LTC Choice

A Simple, Cost-Free Solution to the Long-Term Care Financing Puzzle

presented by the

Center for Long-Term Care Financing

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

Public Release Date: September 1, 1998

Contact information at date of publication:

~~Stephen A. Moses, President~~
~~David M. Rosenfeld, Vice President~~
~~11418 NE 19th Street~~
~~Bellevue, Washington 98004~~

~~Phone: 425-467-6840~~
~~Fax: 425-467-6829~~

~~E-mail: Stephen Moses: smoses@centerltc.org~~
~~David Rosenfeld: david@centerltc.org~~
~~Center: info@centerltc.org~~
~~Web Site: http://www.centerltc.org~~

Current contact information:

Stephen A. Moses, President
Amy McDougall, Executive Director
2212 Queen Anne Avenue N., #110
Seattle, Washington 98109

Phone: 206-283-7036
Fax: 206-283-6536

E-mail: Stephen Moses: smoses@centerltc.org
Amy McDougall: amy@centerltc.org
Center: info@centerltc.org
Web Site: http://www.centerltc.org

Executive Summary

How can America solve the long-term care financing problem?

- The publisher of this study, the Center for Long-Term Care Financing, is dedicated to ensuring high quality long-term care for all Americans.
- The problem of how to finance long-term care for the baby boom generation rivals Medicare and Social Security as the most serious social policy challenge facing the United States.
- Today, America's long-term care service delivery and financing system is fragmented, dysfunctional, and plagued by problems of access, quality, reimbursement, discrimination and institutional bias.
- Nevertheless, we know exactly what we would like our country's long-term care system to provide: universal access to top-quality care for rich and poor alike in the least institutional settings possible.
- Pundits, politicians and policy-makers recognize the problem; they know what the solution should look like; why can't they get the job done? That is the long-term care financing puzzle.
- In this report, we explain how America's long-term care system came to its current sorry state by tracing the history of long-term care financing since the establishment of Medicaid and Medicare.
- We disprove and discard the conventional wisdom that catastrophic long-term care spend-down is widespread and therefore requires expanded public financing.
- We prove and adopt the position that virtually everyone can obtain public financing of long-term care through Medicaid or Medicare after being stricken by chronic illness. This fact explains why so few people plan ahead for the risk of long-term care.

- We demonstrate that the solution to the long-term care financing puzzle is to persuade people to consider and to confront the risk of long-term care while they are still young, healthy, and affluent enough to save or insure privately.
- We offer a simple, cost-free solution called ***LTC Choice***.
- ***LTC Choice*** requires the United States Government to provide information about long-term care risk and financing options to all citizens as soon as possible, but no later than their 65th birthdays.
- Under ***LTC Choice***, every individual may choose to show proof of private insurance or adequate financial reserves to pay for long-term care and thus abstain from public financing entirely and avoid all other reporting requirements.
- Alternatively, anyone who is unable or chooses not to show proof of private long-term care financial protection would have to acknowledge formally in writing that any future eligibility for publicly financed long-term care is contingent upon spending down nearly all his or her income and assets for care expenses first.
- Requiring all citizens to confront the ***LTC Choice*** long before the insurable event occurs will radically increase the proportion of Americans who plan responsibly for long-term care and drastically reduce the incidence of artificial impoverishment to qualify for Medicaid.
- With over $10 trillion about to pass by inheritance to the baby boomers from the WWII generation, Americans have no shortage of private money to save or insure for long-term care.
- All we need to do is eliminate the perverse incentives in the current system that enable denial of long-term care risk and discourage responsible, early planning.

Table of Contents

Preface

What is the Center for Long-Term Care Financing?

This report is the first public policy paper of the Center for Long-Term Care Financing. Another version of this paper will be published as the chapter on long-term care financing in Ken Dychtwald's forthcoming anthology *Toward Healthy Aging*.

Stephen Moses and David Rosenfeld established the Center for Long-Term Care Financing in April 1998. The Center's mission is to promote universal access to top-quality long-term care by encouraging private financing and discouraging welfare financing of long-term care for most Americans.

The Center for Long-Term Care Financing advocates public policy that targets scarce public resources to the neediest, while encouraging people who are young, healthy and affluent enough, to take responsibility for themselves. We believe that private insurance and investment can guarantee quality long-term care for prosperous seniors and help save the Medicaid long-term care program for the truly needy. Toward these ends, the Center offers a range of fee-for-service products to public and private clients including consulting, publishing, training and public speaking. The Center for Long-Term Care Financing also publishes a periodic on-line news service called "LTC Bullets" which covers the latest information and trends in long-term care financing. This publication is available free of charge.

The two principals in the Center for Long-Term Care Financing have many years of experience between them in the fields of long-term care policy, public welfare, aging, law and social work. Stephen Moses was formerly Director of Research for LTC, Incorporated and a senior analyst for the Health Care Financing Administration and the Office of Inspector General of the U.S. Department of Health and Human Resources. He is nationally recognized as an expert and innovator in the field of long-term

care. David Rosenfeld is an attorney and MSW with a growing reputation as an author and speaker on long-term care issues. He specializes in ethical questions affecting elder law. Biographical profiles of Mr. Moses and Mr. Rosenfeld are provided at the end of this report.

Introduction

What is the long-term care financing puzzle?

