

The Myth of Unaffordability:

How Most Americans Should, Could, and Would Buy Private Long-Term Care Insurance

Presented by the

Center for Long-Term Care Financing

“Dedicated to ensuring quality long-term care for all Americans”

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Executive Summary

The publisher of this report—the Center for Long-Term Care Financing in Seattle, Washington—is dedicated to ensuring high quality long-term care for all Americans.

The global aging crisis is a demographic vise closing rapidly and inexorably on America and the world.

In the United States, challenges to our pension (Social Security) and health care (Medicare) entitlement programs capture most of the public's attention.

In the end, however, the paramount problem of aging demographics is long-term care and how to pay for it.

Unfortunately, long-term care service delivery and financing in America are already fragmented and dysfunctional. They continue to decline.

Medicaid and Medicare—the principal public financing sources for long-term care—pay too little for nursing home and home care to assure public access to quality care.

Private financing, including long-term care insurance, remains inadequate to support the home and community-based services and assisted living that most seniors prefer.

Nevertheless, America's World-War-II generation is dying in nursing homes on public assistance while their baby-boomer children blithely ignore the risks of long-term care.

Why do most Americans evade the risk of long-term care and fail to plan, save and insure before the chronic illnesses of old age befall them?

The usual answer—"They're in denial"—begs the question "How can they ignore a nine percent risk of spending five years or more in a nursing home after age 65 at \$50,000 per year?"

The other commonplace answer—"Most people cannot afford to buy private long-term care insurance"—is demonstrably untrue as this report substantiates.

The real reason Americans fail to prepare for the risk of long-term care is twofold:

First: since 1965, they have been able to ignore this risk, avoid the premiums for private insurance, wait until they need long-term care, and get Medicaid and Medicare to pay.

Second: the insurance industry has tried to sell asset protection (which the government is giving away) instead of emphasizing its unique benefit—access to quality care at the optimal level.

The solution to the long-term care financing problem is also twofold:

First: the government should redesign Medicaid to be a loan instead of a grant (for anyone with assets) and simultaneously educate the public about the real risk of long-term care.

Second: the long-term care insurance industry should market much more heavily the crucial benefit of access to quality care at the appropriate level in the private marketplace.

This report demonstrates and documents the fact that most Americans should, could and would purchase private long-term care insurance if the right public policy incentives obtained.

When most Americans *do* purchase long-term care insurance, the public financing programs will be better able to provide for those who are unable to pay privately for their care.

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Preface

This report is the second public policy paper of the Center for Long-Term Care Financing in Seattle, Washington. 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 private insurance and investment can assure 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 an on-line newsletter called *LTC Bullets*, which covers the latest information and trends in long-term care financing. This publication is available free of charge. See the "Appendix" of this report for examples of past issues of *LTC Bullets*.

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 Master of Social Work 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.

For more information about the Center for Long-Term Care Financing, including archives of *LTC Bullets*, an annotated bibliography of our research and publications with ordering information, and extensive quotes by and about Medicaid estate planners, consult the Center's web site at www.centerltc.com.

The Center for Long-Term Care Financing expresses our appreciation to Claude Thau, Senior Officer for Long Term Care at the Transamerica Life Companies, for his extensive and very helpful comments on a draft of this report.

Introduction

This report explains why most Americans do not respond rationally to the problem of long-term care financing. In the face of a huge risk of large expenses, they do not usually save or insure for long-term care. In small, understandable steps this report takes the reader from a gargantuan global crisis down to the manageable challenge of a very real personal problem for every American. It offers solutions for public policy and for individuals and their families.

The report explicates and explodes the last ostensibly credible objection to long-term care insurance, *i.e.*, The Myth of Unaffordability. Finally, it shows how to save public long-term care financing for the needy, by unleashing private long-term care insurance for everyone else.

“The Myth of Unaffordability: How Most Americans Should, Could and Would Buy Private Long-Term Care Insurance” is structured as a series of questions—the kind of questions that might be asked by a citizen, a reporter, a government official, or an insurance prospect, agent, or executive. Questions and answers are presented in logical sequence, but they stand alone as independent topics of discussion. Extensive footnotes provide germane documentation. We intend this background material to be a useful resource for writers, policy makers, legislators, insurance companies, senior advocates and anyone else who needs to understand the complexities of long-term care financing policy.

This report is not a primer, although it only assumes an elementary knowledge of long-term care service delivery, financing and insurance. Readers unfamiliar with these subjects should review one of the many “buyers’ guides” to long-term care insurance published by the National Association of Insurance Commissioners, the Health Insurance Association of America, the United Seniors Health Cooperative and many other similar organizations. All of these groups are based in Washington, D.C.¹

Like the fable of the three blind men who identify an elephant as a hose, a tree, or a wall depending on which part of the animal’s anatomy they touch, America’s complicated long-term care problem lends itself to multifarious diagnoses and prescriptions. An analyst who focuses on access and quality problems may conclude that the government does not spend enough money on long-term care. Another analyst, who emphasizes independence and personal responsibility, might think the insurance industry has failed to market private long-term care insurance effectively. A third, riveted by the burdens of care giving and the tragedy of elder abuse, could reasonably blame the inadequacy of public *and* private long-term care financing. Yet none of these would identify the real problem, much less the solution. To do that, we must step back, put the facts in perspective, and then analyze what we know. That is the intention of this report.

¹ For a commercial guide to long-term care insurance, see Phyllis R. Shelton, *Long-Term Care Planning Guide*, Nashville, Tennessee, 1999 available from Shelton Marketing Services, Inc., P.O. Box 17526, Nashville, TN, 37217-0526. Another good source is Jason G. Goetze, *Long-Term Care*, Dearborn Financial Publishing, Inc., 1999, 1-800-423-4723.

The Myth of Unaffordability: How Most Americans Should, Could and Would Buy Private Long-Term Care Insurance

What is the single biggest challenge humanity faces?

Take your pick. Some observers might suggest global warming, nuclear proliferation, pollution, terrorism, or any number of other daunting challenges. Yet all these and most other major worldwide problems admit of some measure of uncertainty regarding their long-range impact or they are amenable to some measure of amelioration. We face one danger, however, that is bearing down on us with all the certainty of causation, and which we cannot escape.² This danger is the global aging crisis.

Whether we trace the cause to medical advances, falling fertility rates, increasing affluence, or aging baby booms in ours and many other countries, the statistics on global aging are truly frightening. The proportion of elderly people has spiked from one in 40 historically to one in ten today and may go as high as one in three in the future. Global life expectancy may increase another seven or eight years in the next three decades.³ At the same time, worldwide fertility rates are plummeting, down from five children per woman 30 years ago to 2.7 today and only 1.6 in the developed countries...well under the rate of replacement.⁴

By 2030, with more elderly, fewer young people, and no changes in entitlement programs, governments will have to compel the average working couple to pay the pension and health needs of one retiree. The “old-old” (people over 85 years of age), who consume almost four times as much health care as the general population, will increase six-fold within 50 years.⁵ Unfunded entitlement liabilities in the developed countries total \$70 trillion (with a T): half for pensions and half for health care.⁶ The world is rendezvousing with demographic destiny and a collision is just around the next historical corner.

