

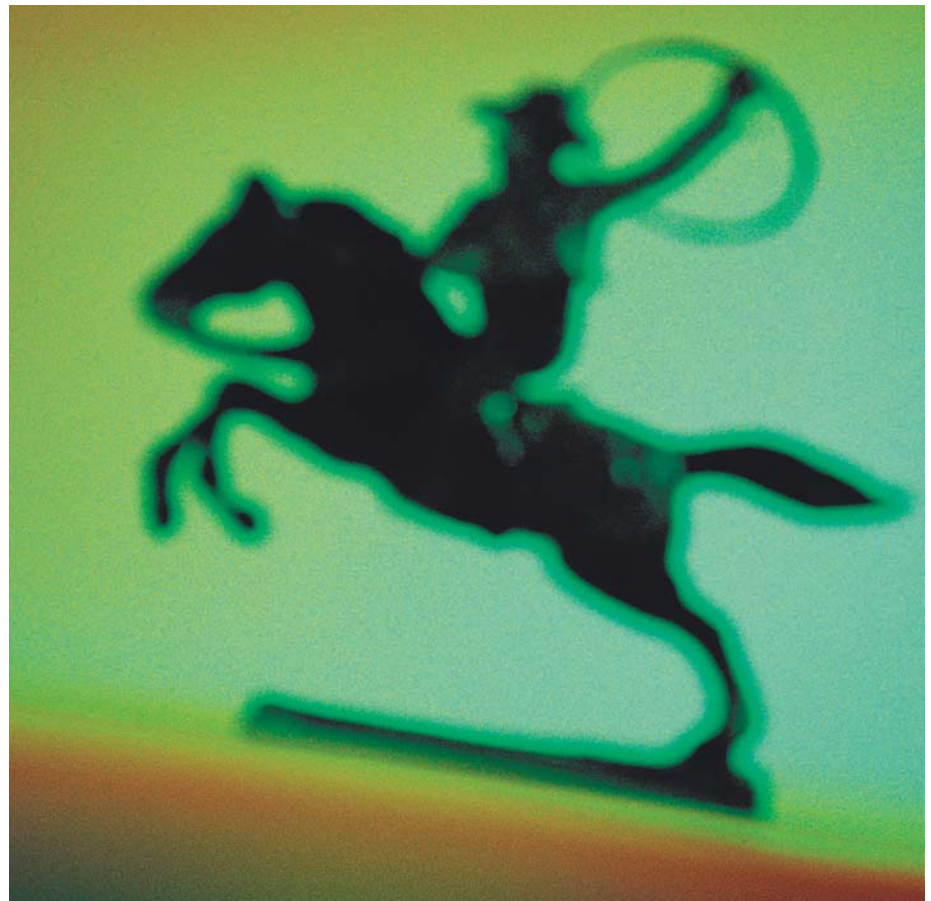
Long-term care's lone realist rides again

Interview with Stephen A. Moses, President, the Center for Long-Term Care Financing

Remember those thunderous hoofs of yesteryear bearing the mysterious Lone Ranger? Or perhaps you've heard of "the voice crying in the wilderness." Stephen A. Moses might be categorized both ways—or, if you're inclined to disagree with him, as a misguided scout pointing in exactly the wrong direction. There's no disputing one thing: Right or wrong, Steve Moses has for years been the lone voice publicly discussing the macro-issues of long-term care financing. Starting in the early 1980s, when he was an employee of the then Health Care Financing Administration (HCFA) and wondering why Medicaid, a program to pay for the healthcare of the poor, seemed to be turning into a nursing home entitlement program for everyone, Moses has been addressing complicated LTC policy issues head-on. He says he's for expanding private financing of LTC, most particularly through private insurance, not because he's particularly antigovernment or beholden to private interests, but because there is no other way short of a national financial meltdown. In September 2004, his Center for Long-Term Care Financing published *The Realist's Guide to Medicaid and Long-Term Care*, an impressive review of ten states' approaches to LTC financing. The report concludes that depending on several factors—most notably their Medicaid eligibility rules, estate recovery programs, and encouragement of private financing mechanisms—the states are at various stops along the way to financial disaster. Recently Moses discussed the Center's findings and prescriptions for improvement—and his personal frustrations as a policy advocate—with *Nursing Homes/Long Term Care Management* Editor-in-Chief Richard L. Peck.