Long-term care in the United States is more than a challenging public policy problem. It is a fascinating puzzle as well. In fact, the question "How will we pay for the needs of a rapidly aging population?" raises a whole continuum of conundrums. For example, why does a prosperous nation like ours warehouse its World War II generation in welfare-financed nursing homes? Why are most Americans in denial about the risks of long-term care when the media warn us constantly about an impending demographic Armageddon? Why do we agree on so many of the problems and solutions of long-term care service delivery and yet fail year after year to initiate decisive corrective action? This report will answer these questions, solve the underlying puzzle, and propose an affordable public policy solution.

Conventional wisdom and scholarly consensus agree: America faces a potentially cataclysmic long-term care financing crisis in the foreseeable future. The evidence of impending danger lies everywhere we look: undeniable trends in aging demographics; reduced availability of informal caregivers; doubts about the quality of formal long-term care; inadequate supply of low-cost home- and community-based services; rapidly escalating nursing-home expenses; poorly structured delivery systems; dwindling public finances; increasingly resistant taxpayers; declining ability or willingness of families to pay privately for long-term care; cracks in our public and private pension systems; and the approaching retirement of the baby boom generation. These are the elements of consensus on the problem.

Just as the public and the experts have come to agree on the problems, they also concur on the architecture of an ideal long-term care system. Certain optimal features show up consistently in task-force reports, think tank studies, policy papers, and published articles. These include: generous eligibility for assistance; integrated acute and long-term care; easy access at a single point of entry; quality control; case or care management; uniform client needs assessment; asset protection; home- and community-based care; nonmedical social services (such as housekeeping and personal care); adult day care; respite care; supportive housing such as assisted living and adult foster homes; pre-admission screening; custodial, skilled, and sub-acute nursing-home care; services to meet the special needs of geriatric, developmentally disabled, mentally ill, and other patients; and coordination of public financing sources (primarily Medicaid and Medicare). These are the elements of consensus on the solution.

Here is the puzzle: We know what is wrong with long-term care in the United States. We know how to design an optimal service delivery system. We live in the world's wealthiest society. Why can't we come together politically and professionally to get the job done?

Historical Perspective

How did America's long-term care system become so dysfunctional?

Academics, pundits, and politicians have struggled for decades with the challenge of financing long-term care. Grand designs for reform like the Pepper Commission's report and the Clinton Health Plan have failed to attract public support. Incremental changes like expanding Medicaid (nursing home) and Medicare (home health) coverage have hastened the current fiscal crisis. When nothing you do seems to work, but your predicament is so desperate you cannot give up, the best strategy is to examine your premises.

Most scholarship on long-term care focuses on the *status quo*, laments the familiar problems, advocates the usual solutions, and blames inaction on a lack of money caused by stingy taxpayers and cold-hearted politicians. If there is a fundamental underlying fallacy in our approach to long-term care, this commonplace analysis will not identify or correct it. The sad fact is: if we keep doing what we have always done, we will keep getting what we have always gotten. Instead, we must ask ourselves: *How did our long-term care system come to be the way it is?* and *What do we need to do differently to achieve more desirable results?*

In 1965, America was just starting to have a serious problem with long-term care. People were living longer, but dying more slowly—of chronic illnesses that caused frailty and cognitive impairment. Older Americans needed more and more long-term care at the very time when women, the traditional caregivers, were entering the formal workforce in much greater numbers. This was when a prosperous private market in low-cost home- and community-based services, geriatric care management, and long-term care insurance might have developed in the United States. It did not.

Instead, with every good intention, the new federal Medicaid program offered publicly-financed long-term nursing-home care. This benefit, initially unencumbered by transfer of assets restrictions and estate recovery requirements, confronted families with a very difficult choice. They could pay out-of-pocket for the home care and community-based services seniors prefer or they could accept nursing-home care paid for by the government. Most people chose the safety and financial benefits of the government's Medicaid option. Therefore, the market for home care withered, private long-term care insurance failed to develop, and Medicaid-financed nursing-home care flourished.

The nursing-home industry took full advantage of this new public financing source by building many new facilities. To have failed to do so would simply have been bad business. As fast as the industry could build them, the new nursing-home beds filled with Medicaid residents. Stunned by the cost, Medicaid attempted to control the construction of new beds with Certificate of Need (CON) programs based on the principle that "we cannot pay for a bed that does not exist." By the mid-1970s, health planning for nursing homes was in full swing. It worked. Fewer new beds were built.

Capping bed supply, however, predictably drove up price and demand. The nursing-home industry raised charges to compensate for the limitation on new beds. What the government saved by restricting bed supply, it lost to nursing-home rate increases. Consequently, Medicaid nursing-home costs grew faster than ever. In response, Medicaid capped reimbursement rates. This move impelled the nursing-home industry to increase private-pay reimbursement rates to compensate. The more the government pushed Medicaid rates down, the more the industry pushed private-pay rates up. So began the highly problematic differential between Medicaid rates and private-pay rates. Today, on average, Medicaid pays only 80% of private-pay rates.