² “The elderly of the first half of the next century have already been born and can be counted—and the retirement benefit systems on which they will depend are already in place [p. 4].... Unlike many predictions about the future, global aging is about as close as social science ever comes to a certain forecast. Absent a Hollywood catastrophe—a colliding comet or an alien invasion—it will surely happen. In fact, it is already happening. The reason is simple: Future 65-year-olds are already born.” [p. 59] Peter G. Peterson, *Gray Dawn: How the Coming Age Wave Will Transform America—and the World*, Times Books, New York, 1999.

³ “Scientists have had astonishing success in recent years in increasing the life spans of laboratory species like worms and fruit flies.... Future generations...may be able to avail themselves of scientifically established techniques to stretch the human life span like a piece of taffy until it reaches 150, even 200 years.... Fundamental questions remain unanswered, but the scientists say, the general direction is clear. For now, what they have is proof of principle and a staggering vision of the future.” Gina Kolata, “Pushing Limits of the Human Life Span,” *New York Times on the Web*, March 9, 1999, <http://www.nytimes/library/national/science/030999sci-aging.html>.

⁴ “Forty-four percent of the world’s population already lives in countries with fertility below the replacement rate.” Peterson, *Gray Dawn*, *op. cit.*, p. 52.

⁵ “Because the elderly spend about 3 1/2 times as much per capita on medical care as do the non-elderly population, aging has profound implications for medical care spending.” Council of Economic Advisers (CEA), *The Annual Report of the Council of Economic Adviser*, U.S. Government Printing Office, Washington, D.C., 1985, p. 130.

⁶ “For the developed countries, the unfunded liabilities for pensions alone are about \$35 trillion. Including healthcare, the figure is at least twice as much.” Peterson, *Gray Dawn*, *op. cit.*, p. 18.

How does the crisis of aging demographics affect the United States?

Actually, the aging crisis America faces is less severe than the one many other nations confront. We are aging slower; our birthrates are higher; we admit more young immigrants; our public pension benefits are stingier; and our private pension systems are stronger.⁷ We have known about the problem for a long time.⁸ Nevertheless, the challenge of an aging society is also huge for us. It has two aspects: demography and dependency.

Demography tells us that the United States will soon experience an explosion in the absolute number and in the proportion of elderly people. Within 45 years, we will have 40 million more Americans over the age of 65, more than doubling their census. The elderly cohort is growing five to eight times faster than the working-age population. Baby boomers, born between 1946 and 1964, who made America famous as a youth culture, are already turning 50 at the rate of one every seven seconds. The senior boomers are rapidly approaching.⁹

Dependency occurs when burgeoning numbers of old people and declining ratios of younger workers intersect with generous entitlement programs and high tax burdens. By official projections, the cost of Social Security and Medicare will rise from 17 percent of taxable payroll currently to between 35 and 55 percent in 2040.¹⁰ According to Peter G. Peterson, writing in *Will America Grow Up Before It Grows Old*: “[A]n irresistible force will soon meet an immovable object as the Baby Boomers retire and demand the benefits they have been promised and exert the political clout to collect them.”¹¹

⁷ “In most of the other developed countries, populations are aging faster, birthrates are lower, the influx of younger immigrants from developing countries is smaller, public pension benefits for senior citizens are more generous, and private pension systems are weaker.” *Ibid.*, p. 6.

⁸ Concerns about the crisis in aging demographics are nothing new as this quote from the 1985 *Annual Report of the Council of Economic Advisers* indicates: “The proportion of the population that is elderly is growing; it will explode as the baby-boom generation retires.... No other demographic change will influence the Nation in the next 50 years as much.... Every American and every facet of the society will be affected.” Council of Economic Advisers, *The Annual Report of the Council of Economic Advisers*, U.S. Government Printing Office, Washington, D.C., 1985, p. 160.

⁹ “The older population—persons 65 years or older—numbered 33.5 million in 1995. They represented 12.8% of the U.S. Population, about one in every eight Americans.... Since 1900, the percentage of Americans 65+ has more than tripled (4.1% in 1900 to 12.8% in 1995), and the number has increased nearly eleven times (from 3.1 million to 33.5 million).... By 2030, there will be almost 70 million older persons.... People 65+ are projected to represent 13% of the population in the year 2000 but will be 20% by 2030.... [pps. 1-2] The older population itself is getting older. In 1995, the 65-74 age group (18.8 million) was eight times larger than in 1900, but the 75-84 group (11.1 million) was 14 times larger and the 85+ group (3.6 million) was 29 times larger.” [p. 2] 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>.

¹⁰ “By 2040, the cost of Social Security as a share of workers’ payroll is projected to rise from today’s 11.5 percent to 17 or 22 percent—depending on whether you accept SSA’s ‘intermediate’ or ‘high-cost’ projection. Add to this both parts of Medicare, which currently cost the equivalent of 5.3 percent of payroll but are growing so rapidly that they will eventually overtake and surpass Social Security in size, and we’re talking about 35 to 55 percent of every worker’s paycheck before we even start to pay for the rest of what government does.” Peter G. Peterson, *Will America Grow Up Before It Grows Old?: How the Coming Social Security Crisis Threatens You, Your Family, and Your Country*, Random House, New York, 1996, pps. 34-35.

¹¹ *Ibid.*, p. 9.

Some experts debunk the gravity of the impending crisis in aging demographics and dependency. Robert Friedland and Laura Summer of the National Academy on an Aging Society recently published a study entitled *Demography is Not Destiny* in collaboration with 11 prominent public policy experts. They concluded that:

There is reason to be concerned about growth in [entitlement] expenditures, but there is more reason to be concerned about economic growth. With little economic growth society faces a significant challenge; with sufficient economic growth the challenge is considerably smaller.... If the economy grows on average 2.8 percent per year between now and 2030, then projected government expenditures will be the same proportion of the economy in 2030 as today, even assuming substantial entitlement spending growth.¹²

One fallacy in this argument is that real economic growth in the United States fell from 4.5 percent per year in the 1960s when entitlement spending really began escalating to 1.9 percent in the 1990s as of 1997.¹³ The heavy payroll and income taxes needed to sustain large and growing entitlement programs have dragged the economy down for decades. Increases in workforce productivity and economic growth in the last two years correspond with concerted efforts to reduce welfare spending and to confront the unsustainable burdens of social insurance programs like Medicare and Social Security.

Economic productivity and social insurance are in counterpoise. To suggest that thriving economic growth can sustain the excessive government spending that causes economic under-performance is illogical and evasive.¹⁴ Such reasoning puts the cart before the horse. Economic policies that encourage private savings and investment while minimizing dependency on social insurance and welfare are prerequisites to achieve the level of economic growth necessary to sustain critical public spending.

