly on getting more money out of the government and concentrate too little on encouraging personal responsibility and private financing.

We then turned to the history of long-term care financing and discovered that our main problem, the main cause of the current welfare-financed, nursing home-based long-term care system, is that the government stepped in and distorted the market for long-term care in 1965. By making nursing home care free or radically subsidized, government intervention had the effect of crowding out private markets for home and community-based services or long-term care insurance.

Next, we examined the welfare paradigm of long-term care, which is the most common explanation of the long-term care issue, and found it to be wanting. So we considered the

entitlement paradigm, a radically different and counterintuitive explanation, but we found it to explain consumer behavior with regard to long-term care much better than the welfare paradigm.

Finally, we examined the evidence in favor of the entitlement paradigm and we found that the entitlement paradigm not only explains the marketplace of long-term care better than the welfare paradigm does, but it comports more closely with the facts about long-term care spending.

What's Going to Happen Next?

So, what's going to happen next? Can Medicaid go on as the primary funder of long-term care in the United States? If not, what will replace it? And what will the consequences be for long-term care providers, insurers, caregivers and care recipients? Let's examine these questions.

Anyone who reads the newspaper or watches the news on television today knows that Medicaid is in a world of hurt financially. The economy is in a down draft and state Governors are having trouble making ends meet in their budgets. We get news almost every day about states cutting back on their Medicaid budgets. It's looking more and more like Medicaid cannot go on paying for the vast majority of all nursing home care, much less a good portion of home and community-based care through various "waiver" programs. So, point one, Medicaid is already in trouble.

But there are two other federal programs that prop up Medicaid's ability to fund long-term care, and hence Medicaid's ability to crowd out the market for private financing alternatives like reverse mortgages and long-term care insurance. These two programs are Social Security and Medicare.

Now when I tell experts in long-term care financing that Social Security and Medicare are critical props under Medicaid's ability to fund long-term care, they tend to look at me like I'm crazy. Everyone knows Social Security doesn't pay for long-term care. Anybody familiar with LTC financing knows Medicare doesn't pay for long-term care. Sure, Medicare pays for some nursing home care, but only short-term rehabilitative services, under very limited circumstances; 20 days full pay; another 80 days with a big deductible. Obviously, neither Social Security nor Medicare pays for long-term care. So how can I say that Social Security and Medicare are critical to Medicaid's ability to fund long-term care and hence Medicaid's ability to crowd out most of the market for private financing alternatives?

How Social Security Props Up Medicaid LTC

As we've explained already, when you're in a nursing home on Medicaid, you have to contribute nearly all of your income toward your cost of care. Where does a lot of the income of elderly people, especially those who are in nursing homes on Medicaid, come from? Right, from Social Security. In fact, as we explained earlier, 13.5 percent of the

entire cost of nursing home care nationally, is nothing more than the spend through of Social Security income by people already on Medicaid.

Now, what do we know about Social Security's financial stability? Will it go on paying for such a big portion of long-term care? Most of you receive a notice from the Social Security Administration each year, right? It tells you how much Social Security will pay if you work until age 62, 66, or 70 before claiming benefits. Have you ever looked at the fine print on that notice? If you haven't, I recommend that you do. It says that, unless by some miracle Social Security is able to climb out of the fiscal hole that it's in, the program will only pay you 76 percent of what they're telling you now to expect. [http://www.ssa.gov/mystatement/sample1.htm] Social Security has a $17.5 trillion infinite-horizon unfunded liability. [http://www.concordcoalition.org/files/uploaded-pdfs/FF_Newsletter_V-3_09-1206_1.pdf] It will be a huge challenge for the United States government to find a way to fill that financial hole. If it doesn't, at some point, everyone on Social Security will take a 24 percent cut.

If you're a senior in the community depending on Social Security for your retirement income, a cut of that size hurts severely. But if you're in a nursing home on Medicaid, you don't care. Well, you're probably cognitively impaired, so you don't know. But if you did know, you wouldn't care because you have to contribute all but a pittance of your income toward your cost of care anyway. So it's Medicaid that will take the hit.