Higher private-pay rates made Medicaid more attractive than ever to private payers. The public's desire to obtain public assistance for long-term care expenses led to pressure on legislators to loosen standards for Medicaid eligibility. A long process of eligibility bracket creep gradually made Medicaid nursing-home benefits available even to upper middle-class people. Anyone who had or could obtain the expertise to manipulate Medicaid's highly elastic eligibility rules became eligible. A whole sub-practice of law—Medicaid estate planning—developed to take advantage of this new opportunity. Artificial self-impoverishment, touted frequently in the national media and in local financial planning ads, became a clever solution to the long-term care financing problem.

With the supply and price of nursing-home beds capped by government fiat and with Medicaid eligibility increasingly generous, nursing-home occupancy skyrocketed to an average of 95% nationally. Given high demand and severely limited supply, nursing-home operators could fill their beds easily with low-paying Medicaid patients. To achieve adequate operating margins, however, nursing homes had to attract a sufficient supply of full-paying private patients or cut costs drastically. Yet, if they tried to attract more lucrative private payers with preferred treatment or accommodations, the nursing homes were deemed guilty of discrimination against Medicaid patients. If they tried to cut costs instead, they came under fire for technical violations or quality problems. In response, Congress and state governments pressured the industry to provide higher quality care without discriminating against low-paying Medicaid recipients. Given the program's fiscal duress, however, Medicaid could not offer higher reimbursement rates to achieve these goals.

Caught between the rock of low reimbursement and the hard place of quality mandates, the nursing-home industry put up a strong fight. Armed with the Boren Amendment, a federal law that required Medicaid to provide reimbursement adequate to operate an efficient nursing facility, many state

nursing-home associations took the battle to court. By this time, however, state and federal Medicaid expenditures were increasing so quickly and taxpayers had become so reluctant to pay for growing public spending that large increases in Medicaid nursing-home reimbursements were out of the question, regardless of which side won the lawsuits. The issue is moot now, of course, because the Boren Amendment was repealed by the Balanced Budget Act of 1997.

In the meantime, a wave of academic speculation in the late 1970s indicated that paying for home- and community-based services (HCBS) instead of nursing-home care could save a lot of money. For years, therefore, Medicaid has experimented with HCBS waivers as a cost-saving measure. In time, however, hard empirical research produced a near consensus that (desirable as they are) home- and community-based services do not save money overall. Medicaid and, more recently, Medicare expenditures for long-term personal and home care have soared in tandem with nursing-home expenditures. It remains true, ironically, that because of the public's aversion to nursing-home care, institutional bias is Medicaid's strongest cost containment tool, one of its gravest deficiencies, and the biggest single obstacle to the expansion of privately-financed home- and community-based long-term care services.

In a nutshell, just as heavy demand was building for a privately financed senior services market in the 1960s, Medicaid co-opted the trend by providing easy access to subsidized nursing-home care. Confronted with a choice between paying out-of-pocket for a lower level of care or receiving a higher level of care at much less expense, seniors and their families made the predictable economic choice. Naturally, the potential market for long-term care insurance and privately-financed home- and community-based services languished. Medicaid nursing-home caseloads and expenditures increased rapidly and drastically. In response, Medicaid capped bed supply and reimbursement rates, which led

inevitably to excessively high occupancy, private-pay rate inflation, discrimination against low-paying Medicaid patients, and serious quality of care issues.

Over time, Medicaid nursing-home care acquired a national reputation for impeded access, dubious quality, inadequate reimbursement, widespread discrimination, pervasive institutional bias, and excessive cost. Medicaid remains, nonetheless, the only way middle-class people can pay for long-term care without selling their homes nor, if they are clever, liquidating their savings. That is why so many otherwise independent and responsible Americans fail to buy private insurance while they are young and healthy enough to qualify for it and afford it, and end up looking to Medicaid planning as the only way to save their estates or their inheritances. It is the reason why a huge proportion of America's proud World War II generation is dying on welfare in nursing homes.

Today, these historical trends have almost run their course. We are on the verge of a promising, but perilous, new world of long-term care. We are floundering forward, compelled by necessity to change the system somehow. Both the private marketplace and public policy are pushing long-term care in a more consumer-friendly direction. Nursing-home occupancy is declining, with the percentage of occupied beds having dropped from the mid-nineties to the mid-eighties in the past decade. The trend toward privately-financed assisted living is exploding. Medicare has entered the arena with rapid growth in its home care and skilled nursing components. New buzz words dominate our professional jargon. We look to concepts like capitation, managed care, dual eligibles, and integration of acute and long-term care for new hope.

Is our dream of a seamless long-term care delivery and financing system just around the next bend in public policy? Or are we at risk of making the same mistakes as in the past, but on a wider

scale and with more disastrous consequences? To answer these questions, we need to find a fresh perspective on the past, present, and future of long-term care financing.

A Conflict of Paradigms

Why do most Americans ignore the risk of long-term care until it is too late?

Whether one reads a newspaper article, a scholarly journal or a full-length book about long-term care financing, one invariably finds an argument that goes something like this:

> Long-term care, especially nursing-home care, is extremely expensive. Very few Americans can afford $3,000 to $5,000 per month in extra out-of-pocket expenses. Therefore, when stricken by the tragedy of Alzheimer's, Parkinson's, or stroke, most people spend down their life's savings quickly and collapse into poverty. Once impoverished, they qualify for Medicaid, which steps in to pay their bills. Consequently, Medicaid nursing-home costs are skyrocketing, and the government's ability to meet growing long-term care needs is severely strained.