¹² Robert B. Friedland and Laura Summer, *Demography is Not Destiny*, National Academy on an Aging Society, Washington, D.C., January 1999, p. 3.

¹³ *Ibid.*, p. 20.

¹⁴ “Wall Street has yet to react to these obviously unfinanceable numbers. But it will. Since financial markets try to anticipate future events, the reaction will surely come years before the first Boomers start retiring on Social Security in 2008, when and if the markets determine that America has irretrievably lost any chance to deal with this challenge in advance.... [p. 34] The same psychology of denial that sustains our present system also increases the risk that financial markets will march off a cliff. This could happen as soon as 2005, when first-born Boomers start withdrawing funds from their 401(k)s and Keoghs. Or in 2011, when they reach age sixty-five. Or in 2013, when Social Security is projected to run its first cash deficit. As all financial analysts are aware, it’s never easy to predict the timing of the market’s response to economic and fiscal developments, even if its ultimate destination is perfectly clear.” [p. 210] Peterson, *Will America Grow Up*, *op. cit.*

What is the biggest age-related challenge America faces?

The sleeping giant of all U.S. social problems is long-term care. Long-term care may be defined as “a wide range of medical and supportive services for individuals who lack some capacity for self-care, and are expected to need care for an extended period of time.”¹⁵ The need for long-term care is directly related to age. For example, the incidence of Alzheimer’s Disease¹⁶ and nursing home institutionalization¹⁷ tends to double approximately every five years after the age of 65. Given the rapidly increasing proportion of elderly Americans, the need for long-term care is likely to grow exponentially in the decades ahead. The cost will be immense and the government will have to struggle mightily to pay as much,¹⁸ if not more of it in the future.¹⁹

Although most long-term care is provided informally in the home by relatives and friends, the number and variety of venues for formal care are increasing rapidly. They include nursing home care, assisted living, adult day care, and home health care, among many others. Nursing home care is the most prevalent and most expensive level of formal long-term care. On average, after age 65, individuals have a 43 percent probability of spending some time in a nursing home.²⁰ The risk is somewhat higher for women and lower for men, because men tend

¹⁵ Dale Larson, *A Comprehensive Guide to Medicare and Health Insurance for Older People*, LTC, Inc., Kirkland, Washington, 1987. A fuller definition from the same source: “In its broadest sense, long term care refers to a whole range of complex and interrelated health care, health related, custodial care, and social services, provided formally, or informally, and designed to provide preventive, therapeutic, rehabilitative, supportive and maintenance care for individuals of all ages who have chronic physical and/or mental conditions which impair the individual’s ability to function at his or her optimum levels of mental, physical and social functioning, or to provide self-care.”

¹⁶ “A continuing study of an elderly population indicated that the annual incidence of Alzheimer’s disease may be higher than previously thought.... Researchers...found that among people in their 60s about 0.6% are developing Alzheimer’s disease each year.... This annual incidence rises steadily to 1% a year for those in their early 70s and to 2% annually for those in their late 70s. The yearly incidence of the memory disorder for those in their early 80s climbs to 3.3% and surges to 8.4% for those over 85 years of age.... By 70 years of age, 4.7% of the elderly had developed the disorder. Among those reaching 80 years of age, 18% had developed Alzheimer’s disease, and of those living 90 years, half had developed the disorder.” *Wall Street Journal*, May 5, 1995, p. B3.

¹⁷ “While a smaller number (1.6 million) and percentage (5%) of the 65+ population lived in nursing homes in 1990, the percentage increased dramatically with age, ranging from 1% for persons 65-74 years to 6% for persons 75-84 years and 24% for persons 85+.” 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/profil196.html>, p. 4.

¹⁸ “By 2020, it is expected that there will be twice as many Americans ages sixty-five and older who need some type of long-term care services, increasing from 7 million today to more than 14 million. Maintaining the moderate growth rate for Medicaid spending will continue to be a challenge for states.” “The Fiscal Survey of States: December 1998,” National Governors’ Association,” cited in *LTC News & Comment*, February 1999, Vol. 9, No. 6, p. 10.

¹⁹ “The biggest *uncovered* item is *long-term care* for elders who don’t or won’t qualify for public assistance. And this is a big item indeed. In the United States, the growth in total spending on formal long-term care over the next forty years is expected to amount to roughly 4 percent of GDP. Government now expects to pay for only half of this cost increase—and provide no help for the even greater increase in informal care within ordinary families. In an aging world full of two-earner couples and short of potential caregivers, government may be forced to pay a much larger share of the long-term care burden.” Peterson, *Gray Dawn, op. cit.*, p. 70.

²⁰ “For persons who turned 65 in 1990, we project that 43 percent will enter a nursing home at some time before they die. Of those who enter nursing homes, 55 percent will have total lifetime use of at least one year, and 21 percent will have total lifetime use of five years or more.” Peter Kemper and Christopher M. Murtaugh, “Lifetime Use of Nursing Home Care,” *New England Journal of Medicine*, Vol. 324, No. 9, February 28, 1991, p. 595.

to die sooner and women tend to take care of them in the meantime. Most nursing-home stays are short-term and do not therefore create a catastrophic financial burden. Some stays, however, are long-term and do. Based on past experience, nine percent of seniors can expect to spend five years or more in a nursing home.²¹ The average cost of a nursing home in the United States in 1999 is at least \$50,000 per year (\$136 per day)²² although the range easily covers \$30,000 to \$80,000. Most nursing home care is paid for by Medicaid (over two-thirds of all patients and four-fifths of all patient days)²³ or Medicare (12.3 percent of total costs).²⁴

Assisted living is one of the newest, most popular and fastest growing methods of long-term care delivery. Assisted living facilities might be compared to a hotel in which one may call room service for assistance in taking a bath or “leave a call” to be reminded to take a medication. They are designed to be more home-like and less like a hospital than the traditional nursing home. The average cost of an assisted living facility is \$67 per day or \$24,433 per year.²⁵ Over 90 percent of all assisted living facility services are privately financed.

Adult day care, as the name implies, is similar to day care for children in that it provides a safe environment, activities and meals during the day while the primary caregiver is away at work. Adult day care is almost exclusively privately financed. Home health care, which enjoyed explosive growth for the past ten years, is very popular with most families. Until recently, Medicare was quite generous in financing this level of care. Lately, Medicare has cut back

²¹ “We project that almost one third of all persons who reached 65 years of age in 1990 will spend at least three months in a nursing home during their lifetimes; 24 percent, at least a year; and 9 percent, at least five years.” *Ibid.*, p. 597.