Medicaid will be devastated by the cost of losing that much Social Security spend-through income. Medicaid already reimburses nursing homes less than the cost of providing the care on average, so they can't take a cut of that size out of the already impecunious reimbursement rates for long-term care providers. When the Social Security cut-back happens, it will be a disaster to Medicaid LTC AND devastating to Medicaid's ability to crowd out the market for private financing alternatives.

How Medicare Props Up Medicaid LTC

How does Medicare prop up Medicaid's long-term care funding? Medicare pays only 19 percent of nursing home costs annually. That's much less than what Medicaid pays. But here's the difference: Medicare pays very generously for the relatively small proportion of nursing home revenue that it supplies. Nursing homes actually make a ten percent to 15 percent profit on the services they provide that are paid for by Medicare.

Unfortunately, Medicare has an $89.2 trillion infinite-horizon unfunded liability. Medicare's financial hole is so huge it dwarfs the problem with Social Security. Now, here's the problem. There is an agency of government called MedPAC, the Medicare Payment Advisory Commission. Every year MedPAC proposes to Congress that they should stop paying skilled nursing facilities so much money under Medicare. They say: "Those people are making a killing on Medicare. It's unconscionable." That's MedPAC's attitude.

The nursing home industry responds saying: "Okay, we are making a profit on Medicare residents, but the problem is we're losing our shirts on Medicaid, which pays for most of the nursing home care in this country. We have to have the extra reimbursement from Medicare to survive providing custodial long-term care to most Americans under the Medicaid program."

MedPAC responds: "Hey, not our problem, our portfolio is Medicare and Medicare only. Go talk to those people who fund Medicaid and get them to pay you more adequately."

But, who pays for Medicaid? Right, the state and federal governments and they're completely broke. Remember the Elephant, the Blind Men and Long-Term Care? State and federal governments are bankrupt. They just haven't done the numbers honestly yet.

MedPAC and the Bush Administration tried hard to cut Medicare reimbursements to nursing homes last year. The nursing home industry barely dodged that bullet in 2008 when the economy was good. There is no way they'll avoid the hit in 2010 with the economy in a tailspin, welfare rolls up, and tax receipts down.

MedPAC, Congress and state governments have Medicare and Medicaid financing of long-term care in their sights. Medicare cannot go on supporting Medicaid's ability to fund most long-term care and hence Medicaid's ability to crowd out private financing alternatives will be radically diminished . . . and soon!

Who is David Walker and Why Does it Matter?

David Walker used to be the Comptroller General of the United States, the person in charge of the Government Accountability Office or GAO. Walker is an expert on Social Security and Medicare. He became extremely concerned about those two programs' unfunded liabilities. Several years ago, as Comptroller General, he started what he calls the "Fiscal Wake-Up Tour." He gave speeches to anyone who would listen about the dismal financial outlook for America's social insurance programs.

Actually, Walker's Wake-Up Tour was part of the inspiration for our National Long-Term Care Consciousness Tour, which is a little narrower in scope, but has the same objective.

Walker found that he could not be as effective as he needed to be to solve the problem as long as he worked for the federal government and was answerable to Congress. So he quit. I did the same thing and for the same reason in 1989. I left government so I could take the muzzle off and tell it like it is to the media and all interested parties. Likewise, Walker walked away from a secure 15-year appointment because he knew he couldn't get the job done on the inside.

David Walker's message is excellent on Social Security and Medicare. He knows very little about Medicaid and long-term care, however, and what he thinks he knows is often wrong. The Heritage Foundation wants to get me an audience with Walker to explain the

Medicaid and long-term care side of the problem and the connection with his number-one interests--Social Security and Medicare.

But, here's what Walker is telling audiences all across the country about Social Security and Medicare. In order to make ends meet in those two programs alone, not counting Medicaid and long-term care, we would have to either double the payroll taxes or reduce the benefits by half.

