THE BRAVE NEW WORLD OF LONG-TERM CARE†

STEPHEN A. MOSES

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

My background includes eighteen years as a career U.S. government employee and a decade working with Medicaid and long-term care issues for the Health Care Financing Administration (HCFA) and the Department of Health and Human Services (DHHS) Office of Inspector General. I am currently president of the Center for Long-Term Care Reform, a private think tank and public policy advocacy organization dedicated to ensuring quality long-term care for all Americans.

I chose "The Brave New World of Long-Term Care" as my topic today, but let me start by describing the "Pusillanimous Old World of Long-Term Care," that is, the status quo. America has a welfare-financed, institution-based long-term care system, in the wealthiest country in the world, but no one wants to go to a nursing home. Long-term care in the United States is characterized by access and quality problems,[1] dismally low reimbursement levels,[2] discrimination against public benefits recipients,[3] institutional bias,[4] loss of independence, welfare stigma,[5] and imminent

† On November 9, 2005, the *Notre Dame Journal of Law, Ethics & Public Policy* hosted a symposium entitled "Long-Term Care for America's Elderly: Who is Responsible, and How Will it Be Achieved?". Stephen Moses was the fourth speaker at the Symposium. His remarks have been revised for publication.

1. *See* GEN. ACCOUNTING OFFICE, NURSING HOME QUALITY: PREVALENCE OF SERIOUS PROBLEMS, WHILE DECLINING, REINFORCES IMPORTANCE OF ENHANCED OVERSIGHT (2003), *available at* http://www.gao.gov/new.items/d03561.pdf.

2. For a more complete discussion of the effects of reimbursement levels on quality of care, see COMM. ON IMPROVING QUALITY IN LONG-TERM CARE, INST. MEDICINE, IMPROVING THE QUALITY OF LONG-TERM CARE 235–47 (Gooloo S. Wunderlich & Peter O. Kohler eds., 2001).

3. *See* Stephen A. Moses, *Aging America's Achilles' Heel: Medicaid Long-Term Care, in* POLICY ANALYSIS NO. 549 (The Cato Institute, POLICY ANALYSIS NO. 549, 2005), *available at* http://www.cato.org/pubs/pas/pa549.pdf.

4. *See* ENID KASSNER, AARP, & LEE SHIREY, NAT'L ACAD. ON AN AGING SOC'Y, MEDICAID FINANCIAL ELIGIBILITY FOR OLDER PEOPLE: STATE VARIATIONS IN ACCESS TO HOME AND COMMUNITY-BASED WAIVER AND NURSING HOME SERVICES 12 (2000), *available at* http://assets.aarp.org/rgcenter/health/2000_06_medicaid.pdf.

insolvency.[6] Most Americans do not worry about long-term care until they need it. Consequently, few save, invest, or insure for the risk of needing long-term care, and they usually end up on public assistance.[7]

How in the world did we get into this mess? The U.S. Government started paying for nursing home care, in 1965, through Medicaid[8] and Medicare.[9] Its good intentions had unanticipated and extremely unfortunate consequences. Because nursing home care was free, institutionalization predominated, and home and community-based care languished for decades.[10] Since the government paid for nursing home care, no one bought private insurance to cover such long-term care.[11] Costs, of course, exploded, as they always do when a benefit is free to consumers.[12]

5. *See* Janice Cooper Pasaba & Alison Barnes, *Public-Private Partnerships and Long-Term Care: Time for a Re-Examination?*, 26 STETSON L. REV. 529, 555, n.150 (1996) (discussing welfare stigma as a possible motivation for buying long-term care insurance).

6. *But see* Moses, *supra* note 3, at 2–7 (detailing ways in which elderly people may shift their assets in order to avoid "spend-down" and still qualify for Medicare and Medicaid).

7. Out-of-pocket costs were estimated to make up only 33% of total long-term care for the elderly spending in 2004, and private long-term care insurance was estimated to cover 4% of such total costs. In contrast, Medicare and Medicaid were estimated to cover a combined 60% of total long-term care costs. CONG. BUDGET OFFICE, U.S. CONG., FINANCING LONG-TERM CARE FOR THE ELDERLY 3 Fig.1-1 (2004), *available at* http://www.cbo.gov/ftpdocs/54xx/doc5400/04-26-LongTermCare.pdf.

8. *See* Social Security Act, 42 U.S.C. § 1396 (2000). For a detailed explanation of Medicaid—a topic too complicated for the purposes of this speech—see Moses, *supra* note 3, and www.centerltc.com.