²² This estimate is based on a conservative projection from the Health Care Financing Administration’s estimates of \$47,000 per year and \$129 per day as of 1996: “Spending for freestanding nursing home care amounted to \$78.5 billion in 1996, implying an estimated cost of a 1-year stay in a freestanding nursing home in excess of \$47,000 [or \$129 per day].” Katherine R. Levit, *et al.*, “National Health Expenditures, 1996,” *Health Care Financing Review*, Vol. 19, No. 1, Fall 1997, p. 161. Total spending for nursing home care increased in 1997 to \$82.8 billion, an increase of 5.5 percent over 1996. Assuming that the cost of a one-year stay increases in proportion with total nursing home costs, the average annual cost of a nursing home stay would have nearly reached \$50,000 by 1997 and the costs are going up every year:

“The Consumer Price Index, which measures out-of-pocket payments for nursing-home care and adult day care, grew 4.8% last year. It grew 2.3% in 1997. The index has been in existence for only these two years. This growth reflects across-the-board growth of healthcare, although at a much slower rate. The CPI for LTC declined 0.2% during October. The medical CPI increased 3.4% during 1998. 95% of the CPI for nursing-home care and adult day care is weighted to nursing homes. There has yet to be a CPI developed for home care. [Source: Bureau of Labor and Statistics.]” Cited in “CPI for LTC Grows 4.8% During 1998,” *LTC News & Comment*, March 1999, Vol. 9, No. 7, p. 11.

²³ “Persons enrolled in Medicaid represented two-thirds of nursing home users and used over 80 percent of total days of nursing home care.” S. Feinleib, P. Cunningham, and P. Short, *Use of Nursing and Personal Care Homes by the Civilian Population, 1987* (AHCPR Pub. No. 94-0096), National Medical Expenditure Survey Research Findings 23, Agency for Health Care Policy and Research, Rockville, MD: Public Health Service, August 1994, p. 4. The percentage of nursing home patients receiving Medicaid jumps to 78.6% for full-year residents, and falls to 53.1% and 57.9% for admissions and discharges respectively. In other words, the more expensive, long-term patients tend to be on Medicaid, whereas the cheaper, short-term patients pay privately or have Medicare coverage. [*Ibid.*, p. 10]

²⁴ Medicare paid 12.3 percent of nursing home costs in 1997 (<http://www.hcfa.gov/stats/nhe-act/tables/t15.htm>), up from 1.5 percent in 1985.

²⁵ Margaret A. Wylde, *National Survey of Assisted Living Residents: Who is the Customer?*, National Investment Conference for the Senior Living and Long Term Care Industries, Annapolis, Maryland, 1998, pps. viii.

severely on home health services placing a tremendous burden on home health agencies and the families they serve.²⁶

In summary, long-term care is already a big problem, but the aging of the population will make it a genuine crisis soon. Long-term care is expensive and it drains public and private pocketbooks alike. Public financing of long-term care is most available for nursing home care, which the public prefers least.²⁷ To obtain the most desirable and popular kinds of care, such as assisted living and home care, people increasingly must be able to pay privately. A major theme of this report is that the availability of public financing—even for the kind of care the public prefers to avoid—reduces the availability of private financing which people need in order to purchase the care they prefer.

What are the current effects of and the future prospects for public financing of long-term care?

Medicare is expected to become insolvent by 2015. Social Security limps along until 2034, assuming the federal government can make good on the IOUs in the so-called “trust fund.”²⁸ How long can Medicaid, which pays for over two-thirds of all nursing home patients in the U.S.,²⁹ hang on before joining the social insurance programs in bankruptcy?

Long-term care is not at the top of the public policy agenda yet for the same reason Medicare and Social Security were not there until recently.³⁰ The political courage to confront a

²⁶ “A shakeout in the home health-care industry is forcing providers to cut back services and disrupting the lives of the elderly and disabled people they care for. At the heart of the turmoil is a sharp reversal in federal policy: After a decade that saw Medicare spending for home health care grow 10-fold, the government is clamping down. Last year’s balanced budget agreement included a \$16.2 billion package of cuts in federal home healthcare outlays over five years.... ‘This is a time of bitter medicine, because the spending growth in the program wasn’t sustainable,’ says NancyAnn DeParle, administrator of the Health Care Financing Administration, which runs Medicare. ‘With home-care spending increasing 30% a year and a big percentage thought to be unnecessary or fraudulent,’ Ms. DeParle says, officials have little choice but to rein in the spending spree. Last year, Medicare home-care outlays totaled \$20 billion, compared with \$2.1 billion in 1988.” *Wall Street Journal Interactive Edition*, 5/1/98.

²⁷ “Surveys find that most people would rather continue living at home than go to a nursing home.... [T]he aversion to such a facility is so strong that a new study of seriously ill people in hospitals found that 30 percent of those surveyed said they would rather die than live permanently in a nursing home.” *New York Times*, August 6, 1997, p. B9, based on findings published in the July 1997 issue of the *Journal of the American Geriatrics Society*.

²⁸ “Relieving some of the political pressure for reform, the government released new actuarial studies Tuesday extending the date at which Medicare can be expected to run out of money by seven years and Social Security insolvency by two years.... [W]ithout any changes in law, the trustees found, the Medicare system should have enough money to pay full benefits until 2015 and the Social Security system should be in the black until 2034. Last year at this time, they projected the insolvency dates to be 2008 for Medicare and 2032 for Social Security.” *New York Times*, March 31, 1999, <http://www.nytimes.com/library/politics/033199socsec-report.html>.

²⁹ “In 1997, nursing facilities reported that their resident census was 9.3 percent Medicare beneficiaries, 67.6 percent Medicaid beneficiaries, and 23.2 percent private-pay or other payer source residents.” K. Jeannine Dollard, *Facts and Trends: The Nursing Facility Sourcebook, 1998*, American Health Care Association, Washington, D.C., 1998, p. iv. The states with the highest percentage of Medicaid residents are Georgia (77.3%), Mississippi (77.7%), Alaska (79.7%), Louisiana (80.6%), and Washington, D.C. (83.9%). The states with the lowest percentage of Medicaid residents are Iowa (52.7%), Delaware (51.6%), Kansas (52.7%), Nebraska (53.4%), and North Dakota (55.2%). *Ibid.*, p. 63.

³⁰ Nevertheless, long-term care is finally beginning to get the attention it deserves in the media and public policy. See, for example, “LTC Bullet #59: LTC is Hot!” in the “Appendix” of this report.

social problem is inversely proportional to the gravity of the problem and to the length of time before a crisis will occur. The long-term care financing problem compares with Medicare and Social Security in magnitude and the meltdown will come much later. No wonder long-term care is the only “third rail” that still retains a lethal political charge. Politicians figure it can wait.