This scenario—call it the *welfare paradigm*—comports with some of the facts. For example: nursing homes *are* very expensive; Medicaid *is* a means-tested public assistance program; approximately two-thirds of all residents in nursing homes *do* receive Medicaid; and Medicaid *does* suffer from severe financial problems. But let us set these matters aside for a moment, step back from the actual long-term care financing system, and ask: If the welfare paradigm is valid, what would we logically expect the long-term care marketplace to look like?

If long-term care impoverishes large numbers of Americans and forces them onto welfare, we would certainly expect seniors and their families: (1) to worry and plan years in advance about the potentially catastrophic costs of long-term care; (2) to avoid nursing-home care as long as possible because of its expense and because of their preference to stay at home; (3) to demand high-quality, low-cost, home- and community-based care alternatives that delay institutionalization and impoverishment; (4) to utilize home equity conversion products (such as reverse annuity mortgages) that can finance home care and postpone liquidation of the family home; and (5) to purchase private long-

term care insurance that can protect against catastrophic financial loss caused by home or institutional care.

In practice, the opposite of these reasonable expectations holds true. First, most families do not plan in advance for the risk of long-term care. That is why so many of them end up in crisis with nowhere to turn but to public assistance. Second, nursing-home care is often the first choice for care, not the last resort. That is why so many people end up in nursing homes who could be cared for at home more comfortably and for less cost. Third, the home- and community-based care sector of the long-term care marketplace has been very slow to develop. That is why many people have no viable choice besides nursing-home institutionalization when a health crisis strikes. Fourth, home-equity conversion has failed, to date, as a private sector financial product, despite strong encouragement from the government. That is why home equity, which is the single biggest financial asset of seniors, goes virtually untapped as a source of financing for quality long-term care. Finally, only about six percent of seniors have purchased private long-term care insurance. That is why nursing-home costs are devastating to most people when they do occur.

The Entitlement Paradigm

Clearly, much of what we would expect rational economic decision makers to do if the welfare paradigm were valid simply does not happen. Instead of torturing the old paradigm to account for these anomalies, we might consider a different view—call it the *entitlement paradigm*:

> In America today, people can ignore the risk of long-term care, avoid the premiums for private insurance, wait to see if they ever require formal care and, if necessary, shelter all their income and assets to qualify (virtually overnight) for nursing-home benefits paid for by Medicaid.

Viewed from the standpoint of the entitlement paradigm, the puzzling behavior described above would be far more comprehensible. For example, people do not plan ahead for long-term care because they can wait until the last minute and receive publicly-financed care. They often go to nursing homes instead of home care first, despite their preferences, because Medicaid pays generously for nursing-home care, but covers very little home care. Few people want to take advantage of home-equity conversion to finance long-term care or insurance premiums because Medicaid exempts the home and all contiguous property regardless of value. Finally, long-term care insurance is unpopular because most people will not pay full dollar for something they can get from the government at a deep discount.

Thus, if the entitlement paradigm is valid, if Medicaid provides easy access to highly subsidized long-term care, we can easily understand why most people are eligible for Medicaid even before they enter a nursing home,[1] why Medicaid nursing-home census and costs have increased rapidly for many years, why induced demand makes Medicaid financing of home care prohibitively expensive, and why private financing of nursing-home care is declining instead of increasing as a proportion of total costs.[2] Furthermore, if the entitlement paradigm is valid, many exciting new public policy options open up for us. For example, it could be possible to save taxpayers a lot of money and to empower many more

---

[1] In fact, the data show that 72.9% of single people, 85.4% of married people, and 77.7% of all people are eligible for Medicaid already when they enter a nursing home. (Frank A. Sloan and May W. Shayne, "Long-Term Care, Medicaid, and Impoverishment of the Elderly," *The Milbank Quarterly*, Vol. 71, No. 4, 1993, p. 585.)

[2] In 1987, private out-of-pocket expenditures accounted for 49.3% of total nursing-home costs nationally; Medicaid paid for 43.9%; and Medicare paid for 1.4%. In 1996, private out-of-pocket expenditures accounted for 31.4% (down 17.9% since 1987); Medicaid paid for 47.8% (up 3.9%); and Medicare paid for 11.4% (up 10.0%). (Source for 1987 data: personal communication with Helen Lazenby, Health Expenditure Analyst, Health Care Financing Administration on February 16, 1989; source for 1996 data: Katharine R. Levit, *et al.*, "National Health Expenditures, 1996," *Health Care Financing Review*, Vol. 19, No. 1, Fall 1997, p. 195.

Americans to pay privately for top-quality long-term care simply by making Medicaid a little less desirable and by providing a stronger incentive for people to plan ahead to avoid public assistance. In other words, the solution to the long-term care financing puzzle may reside in merging the two paradigms to gain the benefits of the welfare system without incorporating its negatives and to eliminate the problems of the entitlement paradigm without sacrificing its advantages.

There is no point, however, in exploring these possibilities further unless the entitlement paradigm is valid. Unfortunately, to most people familiar with the long-term care financing system, the entitlement paradigm will seem highly dubious. Critics of the entitlement paradigm will cite federal and state laws that appear to require impoverishment to qualify for Medicaid. Furthermore, most experts accept the welfare paradigm without challenging it. Certainly, as yet, no one has made the case in the mainstream gerontological literature that the welfare paradigm is invalid and that the entitlement paradigm is a much better model of reality.