Do any of you think that's going to happen? Can you imagine a politician going to a potential constituent and saying: "Mrs. Jones, I want your vote. My platform is to double your taxes and reduce your benefits by half?" How long do you think such a person would remain a politician? Certainly not past the next election.

Well, if the government is not going to double your taxes or reduce your benefits by half, but they have to do something to get out from under the $107 trillion unfunded liability of Social Security and Medicare, what you think they will do?

The Welfarization of Medicaid, Medicare and Social Security

I believe their strategy will be gradually to pull back the social safety net that has been available in the United States ever since 1935. That safety net, starting with the implementation of Social Security, provided not only for the poor, but for the middle class and affluent as well. Medicaid and Medicare were added in 1965 and they too supported all economic levels of society in one way or another. What I think will happen next is that government will slowly, but irreversibly, means test the traditional social safety net programs. Not only Medicaid, but Social Security and Medicare as well. They're going to welfarize the traditional social insurance programs.

And it has already begun . . .

Take Medicaid for example. You probably thought, because it was a welfare program, Medicaid forced people into impoverishment before they could take advantage of it. That was before you heard me talk. Now you know that Medicaid, at least for long-term care financing, has always been a *de facto* entitlement. But Medicaid cannot continue as such.

We traced the history earlier of how the federal and state governments have attempted to get hemorrhaging Medicaid eligibility under control. We discussed the expansion of transfer of assets restrictions, Medicaid estate recoveries, loophole closings, and so on. That process will continue; it will speed up; and it will become much stricter and more aggressively enforced. Medicaid will not go on much longer sheltering up to three quarters of a million dollars in home equity while acting as free inheritance insurance for the baby boom generation against the risk their parents will need long-term care. Our best hope now is that if we act soon we may be able to preserve a decent Medicaid LTC safety net for the truly destitute. But even that modest goal is doubtful now. The poor will be hurt most by Medicaid's collapse.

But what about the traditional social insurance programs, Social Security and Medicare? These programs were always considered to have much greater dignity than welfare. They had no stigma attached. You paid your "premiums," *i.e.* payroll taxes, and you were "entitled" to your "benefits." It didn't matter if you were Bill Gates or Warren Buffett. But that can't continue and isn't continuing. Social Security and Medicare are gradually becoming means tested. They're being converted from social insurance programs into welfare programs.

Welfarizing Social Security

Take Social Security, for example. If you decide to take Social Security benefits at age 62, but you want to continue working, after a very low threshold of $14,160 in annual income, Social Security begins to take away one dollar of your benefit for every two dollars of your earned income. [http://www.ssa.gov/pubs/10003.html] That's a way to place a means test, an income test on your access to the Social Security benefit. It is precisely the opposite incentive that we should have in public policy. We need as many older people continuing to work and pay into Social Security as we can possibly encourage to do so. And yet public policy creates this incentive in precisely the opposite direction.

You have to pay federal income taxes on Social Security as an individual if your total income exceeds $25,000. Couples with income over $32,000 have to pay.

[Source: http://ssa-custhelp.ssa.gov/cgi-bin/ssa.cfg/php/enduser/std_adp.php?p_faqid=493]

President-elect Obama has proposed re-starting the Social Security payroll tax at an annual income of $250,000. Currently, you only pay Social Security taxes on the first $106,800 of income. In 2011, that amount goes to ???. For incomes above that level no one pays any Social Security payroll tax now.

So what would it mean to require people to pay Social Security tax on income over $250,000? Well, who makes over a quarter million dollars a year? Small business owners mostly. They tend to reinvest a good portion of their income into their businesses, thus creating 70 percent of all jobs in the United States. Add an extra 6.2 percent payroll tax on their own income and another 6.2 percent for their employees, and small business owners will be much less likely to expand their businesses and hire more people. Adding such a punishing tax could easily REDUCE the total revenue to Social Security.

An Apolitical Point

Now, I don't like to focus on people's politics. I don't care whether you're a Democrat or a Republican, a liberal or a fiscal conservative. Fiscal conservatives tend to think we should steward our scarce public resources very carefully, so they're an easy sell. But sometimes Democrats and liberals are less quick to see the benefits of what I'm saying.