They are wrong! Today’s 77 million baby boomers start turning 85 years of age in 2030. If past history holds true, more than 20 percent of people over 85 will reside in nursing homes.³¹ By 2030, all the boomers will be over age 65, and roughly five percent of them may already reside in nursing homes.³² Researchers predict that nine percent of people over the age of 65 will spend five years or more in a nursing home.³³ Nursing home care already averages \$50,000 per year (\$136 per day), up from \$31,390 per year (\$86 per day) in 1990.³⁴ If 70 million boomers make it to senior status (over 65) and the researchers are right about the incidence of nursing home care, then almost seven million of the boomers will experience long-term stays costing at least \$250,000 each in today’s dollars. That totals up to \$1.75 trillion. If you add in the cost of (1) nursing home stays lasting less than five years, (2) the popular, new option of assisted living, and (3) home health care, the total liability for long-term care is truly staggering.

So, how long can Medicaid survive as the payer of last resort for long-term care? The United States spent \$82.8 billion on nursing home care in 1997, up from \$30.7 billion in 1985, an increase of 270 percent. HCFA estimates nursing home costs will rise to \$148.3 billion by 2007.³⁵ Of the total spent in 1997, Medicaid paid 47.6 percent, practically unchanged from 47.2 percent in 1985. Medicare, however, paid 12.3 percent, up from 1.5 percent in 1985. Together, these two big public payers contributed 59.9 percent of the total cost of nursing home care in the United States in 1997, up from 48.7 percent in 1985. Clearly, public financing of nursing home care has been increasing rapidly as a proportion of total costs. The relevant portion of the table

³¹ “The findings [from the 1987 National Medical Expenditure Survey] show that nursing home use is a rare event in any given year; less than 1 percent of the total civilian population used a nursing home at any time in 1987. Even among persons age 65 and over, only about 7 percent used a nursing home in 1987. However, the likelihood of nursing home use was much higher for the oldest age cohort; almost one-fourth of the population ages 85 to 89 and 42 percent age 90 and over were nursing home users.” S. Feinleib, P. Cunningham, and P. Short, *Use of Nursing and Personal Care Homes by the Civilian Population, 1987* (AHCPR Pub. No. 94-0096), National Medical Expenditure Survey Research Findings 23, Agency for Health Care Policy and Research, Rockville, MD: Public Health Service, August 1994, p. 14.

³² “While a smaller number (1.6 million) and percentage (5%) of the 65+ population lived in nursing homes in 1990, the percentage increased dramatically with age, ranging from 1% for persons 65-74 years to 6% for persons 75-84 years and 24% for persons 85+.” 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. 4.

³³ “We project that almost one third of all persons who reached 65 years of age in 1990 will spend at least three months in a nursing home during their lifetimes; 24 percent, at least a year; and 9 percent, at least five years.” Peter Kemper and Christopher M. Murtaugh, “Lifetime Use of Nursing Home Care,” *New England Journal of Medicine*, Vol. 324, No. 9, February 28, 1991, p. 597.

³⁴ See footnote 22.

³⁵ Extracted June 8, 1999 from <http://www.hcfa.gov/stats/NHE-Proj/tables/t10A.htm>, “Table 10a: Nursing Home Care Expenditures, Average Annual Percent Change, Percent Distribution and Per Capita Amounts, by Source of Funds: Selected Calendar Years 1970-2007.”

published by the Health Care Financing Administration from which this data was extracted follows.³⁶

Table 7										
Nursing Home Care Expenditures Aggregate and Per Capita Amounts and Percent Distribution, by Source of Funds: Selected Calendar Years 1960-97										
Year	Total	Out of Pocket Payment	Third Party Payments					Medicare	Medicaid	
			Total	Private Health Insurance	Other Private Funds	Government				
						Total	Federal			State & Local
Amount in Billions										
1985	30.7	13.6	17.1	0.8	0.6	15.7	9.2	6.5	0.5	14.5
1997	82.8	25.7	57.0	4.0	1.6	51.4	34.5	16.9	10.1	39.4
Percent Distribution										
1985	100.0	44.3	55.7	2.7	1.8	51.2	29.9	21.2	1.5	47.2
1997	100.0	31.1	68.9	4.9	1.9	62.2	41.7	20.4	12.3	47.6
SOURCE: Health Care Financing Administration, Office of the Actuary, National Health Statistics Group										

What about private financing of nursing home care? Just the opposite holds true. Out-of-pocket nursing home expenditures have fallen from 44.3 percent of the total in 1985 to 31.1 percent in 1997. Furthermore, a large proportion of these so-called “out-of-pocket” costs—possibly as much as two-fifths—are really just “spend-through” of Social Security income that people who are on Medicaid already must contribute toward their cost of care.³⁷ (This explains why Medicaid pays for over two-thirds of all nursing home patient days, but contributes only 48 percent toward the total cost of nursing home care.) In other words, after you deduct the direct and indirect public contributions to nursing home care from the total, very little remains to constitute a genuine out-of-pocket cost to private individuals that might heighten their sense of urgency about the need for early long-term care planning.

If the rate of decline in private out-of-pocket financing of nursing home care were to continue at the same, steady, gradual rate of the past 12 years, out-of-pocket nursing home expenditures would decline to zero by the year 2025. If the rate of increase in public financing of nursing home care were to continue at its same, steady, gradual rate of the past 12 years, Medicare and Medicaid financing of nursing home care would increase to 86 percent by the year 2025. Obviously, neither of these scenarios will occur. As a sage once said, “trends that cannot continue, won’t.” Indeed, public financing of long-term care is already showing terrible strains.

³⁶ Extracted June 8, 1999 from <http://www.hcfa.gov/stats/nhe-oact/tables/t15.htm>, “Table 7: Nursing Home Care Expenditures Aggregate and Per Capita Amounts and Percent Distribution, by Source of Funds: Selected Calendar Years 1960-97.”

³⁷ Although Social Security is not usually considered to be a financing source for nursing home care, the fact is that it contributes very significantly albeit indirectly as “spend-through.” 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 representatives 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 1997 (31.1%) gives an estimate of social security spend-through of 12.8% for 1997. In other words, almost 13 percent of the entire cost of nursing home care in the United States in 1997 came from Social Security benefits.

Medicare is cutting back on growth in nursing home and home-health-care expenditures. Medicaid is struggling under the burden of financing long-term care³⁸ and already has a dismal reputation for problems with access, quality, reimbursement, discrimination and institutional bias. Clearly, Medicaid cannot survive much beyond the seniority of the baby boomers beginning in 2010. So what will replace it?

There's the rub. With every benign intent, government has been sending a message to the public that long-term care is a risk that people can ignore. By increasing Medicaid's contribution to nursing home care rapidly, allowing out-of-pocket nursing home payments to decline drastically, and permitting Medicare long-term home-health care expenditures to skyrocket uncontrollably, the government has anesthetized the public to the real financial risk of long-term care. Consequently, most people do not plan ahead for predictable long-term care expenses. Private long-term care insurance, which allows people to spread this risk, has penetrated less than ten percent of the senior market and virtually none of the crucial baby-boomer market.³⁹ Medicaid estate planning (the practice of artificially impoverishing frail elderly people to qualify them for Medicaid nursing home benefits without spending down their assets) is rampant.⁴⁰ The day of reckoning is still a long way away. But the best time to confront and solve the problem is now.