9. *See* Social Security Act, 42 U.S.C. § 1395 (2000).

10. In 2005, there were 1.46 million people living in nursing facilities. ARI HOUSER, WENDY FOX-GRAGE & MARY JO GIBSON, AARP PUB. POLICY INST., ACROSS THE STATES: PROFILES OF LONG-TERM CARE AND INDEPENDENT LIVING 10 (2006), *available at* http://assets.aarp.org/rgcenter/health/d18763_2006_ats.pdf.

11. In 2001, less than 10% of seniors had purchased long-term care insurance. GEN. ACCOUNTING OFFICE, LONG-TERM CARE: BABY BOOM GENERATION INCREASES CHALLENGE OF FINANCING NEEDED SERVICES 11 (2001) (statement of William J. Scanlon before the U.S. Senate Committee on Finance), *available at* http://www.gao.gov/new.items/d01563t.pdf.

12. *See* HOUSER ET AL., *supra* note 10, at 10 ("Medicaid spent $94.5 billion on long-term care services in 2005, which means that roughly one-third (31%) of total Medicaid expenditures of $300 billion went toward long-term care."). In addition, Medicaid is the largest item in state budgets. *See* NAT'L ASS'N OF STATE BUDGET OFFICERS, 2003 STATE EXPENDITURE REPORT 8 Tbl., 3 (2003), *available at* http://www.nasbo.org/Publications/PDFs/2003ExpendReport.pdf.

To control costs, Medicaid tried to contain expenses by paying too little for this long-term care, thus causing access and quality problems.[13] When that did not control costs, the government tried to restrict access to Medicaid by making eligibility harder to achieve, requiring recovery from recipients' estates, and criminalizing the transferring of assets in order to qualify or penalizing financial advisors who, for a fee, rendered the advice to make such asset-transfers.[14]

Those measures failed because Medicaid eligibility rules are generous to begin with and so elastic that they are easily stretched to cover even affluent people. How can that be—when Medicaid long-term care eligibility requires being impoverished? Simple—it doesn't: There is no limit on how much income people can have, as long as their medical expenses, including private nursing home care, are high enough.[15] There is no limit on assets, either, as long as they are held in exempt form, such as a home,[16] business,[17] automobile,[18] prepaid burial expenses,[19]

13. *See* Moses, *supra* note 3, at 8 (quoting sources to illustrate Medicaid's "dismal reputation for problems of access, quality, reimbursement, discrimination, and institutional bias").

14. *See* 42 U.S.C. §§ 1320a-7b(a) (2006) (criminalizing the act of advising persons to make false statements or representations related to federal health care programs when a fee is charged for such advice); *see also* 42 U.S.C. § 1396p(b)(4) (2007) (defining "estate" in the context of mandatory recovery to the state of any medical assistance paid on behalf of an individual under a state plan).

15. There is no set limit on how much income you can have and still qualify as long as your private medical expenses are high enough or, if you live in an "income cap" state, you have a Miller income diversion trust. All anyone needs to qualify for Medicaid is a cash-flow problem—that is, too little income after all medical expenses are deducted. *See* Moses, *supra* note 3, at 3 (explaining that a Miller income trust enables an individual, with income surpassing a specified limit, to qualify for Medicaid, benefit from Medicaid's low reimbursement rates, and take advantage of additional medical services).

16. *See* U.S. Soc. Sec. Admin., Program Operations Manual System: SI 01130.100 The Home, https://s044a90.ssa.gov/apps10/poms.nsf/lnx/0501130100 (last visited Apr. 18, 2007) (stating "[a]n individual's home, regardless of value, is an excluded resource").

17. *See* U.S. Soc. Sec. Admin., Program Operations Manual System: SI 01130.501 Essential Property Excluded Regardless of Value or Rate of Return, https://s044a90.ssa.gov/apps10/poms.nsf/lnx/0501130501 (last visited Apr. 18, 2007) (stating "[p]roperty essential to self-support used in a trade or business is excluded from resources regardless of value or rate of return . . .").