Peck: What was your purpose in publishing this ambitious 80-page study?

Moses: The purpose is the same as I've al-



ways had, since I worked for HCFA in 1983: to understand and explain why we have this mess, a welfare-financed, institution-based LTC system in a wealthy country where no one wants to go to a nursing home.

Peck: In the public forum, your voice has been virtually alone in discussing the basic issues of long-term care financing. How do you feel about that?

Moses: Very frustrated. I can't seem to wake up the insurance and provider industries to start informing the public about this problem. I've asked the academics to do the research, but they won't. Those who are involved in the public discussion have a stake in the status quo—whether it's Medicaid policymakers, Medicaid planners, or senior

advocates, so they fight change. I guess the ones we really need to persuade are those who stand to gain from the system working the way it's supposed to—that is, the poor and those who favor the nonpoor taking personal responsibility for themselves. Right now, though, each interest group huddles inside its own silo—for example, the providers want more money from Medicaid, which is broke, and the insurers try to frighten people into protecting their assets, which people don't believe are at risk for long-term care.

The easy availability of Medicaid LTC benefits enables the public's denial. Although it's true that most people still think that Medicare covers long-term care, insurers look at

this and think that the key is to educate the public—but education isn't enough to motivate people when they don't believe they are at risk and government does, in fact, pay for most LTC services through Medicaid. No one is really acknowledging that there is no future in either Medicare or Medicaid for long-term care, and that planning ahead for those who are able to save, invest, or insure is a matter of great urgency.

Peck: Those who have looked at the private financing alternative, long-term care insurance, think it has too many knocks against it: They're saying it's too costly, too out of line with middle-aged people's financial priorities, and too unstable to rely upon over the long term. Your response?

Moses: As we discussed in the Center's *Myth of Affordability* study published a few years ago, the LTC insurance affordability problem is a myth. The real problem is people's lack of prioritization. Nothing seems affordable that you don't think you need. Consumer advocates tell the public that long-term care insurance is too expensive to purchase unless you have a lot of assets to protect, and that Medicaid is a practical alternative. Leaving aside the questions of Medicaid's financially perilous state and lowered expectations of quality care, this stance ignores the fact that middle-class, middle-aged people can afford private insurance. For the professional couple in their 50s or early 60s with no children to support anymore, the insurance will cost them less than dining out once a week. The family with kids, car payments, and college expenses is indeed in a bind, but would it be unreasonable for their kids, when they come of age, to help with the premiums to protect Mom and Dad and perhaps their inheritance? But right now, they don't have the incentive because they don't see that their inheritance is at risk. Medicaid has in fact become inheritance insurance for baby boomers, anesthetizing them to the risk and cost of long-term care, both for their parents and themselves.

As for the quality of LTC policies, it's true that this has been questioned in the past, but policies have improved considerably over the years. Those large rate increases people worry about are coming these days mostly from a small group of insurers that offered artificially low rates that ended up getting

them in trouble. Also, given the newness of the product and the absence of actuarial data on morbidity, it's not surprising that some companies missed the mark and had to raise premiums. The National Association of Insurance Commissioners issued a model state statute a couple of years ago that makes rate increases a very undesirable alternative for insurers. I think today we're seeing rates that are much more reflective of likely future claims experience.

Peck: What sort of coverage do you have for yourself?

Moses: My wife and I purchased a policy at age 50 priced at \$400 a year for each of us, which covers nursing homes' expenses, after a 90-day deductible, at \$200 a day and assisted living at \$120 a day, with no coverage for home healthcare. My objective was to cover the catastrophic risk of long-term institutional care at the lowest possible premium while I still had house and car payments and a son in college. We could supplement our coverage in the future, assuming we're still insurable, and decide then if we need more coverage. But we were overinsured in the meantime. I wouldn't recommend this approach to someone who doesn't follow the insurance industry as closely as I do. Probably a better idea would be to buy comprehensive coverage right from the start if one can afford it.

I prefer to self-insure for home healthcare because, unlike nursing home care, the need for home healthcare someday is a virtual certainty. The purpose of insurance is to replace the small risk of a catastrophic loss with the certainty of an affordable premium. With home healthcare, you don't necessarily need to jump into a risk pool from which everyone will be making withdrawals; rather, you can save and invest for this risk. Some people need the discipline of an insurance plan, however, to help them save for home health so, again, I wouldn't recommend my approach to everyone.