The Center for Long-Term Care Financing has proposed a solution called *LTC Choice* that—compared to the measures needed to save Medicare and Social Security—is a relatively easy fix.⁴¹ The government should educate American citizens about long-term care risk no later than when they reach age 60 to 65. People should be encouraged to insure privately for long-

³⁸ Federal Medicaid Director Sally Richardson recently warned state Medicaid directors about the impending collapse of major nursing home chains that are dependent upon Medicaid financing to care for infirm seniors. See "LTC Bullet #101: HCFA Tells States to Prepare for Looming Crisis" in the "Appendix" of this report.

³⁹ "About 6 percent of elderly people and a very small number of baby boomers have purchased long-term care insurance." Janemarie Mulvey and Barbara Stucki, *Who Will Pay for the Baby Boomers' Long-Term Care Needs?: Expanding the Role of Long-Term Care Insurance*, American Council of Life Insurance, Washington, D.C., April 1998, p. 11.

"As of the end of 1993, there were 1.2 million individual long term care policies in-force. Of these, approximately 840,000 were issued to persons aged 65 or over. This is relatively small when compared to the potential over-65 market. Out of 33 million persons over 65, KPMG estimates that 15 million can afford long term care insurance. Of these, 13 million can be considered insurable risks based on health status. This indicates that the potential long term care market of 13 million persons is only 7% tapped." [p. 6] "As of the end of 1993, there were 494,000 group long term care certificates in-force.... This indicates even less penetration of the potential under-65 market than that achieved in the over-65 market." [p. 7] Vincent L. Bodnar, *Long Term Care Insurance Trends and Benchmarks: 1995*, KPMG Peat Marwick, Lawrenceville, New Jersey, 1995.

⁴⁰ "Thousands of lawyers around the country study the 'nooks and crannies' of Medicaid eligibility policy and make their livelihood off helping middle- and upper-class people protect their wealth and still qualify for Medicaid long-term care benefits. . . . Instead of striking it rich, Medicaid estate planning is truly a process of 'striking it poor.'" Brian Burwell and William H. Crown, "Medicaid Eligibility Policy and Asset Transfers: Does Any of This Make Sense?," *Generations*, Fall, 1996, pps. 78-83.

"...[M]illions of Americans are so eager to have the government pick up the tab for their own or their parents' long-term care that they are willing to bend the rules.... The availability of long-term care benefits provided by Medicare and Medicaid causes many middle-class, middle-aged Americans to conclude that they have no need to purchase private long-term-care insurance or otherwise save up for the real cost of their old age." Phillip J. Longman, *U.S. News and World Report*, August 11, 1997, pps. 19, 20.

⁴¹ For a more detailed description of the "LTC Choice" proposal, see the section below entitled: "What should government do to make long-term care more available and affordable for all Americans, rich and poor alike?"

term care, but those who do not should have to agree in writing that they can expect no financial assistance for long-term care from the government until they exhaust their personal wealth. We ought not to force people to impoverish themselves in order to gain access to a welfare-financed nursing home, however, as the current system does. Instead, the government should offer a line of credit on the estates of the uninsured to empower them to purchase quality long-term care in the private marketplace at the appropriate level of care. Seniors would pay back these fully secured loans out of their estates. This would send a very strong message to everyone else, especially their heirs, that long-term care is a risk they should take seriously and protect against early. Confronted with genuine risk of this kind, most Americans would do the responsible thing, insure and pay privately for long-term care, and thereby allow Medicaid to survive as a safety net for the truly needy.

If we act now to educate the public about long-term care risk and to provide strong, positive incentives to insure privately, America can avoid the worst consequences of a long-term care financing crisis. If we continue to hide behind the more proximate problems of Medicare and Social Security, we may finally resolve those matters only to find another huge fiscal catastrophe confronting us.⁴²

How do we handle long-term care service delivery and financing in the U.S. today?

Upwards of 80 percent of all long-term care is provided informally by family members or friends,⁴³ especially women:⁴⁴ this responsibility places a terrible strain on these unpaid

⁴² This section was adapted from an article by Stephen Moses entitled "LTC Insurance Could Play Role in Solving Medicaid Woes" originally published in *National Underwriter Life & Health Edition*, Vol. 103, No. 2, January 11, 1999, pps. 13-14.

⁴³ "Using large national data sets we estimate that the national economic value of informal caregiving was \$196 billion in 1997. This figure dwarfs national spending for formal home health care (\$32 billion) and nursing home care (\$83 billion)..." [p. 182] "The mid-range estimate [for number of caregivers] is 25.8 million. Applying the average weekly figure of 17.9 hours of informal caregiving to the number of estimated caregivers yields approximately 22-26 billion hours of caregiving per year, nationwide..." [p. 184] Peter S. Arno, Carol Levine, and Margaret M. Memmott, "The Economic Value of Informal Caregiving," *Health Affairs*, Vol. 18, No. 2, March/April 1999, pps. 182-188.

⁴⁴ Long-term care is often described as a women's issue, because women are disproportionately affected both as care needers and as care givers: "Over 80 percent of women between the ages of 65 and 85 report at least one chronic disease such as diabetes, arthritis, or hypertension; half report more than one; and one-fourth report three or more chronic conditions." _____, "Changes In Health Care Delivery And Financing Are Needed To Meet The Unique Needs Of Older Women With Chronic Conditions," *AHCPR Research Activities*, April 1999, No. 225, p. 2, citing Drs. Bierman and Clancy, "Women's Health, Chronic Disease, and Disease Management: New Words and Old Music?," *Women's Health Issues*, Vol. 9, No. 1, pps. 2-17.

"Female informal caregivers aged 33-51 provided an average of 22 hours of care to a family member, as reported in a recent survey by the National Alliance for Caregiving. However, about 40% of the caregivers averaged 10 or less hours per week. Only half of the caregivers were still providing LTC 18 months later. Half the caregivers also report that they use paid services in addition to the care they provide. About 20% of the caregivers felt a strong financial hardship as a result of their caregiving. Half of them did not feel such a hardship. Over half of the caregivers felt relatively unprepared for their own possible need for LTC, while 6% felt very prepared. The remainder felt somewhat prepared. Over one-third of these caregivers report that they have taken specific actions to plan for their own possible LTC, either by increasing investments or by buying insurance. [Source: 'The Caregiving Boom Baby Boomer Women Giving Care,' National Alliance for Caregiving, September 1998.]" Cited in _____, "Informal LTC Caregivers Average 22 Hours per Week of Care," *LTC News & Comment*, Vol. 9, No. 7, p.