18. *See* U.S. Soc. Sec. Admin., Program Operations Manual System: SI 01130.200 Automobiles and Other Vehicles Used For Transportation, https://s044a90.ssa.gov/apps10/poms.nsf/lnx/0501130200 (last visited Apr. 18, 2007) (stating "[o]ne automobile per household is excluded regardless of the value if it is used for transportation of the eligible individual/couple or a member of the eligible individual's/couple's household).

term life insurance,[20] home furnishings and other personal belongings, etc.[21] The bottom line is that most elderly people who have the need for a nursing home level of care qualify for Medicaid. Lawyers and other advisors who specialize in artificially "impoverishing people" can easily qualify people far above the already generous levels.[22]

After over forty years of publicly financed long-term care, consumers are anesthetized to the high risk and catastrophic costs of such care because the government pays for the vast majority of all long-term care in the United States.[23] Amy Finkelstein and Jeffrey Brown have confirmed this fact in two papers: They found that two-thirds to ninety percent of the potential market for private long-term care insurance has been crowded out by Medicaid.[24] The key point is that Medicaid and Medicare took on too much of the burden of long-term care financing and distorted the market, impeding the development of home-based and community-based care infrastructures and discouraging private insurance to pay for it. Both programs are now spiraling toward financial collapse.[25]

19. *See* U.S. Soc. Sec. Admin., Program Operations Manual System: SI 01130.400 Burial Spaces, https://s044a90.ssa.gov/apps10/poms.nsf/lnx/0501130400 (last visited Apr. 18, 2007) ("A burial space or agreement which represents the purchase of a burial space held for the burial of the individual, his or her spouse, or any other member of his or her immediate family is an excluded resource, regardless of value.").

20. *See* U.S. Soc. Sec. Admin., Program Operations Manual System: SI 01130.300 Life Insurance, https://s044a90.ssa.gov/apps10/poms.nsf/lnx/0501130300 (last visited Apr. 18, 2007).

21. *See* U.S. Soc. Sec. Admin., Program Operations Manual System: SI 01130.430 Household Goods, Personal Effects, and Other Personal Property, https://s044a90.ssa.gov/apps10/poms.nsf/lnx/0501130430 (last visited Apr. 18, 2007) (excluding household goods and personal effects as resources when deciding whether a person is eligible to receive Supplemental Security Income benefits).

22. *See* Moses, *supra* note 3, at 3–6 (providing examples of common strategies used to manipulate assets in order to qualify for Medicaid and citing sources explaining those methods).

23. *Id.* at 7 ("The fundamental problem with [long-term care] financing is that government pays for so much of it that the public has been anesthetized to the risk and expense of high-cost extended care.").

24. *See* Jeffrey R. Brown, Norma B. Coe & Amy Finkelstein, Medicaid Crowd-Out of Private Long-Term Insurance Demand: Evidence from the Health and Retirement Survey (2007), http://www.aeaweb.org/annual_mtg_papers/2007/0107_1300_0701.pdf. This report is among those for the 2007 American Economic Association Annual Meeting.

25. Moses, *supra* note 3, at 1 (stating that "[s]eventy-seven million aging baby boomers will sink America's retirement security system" if action is not taken soon, that "Medicare is [a great] problem, with $60 trillion in unac-

The good news is that if we stop doing what we have always done, we will get a different result. After all, isn't that the very definition of "sanity"? If the current problems of long-term care have been caused by excessive dependency on public financing, the solution is clear: Target Medicaid to the truly needy, and others will plan early to save, invest, or insure for long-term care.[26]

That is finally starting to happen. The Deficit Reduction Act (DRA) of 2005[27] took several baby steps in that direction. Before the DRA, anyone could shelter unlimited assets in a home and contiguous property.[28] Now, there is a cap on home equity of $500,000 (or $750,000 at a state's discretion).[29] With the average home equity in America only $86,000,[30] that's only a start. But keep in mind, Britain, with its socialized health care system, only allows people $36,000 of home equity while receiving publicly financed long-term care.[31]

The DRA also extended the look-back period, for asset transfers done to qualify for Medicaid, to five years.[32] This is also just a start, as the average period of time from the onset of Alzheimer's Disease to death is eight years,[33] and Medicaid planners are already urging people to begin much earlier to plan for public welfare.[34] In Germany, another European socialized system, the look-back period for asset transfers is ten years, that is, double ours.[35] Ironically, America's long-term care system is far

counted-for obligations, and that Medicaid is a welfare program that "bears scrutiny but receives much less attention").

26. Moses, *supra* note 3, at 14 (See the conclusion for a more detailed explanation of this statement.).

27. Deficit Reduction Act of 2005, Pub. L. No. 109-171, 120 Stat. 4 (This Act is codified in scattered sections of 42 U.S.C. and 20 U.S.C.).

28. *See supra* note 22.