A Phalanx of Fallacies

Why does a fundamental misunderstanding of the long-term care problem still persist?

The welfare paradigm—the perspective that our long-term care financing system's biggest problem is widespread catastrophic spend-down—is invalid. But the welfare paradigm is surrounded by a phalanx of fallacies that shelter it from critical scrutiny. The entitlement paradigm—the perspective that the United States has a publicly-financed long-term care entitlement program that impedes market-based solutions the public prefers—is valid. But the entitlement paradigm contradicts conventional wisdom and must be proved. The remainder of this report will refute the welfare paradigm, confirm the entitlement paradigm, and draw public policy recommendations that follow logically from these conclusions.

A key fallacy of the welfare paradigm is that most people who need long-term care spend down their life's savings and fall, sooner or later, into the social safety net of Medicaid. The truth is very different. Seventy-eight percent of all people who enter nursing homes are already eligible for Medicaid before they are admitted to this expensive level of care.[3] The vast majority of all patient days in America's nursing homes are paid for by someone other than the patient. Medicaid alone pays at least in part for 71.7% of all nursing-home patient days.[4] In 1996, more than three-fourths of all dollars paid for nursing-home services came from a combination of publicly-financed programs including Medicaid

[3] See footnote #1.

[4] *McKnight's Long-Term Care News*, December 1996, p. 3 citing *HCIA's Guide to the Nursing Home Industry*, 1996.

(47.8%), social security "spend-through" (12.8%),[5] Medicare (11.4%), veterans' benefits and other government sources (2.3%), and from private health insurance (5.2%) or patient out-of-pocket income (not assets).[6] Empirical evidence of widespread catastrophic asset spend-down in nursing homes is nonexistent. In fact, numerous academic studies recently proved that only 15% to 25% of Medicaid nursing-home patients spent down to qualify (including those who did so artificially through asset divestiture), instead of the 50% to 75% previously thought.[7]

Another important fallacy of the welfare paradigm is that Medicaid eligibility requires impoverishment. The truth is very different. Virtually anyone, regardless of income or assets, can qualify quickly and easily for nursing-home care paid for by the government. Most states place no limit on how much income someone can have and still qualify for Medicaid nursing-home benefits. If one's total medical costs—including nursing-home care—approximate or exceed one's income, one is eligible.

---

[5] Social security spend-through refers to income most seniors collect in the form of social security benefits which must be contributed toward their cost of care when they receive nursing-home services paid for by Medicaid. According to HCFA: "An estimated 41 percent...of out-of-pocket spending for nursing home care was received as income by patients or their representa-tives from monthly social security benefits." (Helen C. Lazenby and Suzanne W. Letsch, "National Health Expenditures, 1989," *Health Care Financing Review*, Vol. 12, No. 2, Winter 1990, p. 8.) Applying this percentage to the proportion of nursing-home costs paid out-of-pocket in 1996 (31.4%) gives an estimate of social security spend-through of 12.8% for 1996.

[6] Katharine R. Levit, *et al.*, "National Health Expenditures, 1996," *Health Care Financing Review*, Vol. 19, No. 1, Fall 1997, p. 195. The proportion of out-of-pocket costs attributable to patient income, other than social security spend-through, is unknown but substantial. Seniors often receive income from their investment assets, for example, which would be spent for long-term care before dipping into the assets themselves. Consequently, the total portion of nursing-home costs paid by sources other than patients' assets could approach as much as 80% to 90%.

[7] Two or three dozen "spend-down" studies were conducted in the late 1980s and early 1990s. They are easily accessible in the scholarly literature. Some of the principal authors were Mark Meiners, Brian Burwell, Joshua Wiener, Korbin Liu, Pam Doty, and Kenneth Manton.

Even in the toughest "income cap" states, the median elderly person—in terms of income and assets—qualifies easily for Medicaid nursing-home benefits without complicated estate planning.[8] The "Miller income trusts" authorized by the Omnibus Budget Reconciliation Act of 1993 lifted the lid on income caps altogether for most people.

The widely reported $2,000 Medicaid eligibility limit on assets is highly misleading. Medicaid recipients can keep unlimited exempt assets—such as a home, a business, and a car—of any value. Many other assets are exempt as well. Converting nonexempt assets such as cash into exempt assets such as home equity is the easiest and most commonplace method of Medicaid planning. For married people, qualifying for Medicaid is even easier than for single people. Couples can shelter up to an additional $80,760 in assets and $2,019 per month in income as of 1998. Furthermore, these levels increase annually with inflation.

For the well-to-do who can afford professional legal advice, even these generous eligibility limits are easily overcome. Any competent Medicaid estate planner can deliver Medicaid nursing-home eligibility almost overnight to practically anyone for less than the cost of one month in a private nursing home.[9] The same advisers can evade estate recovery liability for their clients with equal facility. As explained below, these facts remain true despite strong initiatives taken by Congress and the President in 1993, 1996, and 1997 to close Medicaid loopholes, mandate estate recoveries, and criminalize asset transfer advice.

---

[8] The Medicaid income cap increases every year with inflation. For 1998, it was $1,482 per month or $17,784 per year as compared to an average annual income (in 1995) of $16,484 for elderly males and $9,335 for elderly females. (Department of Health and Human Services, Administration on Aging, "A Profile of Older Americans: 1996," Washington, D.C., December 1996, http:www.aoa.dhhs.gov/aoa/pages/profil96.html, p. 6.)