They like to help people, especially the poor, but also middle-class people. The way I explain the issue to fiscal liberals and Democrats, therefore, is like this: "Why in the world would you want to use your scarce public welfare resources to indemnify affluent heirs of well-to-do seniors? They're probably all a bunch of Republicans, anyway."

Welfarizing Medicare

What about Medicare? Has it been welfarized yet? Are there any means tests that have been put in the way of accessing Medicare benefits?

Indeed there have. In 2007, for the very first time, the Part B premium increases with a beneficiary's income level. And it increases radically at higher income levels. Also, the premium for Part D, the new pharmaceutical program that increased Medicare's unfunded liability by $11 trillion, is also tied to income.

The higher your income, the higher your "premiums" for these formerly social-insurance, but increasingly welfare programs.

The Bottom Line

No matter how you look at it, individuals and families will be much more personally responsible in the future: not only for their long-term care security, but I believe also for their retirement income and even for their acute health care security. This will become, and is already becoming, obvious as the pressures mount on Medicaid, Medicare and Social Security with the aging of the baby boom generation.

Historically, we had a very large baby boom generation paying into the social insurance programs to support a relatively small World War II generation. That's all about to change. A much larger generation drawing resources out of these programs will depend on support from a much smaller generation. Gen X or Gen Y, whatever you want to call them. Within a very short number of years, it will take two workers to support each aging baby boomer. So, the demographic and financial numbers just don't add up. There's no way each working couple can carry one of us aging boomers on their backs and still live a good life, raise and support children, and continue to finance all the other things the government needs to do.

So, in closing, here's my message to you. First, take responsibility for yourself and for your own families. Make sure you are prepared. Second, warn everyone who's life you touch about what's coming and encourage them to take personal responsibility. Third, realize that this is not only a personal responsibility, but almost a civic duty.

There's an old saying: "The best way to help the poor is not to become one of them."

And yet that is exactly the perverse incentive built into current public policy, which says: "Don't worry about long-term care; wait and see if you ever need it; and if you do, simply

impoverish yourself artificially, give your kids an early inheritance, and take advantage of the public welfare program to fund your long-term care."

The late economist Herbert Stein used to like to say that trends which can't continue, won't. The trend toward more government dependency and less personal responsibility for long-term care is clearly one the can't, and therefore, won't continue.

You owe it to yourselves and to your families, to your prospects and to your clients, to tell them the truth, the whole truth about what's likely to happen next. But that can be a ticklish problem. You don't want to use scare tactics and much of what I presented in this class is very scary.

Hopefully your conscience will suffice to ensure that you don't overdo this information. Nevertheless, you should also always assume that the insurance commission has a little eye in the sky watching everything you do. But that's why I publish a daily newsletter, "LTC E-Alerts or "LTC Bullet's." The purpose of those publications is to provide you with reliable third-party sources that can say what needs to be said without your having to say it so directly yourself. I draw on all kinds of sources, including the Government Accountability Office, the Congressional Budget Office, think tanks like the Urban Institute, Brookings, and Cato, peer-reviewed journal articles, and so on.

Send your e-mail address, phone number, and other contact information to info@centerLTC.com and we'll be happy to add you to the mailing list for these publications for a month, free of charge. If after that you find value in our publications and from the back end of our website, "The Zone," then join the Center and become part of the solution.

Finally, one last point, especially for financial advisors who don't currently market LTC insurance or reverse mortgages. You don't have to sell these products, but you do have a moral and fiduciary responsibility to your prospects and clients to get them protected against the risk and cost of long-term care.

So, if you're going to stick to your knitting and leave long-term care alone, then get your clients protected for LTC by forming a professional relationship with LTC specialists you trust. Trade referrals or split commissions. Do whatever you have to do to make if work professionally for you and the LTC specialists.

That's how to make it a Win/Win/Win for your clients, for you, and for the AMGs struggling to sell long-term care insurance.

Thank you for your attention.