29. *See* 42 U.S.C. § 1396p (2000).

30. NAT'L INST. ON AGING, U.S. DEP'T. HEALTH AND HUMAN SERVS., & U.S. CENSUS BUREAU, U.S. DEP'T. COMMERCE, 65+ IN THE UNITED STATES (2005), http://www.census.gov/prod/2006pubs/p23-209.pdf.

31. See Stephen A. Moses, President, Center for Long-Term Care Reform, Testimony Presented to the Small Business Roundtable on The Future of Long-Term Care and Medicaid (July 10, 2006) (transcript available at http://www.centerltc.com/speakers/testimony071006.htm).

32. *See* Deficit Reduction Act of 2005, tit. 6, ch. 2, subch. A, § 6011, 120 Stat. 4 (2006) (lengthening look-back period and changing the beginning date for period of ineligibility).

33. *See* B.C. Jost, et al., *The Natural History of Alzheimer's Disease: A Brain Bank Study*, 43 J. AM. GERIATRICS SOC'Y 1248 (1995) (The total disease duration for this typical Alzheimer's patient is just over 101 months, or approximately 8.5 years.).

34. *See, e.g.*, Moses, *supra* note 31.

35. *See id.*

more generously available than are some of the ostensibly socialized systems in Europe.

The DRA is further effective by changing the penalty period regarding asset transfers done to qualify for Medicaid in order to eliminate the half-a-loaf strategy, which was the single most common technique used to impoverish people artificially for Medicaid.[36] Critics have claimed that imposing the asset transfer penalty later than before will deny care to people actually in need of care, but that won't happen.[37] Why? Because we have eliminated the main reason to transfer assets in the first place. However, even if someone, in need of care but penniless and ineligible for Medicaid, does accidentally end up penalized for transferring assets, the DRA strengthened the provisions for undue hardship waivers in order to protect such people.[38]

The DRA also blocked several other abuses previously used to divert people, who should have paid their own way for long-term care, to Medicaid. There are more restrictions on the use of annuities to convert countable, disqualifying assets into non-disqualifying income.[39] The "income first" rule has replaced the "asset first" option, thus preventing huge extra asset exemptions for community spouses.[40] I have described these and other provisions of the Deficit Reduction Act that bear on Medicaid eligibility in testimony before Congress.[41]

Finally, the DRA did two other critical things related to long-term care. Long-term care partnerships may now be expanded to all states.[42] That's nice but not decisive. The partnerships allow people who buy long-term care insurance to exempt extra assets from Medicaid spend-down.[43] So, if there is no real spend-down requirement as in the past, the partnerships have, and

36. *See* Deficit Reduction Act of 2005, Title VI, ch. 2, subch. A, § 6011(b), 120 Stat. 4 (2006) (changing the dates of the penalty periods regarding asset transfer rules).

37. *See generally* Amy Fagan, *AARP Ads Fight Medicaid Changes*, THE WASHINGTON TIMES, Dec. 5, 2005, *available at* http://www.washingtontimes.com/national/20051204-113549-6448r.htm.

38. *See* Deficit Reduction Act of 2005, Title VI, ch. 2, subch. A, § 6011(d)–(e), 120 Stat. 4 (2006) (discussing the availability of hardship waivers).

39. *See* Deficit Reduction Act of 2005, Title VI, ch. 2, subch. A, §§. 6012–6014 (2006).

40. *Id.*

41. *See* Moses, *supra* note 31.

42. *See* Deficit Reduction Act of 2005, Title VI, ch. 2, subch. B, § 6021 (discussing state long-term care partnership programs).

43. *Id.*

indeed they have had in the four states that have tried them already, little effect.[44]

The last key thing the DRA did was to unleash Medicaid to pay for more home and community-based services ("HCBS") instead of nursing home care.[45] States will no longer have to obtain waivers to cover HCBS; they can do so under their regular Medicaid state plans.[46] This is a double-edged sword, however, unless states also control the hemorrhage in Medicaid eligibility. HCBS and assisted living are popular services that everyone wants. When private long-term care insurance started paying for them, costs and premiums exploded. The government is about to learn the same bitter lesson.[47]

The Deficit Reduction Act, with its constraints on Medicaid long-term care eligibility and its encouragement of personal responsibility through private insurance and home equity conversion, is definitely the direction in which we must move. When we target Medicaid's scarce resources to the genuinely needy, those needy will get better care across a wider spectrum of services. When more people pay privately for long-term care, they will command red-carpet access to top-quality care at the most appropriate level of care. When people with money have to pay for their own long-term care, they will buy long-term care insurance and use their home equity, which means those businesses will boom, provide more jobs, and pay more taxes. When long-term care providers have more private payers, nursing homes, assisted living facilities, and all other caregivers will be more financially solvent. Debt and equity capital, which are desperately needed to finance the construction and operation of long-term care facilities, will return to the marketplace.