[9] See the box insert on the next page.

Welfare for the Well-To-Do

Hundreds of law journal articles over the past 15 years attest to the fact that Medicaid is available to anyone with enough money to hire the right attorney. The following are typical passages from two mass media legal self-help books that provide Medicaid estate planning advice to the lay public.

"So is there any practical way to juggle assets to qualify for Medicaid—before losing everything? The answer is yes! By following the tips on these pages, an older person or couple can save most or all of their savings, despite our lawmaker's best efforts...Here are the best options: Hide money in exempt assets...Transfer assets directly to children tax-free...Pay children for their help...Juggle assets between spouses...Pass assets to children through a spouse...Transfer a home while retaining a life estate...Change wills and title to property...Write a durable power of attorney...Set up a Medicaid Trust...Get a divorce...." (Armond D. Budish, *Avoiding the Medicaid Trap: How to Beat the Catastrophic Costs of Nursing-Home Care*, Henry Holt, New York, 1989, p. 34.)

"We have committed an act of piracy—we have broken into the Fort Knox of Government benefits and uncovered the best legal strategies available to you for claiming your share of the gold from the Government's treasure chest....We'll explain how you can 'strike gold' in the social security [including SSI], Medicare, and Medicaid programs....With this book we are handing you the treasure map, deciphered from a mine of unintelligible government rules and regulations." (Amy and Armond D. Budish, *Golden Opportunities: Hundreds of Money-Making, Money-Saving Gems for Anyone over Fifty*, Henry Holt and Company, New York, 1993, p. xiii.)

Discussion

Why don't people plan ahead for long-term care and buy private insurance?

Shall we assume, therefore, that because government pays for or subsidizes most nursing-home care in the United States, seniors are intentionally planning to go on welfare and into nursing homes if they ever need formal long-term care? Is that why so many of them fail to buy insurance or pay privately for lower levels of care? No! Most people simply do not worry or care about who pays for long-term care. They do not know whether the source of funding is Medicaid, Medicare or Make-a-Wish. They are aware, however, that *somebody* else pays and that the horror stories that magazine articles and insurance agents tell them about losing their life's savings can be ignored with impunity. Ironically, they are right.

The easy, almost universal availability of publicly-financed nursing-home benefits *enables* widespread public denial concerning long-term care risk. People only insure against real risks, and they naturally hesitate to pay full price for something that is easily available by government subsidy. If the social safety net suddenly disappeared, if people really had to become impoverished before the government helped them out, they would quickly realize they could no longer enjoy the luxury of their denial. They would plan ahead for long-term care risks, buy insurance, tap home equity, employ geriatric care managers to find and coordinate the best available free or fee services, and pay privately for the lowest, least expensive, and best levels of care they could afford.

The social safety net is not going to disappear, however. The third rail of politics—senior benefits—retains sufficient voltage to stifle any politician who might attempt to eliminate long-term care benefits completely. Fortunately, there is a better way to solve the problem and we already have many

of the legislative and bureaucratic tools in place to implement it. The Omnibus Budget Reconciliation Act of 1993 (OBRA '93), President Clinton's first budget, provided much of what is needed. OBRA '93 closed many of the loopholes that made Medicaid eligibility so attractive and required every Medicaid program in the country to recover benefits paid from the estates of deceased recipients. In essence, OBRA '93 told the middle class: "Medicaid is a loan, not a grant. If you don't want to die on welfare *and* pay for the privilege, then buy long-term care insurance, pay privately for the long-term care services you prefer, and leave public assistance for the poor." The Health Insurance Portability and Accountability Act of 1996 (HIPAA or the Kennedy/Kassebaum Act) went even further. It criminalized certain Medicaid asset transfers executed for the purpose of qualifying for public assistance. HIPAA also made private long-term care insurance more attractive by making the premiums tax-deductible.

Why haven't these changes in public policy already unleashed the full potential of market-based solutions like supportive housing, home equity conversion, private geriatric care management, and long-term care insurance? Unfortunately, America has an entrenched welfare industry that thrives on impoverishing people artificially and profiteering from their dependency. Thousands of Medicaid estate planners throughout the United States work assiduously to pry back open the eligibility loopholes closed by OBRA '93 and to weaken estate recovery. Numerous well-intentioned legal assistance and seniors' organizations aid and abet the private bar by referring affluent seniors to for-profit Medicaid planners. The Health Care Financing Administration (HCFA), which administers Medicaid and Medicare, does not enforce OBRA '93 aggressively, provides little technical assistance to the states, and openly advises Medicaid estate planners on how to circumvent the law. State Medicaid programs, which are experts at providing benefits and spending money, have little aptitude for or interest in controlling eligibility or

collecting from estates. Many Medicaid eligibility workers actually help people spend down artificially to qualify for nursing-home benefits. The Balanced Budget Act of 1997 diluted the provisions in HIPAA '96 by targeting criminal penalties for asset transfers at Medicaid planners and other financial advisers, while exonerating their clients. Finally, the Medicaid planners and their professional association have mounted a nationwide public relations campaign to repeal criminalization altogether or have the law declared unconstitutional. As so often happens, our public policymakers, and the interest groups that lobby them, have one foot on the accelerator and one foot on the brake of privatizing long-term care financing.