Peck: What do you think of the drive toward home- and community-based waivers for Medicaid long-term care?

Moses: I think the states are very careless in pursuing this objective without controlling Medicaid eligibility first, because HCBS [home- and community-based services] are going to explode in costs and perpetuate people's reliance on Medicaid, giving them even less incentive to protect themselves with long-term care insurance or home equity con-

version. My goal is to redirect Medicaid away from the affluent and middle class in order to save it for the poor, for whom it was intended. We'll never see a healthy HCBS system until people are able to pay for it privately.

Peck: Your *Realist's Guide* offers a fascinating tour of the LTC planning approaches of several states, defining some that are close to "basket cases" and others that are closer to what might be described as "model" states. What are the patterns that seem to define them one way or another?

Moses: First of all, I wouldn't use the term "model" states. They're all basket cases to some degree or another, although it's not entirely their fault. They're hampered by various federal restrictions. But some are doing less well than others with the tools already at hand to ease their Medicaid burdens.

For example, California is still allowing a pyramid divestiture schedule—outlawed by OBRA '93—that allows the wealthy to give away as much as \$1 million in assets in a small fraction of the time allowed by federal law to qualify for Medi-Cal. Georgia, Michigan, and Texas have only just started implementing estate recoveries to reimburse their Medicaid programs for long-term care expenses. I predict that none of these three states will recover enough to pay for the estate recovery program itself because of the exclusions and exemptions they've built into their programs. Oregon has been doing estate recoveries since the inception of its Medicaid program, and today collects \$15 for every \$1 invested in running the program. In fact, it was the Oregon program that first got me interested in this question when I was at HCFA in the early 1980s. I calculated back then how much the country as a whole would save in Medicaid expenditures if it did the same thing as Oregon and published the results for the Office of Inspector General. Since then it's become even more clear that the potential to help support Medicaid for the poor and wake up baby boomers to their financial risks in relying on Medicaid is huge if and when Medicaid estate recoveries are pursued cost effectively.

This does not necessarily have to be a political problem, by the way, as some have called it. To get across the appropriateness of estate recovery, you show the public how the genuinely poor are hurt as they lose ac-

cess to Medicaid-funded services, while the affluent just skate by.

Minnesota has a relatively strong estate recovery program and strict eligibility rules, along with a 10 to 14% penetration of long-term care insurance and active home equity conversion. Although its recent HCBS push has been counterproductive in the absence of stronger eligibility controls, it has a Medicaid nursing home census of only 59%. So it's less a "basket case" than some others.

In general, the states do have options to make Medicaid eligibility more rational, and we need the federal government to give states more authority to do so. The market *is* heading in that direction. All I'm saying is, let's expedite this and get the thing fixed before the whole system collapses.

Peck: Aside from getting out of states' way, what do you see as the federal role in long-term care financing?

Moses: I know one thing that won't happen—having the federal government assume the entire long-term care portion of Medicaid, as some states have asked. It's just too expensive for the federal budget. I don't see the type of partnership arrangement where you have private insurance covering the first few years of LTC expenses with the federal government covering the back end. As I mentioned, insurance is for replacing the small risk of a large loss with the certainty of an affordable premium, not for dollar-cost-averaging a more likely event. Nor would I count on adding a new Medicare part for long-term care because with the financial situation Medicare is headed toward, it would be

like adding deck chairs to the Titanic after its encounter with the iceberg.

Social insurance is based on the idea "from each according to his ability to each according to his need." The problem is, need is unlimited, but ability is not. Government should be careful not to discourage private incentives and personal responsibility. That should be a public policy priority. When it is, government will be better able to provide a real and affordable safety net for the truly needy. ■

The Realist's Guide to Medicaid and Long-Term Care is available at the Center for Long-Term Care Financing's Web site: www.centerltc.org. For further information, phone (206) 283-7036 or e-mail smoses@centerltc.org. To send your comments to the author and editors, please e-mail 2peck0305@nursinghomesmagazine.com. For reprints in quantities of 100 or more, phone (866) 377-6454.