44. *See* Moses, *supra* note 31 ("Studies conducted of the partnerships programs in the four original states indicate that they helped expand the long-term care insurance market on the margin, but they hardly made a qualitative difference as compared to the market for the product in other, non-partnership states.").

45. *See id.* (discussing the advantages of the DRA provisions that expand Medicaid-funded home and community-based services).

46. JEFFREY S. CROWLEY, HEALTH POLICY INSTITUTE, GEORGETOWN UNIVERSITY, MEDICAID LONG-TERM SERVICES REFORMS IN THE DEFICIT REDUCTION ACT 2 (2006) (This brief was published by the Henry J. Kaiser Family Foundation Commission on Medicaid and the Uninsured.), http://www.kff.org/medicaid/upload/7486.pdf.

47. U.S. GEN. ACCOUNTING OFFICE, THE ELDERLY SHOULD BENEFIT FROM EXPANDED HOME HEALTH CARE BUT INCREASING THOSE SERVICES WILL NOT INSURE COST REDUCTIONS (1982), http://archive.gao.gov/f0102/120074.pdf (discussing how research and past experiences indicate that offering additional services will not necessarily bring cost reductions).

Finally, what is wrong with other proposals commonly offered to solve this problem? Many seek to solve the problems of long-term care service delivery and financing with compulsion. They want to force people to pay for long-term care insurance or load up Medicare with a long-term care benefit.[48] That won't work, and it hasn't worked. If excessive public financing has caused the problems we have now, then trying to solve them by adding more government financing would be like trying to put out a fire by dousing it with gasoline. Social Security and Medicare have unfunded liabilities totaling $86 trillion, at latest count.[49] To fix this, we would have to double payroll taxes or halve the benefits of these programs. Neither option is politically popular. The more likely outcome is that these programs will be means-tested. In other words, they will be turned into welfare programs. In time, they will lose political support in the same way Medicaid already has. Adding long-term care to Medicare, therefore, would be like adding deck chairs to the Titanic after the incident with the iceberg.

Here is the irony: our problems in long-term care are self-inflicted by well-intentioned but perversely counterproductive public policy. The good news is that the problems are easy to fix. We can do it responsibly through public policy, or we can just stand by and let the existing social insurance and welfare house of cards collapse. The Brave New World of Long-Term Care is here.

My advice to you as individuals, families, and citizens is to take responsibility for your own long-term care. Plan early, and save, invest, or insure. Maybe you can't solve the public policy problem alone, but you can protect yourselves and your families. Doing so is an important contribution. After all, as a wag once said: "The best way to help the poor is not to become one of them."[50]

Politically, my advice to you is to support targeting Medicaid to the poor, in order to save the fraying safety net, and supplementing long-term care with private financing sources. Do you wonder how the new Democratic majority in Congress will lean? Remember: some of the most stringent controls on Medicaid

48. *See generally* Richard L. Kaplan, *Cracking the Conundrum: Toward a Rational Financing of Long-Term Care*, 2004 U. ILL. L. REV. 47 (2004).

49. OFFICE OF ECON. POLICY, U.S. DEP'T OF TREASURY, SOCIAL SECURITY AND MEDICARE TRUST FUNDS AND THE FEDERAL BUDGET 18 (2006), http://www.ustreas.gov/offices/economic-policy/reports/budget_trust_fund_perspectives_2006.pdf.

50. *See, e.g.*, Quotations - Laing Hancock, http://thinkexist.com/quotes/laing_hancock (quoting Laing Hancock).

long-term care eligibility in the past came under Democratic presidents and Congresses.[51] Besides, for Democrats, this is a "fairness" issue. Why use scarce public resources to indemnify well-to-do heirs of affluent seniors? They're probably all Republicans anyway!

Thank you for your attention.

51. *See generally*, Colleen Grogan & Eric Patashnik, *Between Welfare Medicine and Mainstream Entitlement: Medicaid at the Political Crossroads*, 28 J. HEALTH POL. POL'Y & L. 821 (2003) (discussing various enactments of Medicaid policies and controls over the 1980s and 1990s).