Clearly, the conventional wisdom that public assistance is available only to people after they have impoverished themselves paying for long-term care (the welfare paradigm) is wrong. The reality is that most people qualify easily for Medicaid nursing-home benefits, and virtually anyone can qualify quickly with the right advice (the entitlement paradigm). Consequently, it should come as no surprise that most people in America do not worry in advance about long-term care, that they end up in nursing homes on Medicaid instead of in the less institutional settings they prefer, and that they fail to tap the equity in their homes for long-term care expenses or to purchase private insurance.

Fortunately, this state of affairs is reversible. Today, the political imperatives to reduce government spending and curb entitlements have opened a pathway to major reform. We no longer need to effect incremental change to an obsolete welfare program that is morally, intellectually, and financially bankrupt. By virtue of its excessive cost and its reputation for serious access and quality problems, Medicaid is finished as a long-term care financing system for the middle class. America stands poised on the brink of a revolutionary new approach to long-term care financing.

Summary of the Problem

What is the bottom line?

The 1970s should have been the golden age of long-term care in America. The gerontological wedge pushed into American demographics during that decade could have opened an era of unprecedented entrepreneurial problem-solving. By now, we would have a market-driven continuum of care seamlessly covering everything from chore services to assisted living to sub-acute care. We would also have an infrastructure of long-term care insurance and home equity conversion to finance it. Public welfare might still have a role to play in long-term care, but that role would not be the tragedy of perverse incentives and unsatisfactory outcomes it is today.

Instead, with every benevolent intent, Medicaid co-opted long-term care by the late 1960s. It impeded the private market for low-cost senior services and housing and discouraged the development of private long-term care insurance by providing free or subsidized nursing-home care. It created a Frankenstein's monster of institutional care by targeting public money only to nursing homes. It stifled competition, thereby impairing access and quality, by constricting bed supply and reimbursement rates artificially. It drove the middle-income consumer out of the private long-term care marketplace by creating a ponderous, publicly-financed monopsony. In time, Medicaid choked the nursing-home industry almost to death with regulations intended to correct the very problems the program itself engendered. Nevertheless, in the absence of affordable alternatives and the means to pay for them, middle-class Americans in the hundreds of thousands are still being directed into Medicaid-financed nursing homes by well-intentioned public administrators and Medicaid estate planning attorneys.

Public Policy Recommendations

What needs to be done to ensure quality long-term care for all Americans?

What is the solution? Obviously, we cannot dismantle Medicaid overnight and leave the old, the sick, and the frail to fend for themselves. Rather, the first step is to preserve and improve a publicly-financed long-term care program for the truly poor. To command good access and high quality, however, such a program must be able to pay market rates for every appropriate level of care. That will be expensive.

The only way to pay for such a program is to divert the middle class and affluent away from it and into private financing alternatives. This can only be achieved by imposing a strong means test, eliminating all eligibility loopholes, and strictly enforcing estate recovery rules. There is no other option. We have to give Medicaid back to the poor and show everyone else how to plan ahead and remain self-sufficient.

We cannot compel middle-class Americans to impoverish themselves, however, before they receive any assistance from their government. That policy already failed. It invites resentment, fraud, and legal circumvention of the rules. Instead, we must provide a kinder alternative to families who need long-term care, but cannot afford to pay for it without devastating themselves financially.

Given the precarious state of government entitlements, however, public funding for a new middle-class long-term care program is nonexistent. Any new program will have to pay its own way. Fortunately, adequate privately-held resources are readily available in this country to finance market-driven supportive housing and long-term care. In fact, $1.5 trillion lies illiquid and untapped today in seniors' home equity alone and another $10 trillion is about to fall into the laps of the baby boomers in

the form of inheritance. The secret is to unlock these resources and put them to work paying for long-term care. Forcing seniors to sell their homes or consume their estates before they can get help is not an acceptable strategy, however. The desire to preserve the family homestead and pass on a legacy is too deeply ingrained in American culture. We must find a more creative, less draconian approach. We recommend ***LTC Choice***.

LTC Choice

How can America afford universal access to top-quality long-term care?

A better approach to long-term care financing is to let seniors keep their income and assets (including their homes) as long as these resources are needed to support themselves or their immediate dependents. When someone requires care for which the family has insufficient cash flow to pay, let the government guarantee payment of the bill for whatever private service the family chooses. Simultaneously with the initiation of this public assistance, tally the family's income and assets, secure the entire estate with a binding legal encumbrance, and subtract the government-sponsored contributions from the ledger every month. Whatever the family is able and chooses to contribute toward the cost of care is not subtracted from the ledger. Everything the government or its agent contributes plus interest depletes their estate and is recovered upon the death of the last surviving exempt dependent relative. If the ledger is depleted entirely, then the family is completely destitute and eligible for a newly reformed and financially reinvigorated Medicaid program, *i.e.*, welfare.