caregivers.⁴⁵ Access to formal care is very limited: Medicare has cut back severely on long-term home care benefits and Medicaid nursing home care is notorious for long waiting lists.⁴⁶ Quality of care is often deficient: horror stories abound about inadequate long-term care and even physical abuse by caregivers.⁴⁷ Reimbursement for long-term care services is frequently inadequate.⁴⁸ Medicaid routinely pays less than the cost of providing nursing home care⁴⁹ and

11. For more information on this study, see “LTC Bullet #54: Caregivers Plan for LTC” in the “Appendix” of this report.

⁴⁵ “Half (49 percent) of family caregivers agreed that their caregiver duties cause stress within their immediate families, and 48 percent feel they do not have enough time for themselves. Most caregivers have been caring for their loved ones for an average of four years and more than one-third (34 percent) fear they may not be able to care for them much longer. These family and personal stresses worsen as the loved one’s condition becomes more severe. Caregivers of those with moderate to severe Alzheimer’s disease were more likely than caregivers of those with mild Alzheimer’s to describe their duties as ‘frustrating’ (90 percent), ‘draining’ (87 percent) and ‘painful’ (87 percent).” Yankelovich Partners, Inc., *Alzheimer’s Disease Survey*, Alzheimer’s Association, Chicago, 1996.

⁴⁶ “There is strong evidence that Medicaid eligibles face substantially lower access to nursing home services than private payers.... In any event, many are likely to be forced into care arrangements that are more expensive. Studies suggest that patients receiving long-term care in hospitals while waiting for admission to nursing homes are disproportionately Medicaid eligible.” James D. Reschovsky, “Demand for and Access to Institutional Long-Term Care: The Role of Medicaid in Nursing Home Markets,” *Inquiry*, Vol. 33, Spring 1996, p. 16.

“Nationwide, the median wait for a nursing home bed is 60 days.... The longest waits were reported at public nursing homes (240 days).... Some facilities with 100% occupancy had waiting lists of six months or more.” *Eldercare Business*, March 5, 1990.

⁴⁷ “More than half of home care clients said they had been victims of abuse or neglect by personal care aides, in a study by Julianne Oktay and Catherine Tompkins of the University of Maryland School of Social Work. The researchers found personal care aides had little training and low pay, leading to a high potential for abuse of home care clients. An anonymous study was conducted of 158 personal care clients of all ages. The most common forms of abuse reported were theft, verbal abuse and neglect.” *Older Americans Report*, November 4, 1994, p. 370. “[T]he proportion of Medicaid recipients is indeed associated with lower levels of RN staffing and a higher proportion of residents not toileted...higher proportions of Medicaid were found to be associated with lower nursing home quality, suggesting that the Medicaid program in fact exercises its power to bargain for price rather than quality.... A higher proportion of residents whose care is reimbursed by Medicaid is associated with lower quality as measured by these indicators.... Residents in homes with few private-pay patients (implying more public-pay patients) were found to be 30 percent more likely to experience functional decline.... Simply raising Medicaid rates or mandating parity across payers may not provide sufficient incentives for increasing quality. Under conditions of excess Medicaid demand, there may be little incentive to provide quality at any price....” Jacqueline S. Zinn, “Market Competition and the Quality of Nursing Home Care,” *Journal of Health Politics, Policy and Law*, Vol. 19, No. 3, Fall 1994, pps. 570, 573, 574-575.

“One reason for poor quality is inadequate and poorly targeted reimbursements by Medicaid/Medicare, which forces some nursing home operators to ‘cut corners’ on care.” United States Congress, Senate Special Committee on Aging, *Nursing Home Care: The Unfinished Agenda*, Serial No. 99-J, U.S. Government Printing Office, Washington, D.C., 1986, p. vi.

⁴⁸ The median “average daily rate a nursing facility could be paid by Medicaid for a single Medicaid resident” as of 1998 was \$94. Alaska had the highest Medicaid reimbursement rate (\$329.62) followed by Washington, D.C. (\$210.35), and New York (\$165.80). Nebraska had the lowest Medicaid reimbursement rate (\$62.58), followed by Arkansas (\$63.99) and Oklahoma (\$64.20). K. Jeannine Dollard, *Facts and Trends: The Nursing Facility Sourcebook, 1998*, American Health Care Association, Washington, D.C., 1998, p. 57.

⁴⁹ “Because Medicaid pays nursing homes less than the cost to provide the service, many nursing homes are reluctant to accept Medicaid patients.” United Seniors Health Cooperative, *Long-Term Care: A Dollar and Sense Guide*, Washington, D.C., 1988, p. 32.

“In the case of residents who rely on Medicaid funding—which is to say, most of the nation’s 1.6 million nursing home occupants—the pickings remain pretty slim. Facilities that are getting about \$100 per day from the government to house, feed and provide skilled care to chronically ill people are hardly in a position to offer the finer things in life. Spartan staffing, bare-bones service offerings and minimal accommodations are pretty much the norm. However, residents willing to pay \$5,000 or more per month are likely to find that higher-quality services

very few Americans have private long-term care insurance to soften the blow.⁵⁰ Discrimination is commonplace: long-term care providers cater to private payers and may give short shrift to people who are unable to pay or who depend on public financing sources like Medicaid that underpay the market rate.⁵¹ Institutional bias still prevails: most formal long-term care is provided in nursing homes under a medical model although nearly all infirm seniors would prefer to receive home and community-based services instead. Clearly, delivery of long-term care services in the United States remains haphazard, fragmented, dysfunctional and unsatisfactory for most consumers.

The underlying problem that drives all of these deficiencies in America's long-term care system is inadequate financing.⁵² The lack of a sufficient and reliable funding source for long-term care services:

and amenities are available, along with better-trained staff. Any contractor will tell you that when you cut corners to save costs, the product suffers. It's a basic rule of the marketplace. In fact, the only people who seem to be perplexed by this dynamic are the politicians and regulators who decide how much Medicaid funding nursing homes should receive. And rather than admonish themselves for short-changing providers, they are instead leading a feeding frenzy against 'poor-performing' nursing facilities. Which begs the question: Who's really to blame for bad nursing homes?" John O'Connor, "Commentary: Partners in Crime," *McKnight's Long-Term Care News*, Vol. 20, No. 6, May 5, 1999, p. 41.

"In the long run, restrictive Medicaid payment policies will limit the supply of beds below needed levels. Without adequate Medicaid payment levels, the supply of nursing home beds will grow sufficiently to meet only the demand from private patients. Because the Medicaid programs currently are the only major third-party payers of nursing home care, and unless new financing options are created, the long-term care services available to many elderly Americans will be severely restricted in the future." Robert J. Buchanan, R. Peter Madel, and Dan Persons, "Medicaid Payment Policies for Nursing Home Care: A National Survey," *Health Care Financing Review*, Vol. 13, No. 1, Fall 1991, p. 55.

⁵⁰ "According to a monograph just released by the American Academy of Actuaries, the best case scenario projects that by the year 2040 the population of severely disabled (3+ ADLs) elderly will increase by 90%....