This approach, call it ***LTC Choice***, has many advantages over the current situation. Middle-class seniors regain their dignity: it is not welfare if you pay it back. Vulnerable elderly people get red-carpet access to top-quality care: there is never a shortage of preferred long-term care beds or services for full-paying customers. Consumers return to the market place: someone else may pay the monthly bill, but it all comes out of the family's estate in the long run, so buyers will be wary of price and quality. Providers receive the full market price for their services: home care companies, assisted living facilities, nursing homes, and even hitherto unforeseen purveyors of housing and care will compete avidly to offer the best possible services for the lowest possible fee. Government and the taxpayers save money: the

only up front cost, which is more than compensated by savings in the old Medicaid colossus, is a loan guarantee program to attract private lenders to fund the fully collateralized system.

The biggest advantage to ***LTC Choice***, however, is the change in consumer behavior it will engender. Families will know with strict certainty that they cannot ignore the substantial risk of long-term care. The choices will become stark for 40- and 50-year-olds. Plan now and buy insurance while you are young and healthy and good coverage is inexpensive. Or, take your chances, hope for the best, accept a dollar for dollar loss to your estate if you ever have to rely on the public program, and explicitly assume the risk that you may ultimately lose everything, including your home equity, and become dependent on welfare.

Confronted with genuine risk like this, more people will choose to insure privately than in the past. Fortunately, good insurance policies that cover home care, assisted living, and nursing-home care are already easily available and affordable to most non-elderly people. Those who cannot afford coverage, such as many older people, may seek private home equity conversion to generate a sufficient cash flow to pay their premiums. Heirs, especially adult children who will stand to lose their inheritances entirely otherwise, are likely to encourage their elders to purchase insurance coverage and may also help to pay the premiums. Instead of rewarding people for ignoring the risk, avoiding the premiums, and taking advantage of the public dole as the current system does, this approach rewards responsibility and exacts a gradual and predictable penalty for irresponsibility.[10]

---

[10] One sure way to derail the privatization of long-term care financing and destroy its promise is to make publicly-financed long-term care even more attractive to consumers than it already is. The damage done by easily accessible Medicaid nursing-home benefits has been mitigated by the fact that most people do not want to go to nursing homes. If grand plans now under discussion to pool Medicaid and Medicare monies and provide home- and community-based services for dual eligibles are implemented without a strongly enforced means test and mandatory estate recovery, dire consequences

Obviously, for ***LTC Choice*** to succeed, it cannot be abused and manipulated as Medicaid has been. We will have to assure that the public understands the high probability of needing long-term care and that individuals and families, not the government, are primarily responsible for this huge potential expense. Therefore, before they are too old, frail or sick to save or insure for their own protection, the federal government should deliver comprehensive information on long-term care to aging Americans and require them to make a tough choice about how they intend to protect themselves from this risk. The tough choice is whether or not they will insure privately or rely on the ***LTC Choice*** program. If they insure privately, or earmark sufficient assets permanently for long-term care, their problem is solved. If they choose to rely on the government-backed ***LTC Choice*** program, they must report annually on their income and assets in order to secure their estates as collateral and to eliminate the problem of artificial self-impoverishment which has plagued the Medicaid program. Of course, every American will always be free to dispose of personal wealth as he or she sees fit. The ***LTC Choice*** program merely requires that no one who expects to receive public assistance in the future may spend, divest, divert or shelter wealth that could have been used to pay for long-term care.

The best time to present these hard realities of long-term care to the public is as early as possible, but no later than when they sign up for Social Security and Medicare. At this time of life, seniors and their families are most sensitive to the financial and health security challenges of aging. Most

---

will follow. Expanded public financing for more desirable kinds of care will not merely exacerbate the "woodwork factor" of induced demand as other writers have warned, it will make Medicaid estate planning more attractive to consumers and more lucrative to elder law practitioners. It will inhibit the market for privately-financed chore services, home care, assisted living, and geriatric care management. And it will decimate demand for private long-term care insurance. Public benefits have always been and will always remain starved for financing. Our only hope to achieve a fully financed, universally available, comprehensive long-term care service delivery system is to draw as heavily as possible on private financing and depend on public resources only to cover the interstices of need left unfilled by the private

of them remain relatively secure financially and insurable. When it sends information on Medicare and Social Security to aging Americans, the federal government should also provide advice and guidance on the risks and costs of long-term care, on low-cost home- and community-based services options, on home equity conversion, on private long-term care insurance and on the ***LTC Choice*** alternative once it is enacted.

---

market.

Conclusion

Do we have the courage of our convictions?

Long-term care for a rapidly aging population presents an enormous challenge to the United States. Our country must meet this challenge while simultaneously confronting similar strains on Social Security and Medicare. To preserve our prosperity and protect our elderly, we will need to reassert the traditional values of freedom, independence, and individual responsibility that brought economic greatness to America in the first place. A simple public policy, with which most of our countrymen will agree, would suffice to achieve this goal if unstintingly observed:

> We have very limited dollars available for public assistance. We must take care of the truly poor and disadvantaged first. The middle class and well-to-do should pay privately for long-term care to the extent they are able without suffering financial devastation. Prosperous people who rely on public assistance for long-term care should reimburse the taxpayers before giving away their wealth to heirs. Seniors and their heirs who wish to avoid such recovery from their estates should plan ahead, purchase private long-term care insurance, and pay privately for the care of their choice when the time comes.

LTC Choice is a viable, simple, and cost-free means to implement this policy and solve the long-term care financing puzzle once and for all. We need only the vision to see the way, the courage to embrace the change, and the will to follow the course.