- There are currently about 3.5 to 3.7 million LTC policies in force.
- Between 60% and 64% of all in-force LTC policies are owned by the elderly.
- **About 6% to 7% of the elderly currently own an in-force LTC policy.** [Emphasis added]
- 22% of the elderly are currently in need of some form of LTC.
- 5% of persons aged 65-74 are severely disabled compared to more than 40% of those aged 85 and over.
- The best case scenario projects that the LTC population of all ages will increase 60% by 2040; the worst case scenario projects a 92% increase.
- The aggregate burden of LTC will almost double by 2040, but the working-aged population will increase only 25% during this time. [Source: Long-term Care, Actuarial Issues in Designing Voluntary Federal-Private LTC Insurance Programs, January 1999.] Cited in "Actuaries Project 90% Increase In Severely Disabled Elderly," *LTC News & Comment*, March 1999, Vol. 9, No. 7, p. 5.

⁵¹ "It is usually easier to enter a nursing home of your choice if you are a private pay patient than if you are on Medicaid. Because the Medicaid approved rate of payment is lower than what the nursing home charges private pay patients, many nursing homes are reluctant to accept Medicaid patients. After you are in a nursing home, you may later qualify for Medicaid and remain at the facility. Once you are on Medicaid, the reluctance of some nursing homes to accept Medicaid patients may make it difficult for you to transfer to another facility, even though discrimination is illegal.... Nursing homes are not supposed to discriminate against patients who go on Medicaid. However, some states do allow Medicaid patients to be assigned to a separate wing of the nursing home, or to be discharged to another nursing home if no Medicaid bed is available. If you have to receive acute care in a hospital, the nursing home will keep your Medicaid bed for you for a limited time. If this period expires, the nursing home may not readmit you." United Seniors Health Cooperative, *Long-Term Care Planning: A Dollar and Sense Guide*, Washington, D.C., March 1997, p. 53.

⁵² Some of the key political players in long-term care financing policy recognize the seriousness of inadequate public financing as indicated by this recent quote from Senator Charles Grassley, Chairman of the Senate Special

- increases the pressure on unpaid caregivers,⁵³
- inhibits access to formal home and facility care,⁵⁴
- drags down the quality of available services,⁵⁵
- undermines the financial viability of long-term care providers,⁵⁶
- contributes to discrimination by providers who must seek to attract the best payers,⁵⁷ and

Committee on Aging: “I think it’s an open secret that Medicare and Medicaid reimbursements are not truly adequate for any of our health care providers, including skilled nursing facilities. Both insurance programs are really stuck between a rock and a hard place; we keep ratcheting down provider payments lower and lower, but both programs are fiscally unsustainable even at current low levels of reimbursement. And with Medicare, we’re facing a huge increase in the number of beneficiaries in just a few years, compounding our current problems. So we all need to figure out ways to reimburse our facilities and health care professionals better—and the only way that can happen, in my opinion, is for us to put the federal programs on a sound and sustainable fiscal footing.” _____, “Enforcement is Not Working: An Interview with Senator Charles Grassley,” *McKnight’s Long-Term Care News*, Vol. 20, No. 7, May 26, 1999, p. 16.

⁵³ “Nearly half of caregivers (49%) report having made financial sacrifices to care for their loved ones. Of these sacrifices, having stopped working is the most frequently reported by caregivers (14%). Two out of three (65%) say caring for a person with Alzheimer’s has affected their finances and a majority (59%) report having contributed their personal income or savings to the care of their loved one. Nearly two-thirds (62%) of caregivers report having missed days at work because of their caregiving responsibilities. The average number of days caregivers report having missed in the past year is 17.” Yankelovich Partners, Inc., *Alzheimer’s Disease Survey*, Alzheimer’s Association, Chicago, 1996, p. 5.

⁵⁴ “[T]here is a shortage of beds in many nursing home care markets and, under such circumstances, only private patients will have a free choice among nursing homes.... Thus, if beds are occupied in the more desirable homes, Medicaid patients could be forced to choose a home that they would not otherwise have chosen. Private patients, since homes are competing for their business, will tend to have an unconstrained choice among homes.” John A. Nyman, “The Private Demand for Nursing Home Care,” *Journal of Health Economics*, Vol. 8, No. 2, June 1989, p. 210.

⁵⁵ “Nursing homes whose patients are mostly private generally provide higher-quality care than facilities dependent on Medicaid patients.” Alice M. Rivlin and Joshua M. Wiener, *Caring for the Disabled Elderly: Who Will Pay?*, The Brookings Institution, Washington, D.C., 1988, p. 9.

⁵⁶ “Pushed to the breaking point by an escalating barrage of costly regulation and a faltering reimbursement system, more and more facilities are questioning whether Medicaid participation is worth the aggravation.... When push comes to shove, nursing homes in many states may very well find themselves in a no-win situation by participating in Medicaid. This could lead to mass defections, according to a Health Care Financing Administration official.... If a substantial number of Medicaid defections does materialize, it’s bound to turn the long-term care system on its ear. Traditional access, quality of care and financing patterns would quickly fall to the wayside. The new order of the day could very well be a two-tiered long-term care system that blatantly segregates the haves and have nots, with far fewer facilities available to care for the have nots.... [P]roviders of choice would draw the more lucrative admissions and referrals, leaving a smaller pool of Medicaid facilities with significantly more high cost, low margin residents. This could ultimately force Medicaid providers into an even deeper financial quandary, leading to quality of care compromises and the disintegration of Medicaid’s long-term care infrastructure.” Jim Bowe, “Power Outage: Medicaid Overload Forces Providers to Pull Out,” *Contemporary Long-Term Care*, Vol. 15, No. 7, July 1992, pps. 31-32, 7.

⁵⁷ “The findings in this paper lend empirical support to the hypothesis that nursing homes preferentially admit non-Medicaid patients, leading to barriers to care among certain subgroups of the Medicaid population.” Susan L. Ettner, “Do Elderly Medicaid Patients Experience Reduced Access to Nursing Home Care?,” *Journal of Health Economics*, Vol. 12, 1993, p. 278.

- tips the marketplace balance against home and community-based services (for which little third party financing is available) and in favor of institutional care (for which Medicaid pays albeit sparingly).

In a nutshell, the long-term care problem is this: (1) public programs like Medicare and Medicaid reimburse too little for long-term care and are biased in favor of nursing home care (which most people would rather avoid) and against home and community-based services (which most people prefer), (2) the public usually cannot afford to purchase long-term care services out of pocket because of the high cost and long duration of such services, and (3) very few people have purchased private insurance that would cover their long-term care expenses.

Given the challenge of aging demographics, the widespread doubts about Social Security's viability and the government's track record of constraining Medicare and Medicaid long-term care spending, we cannot look to public financing for a simple solution to these problems. Nor is it reasonable to expect that tomorrow's infirm elderly will be any better able to cope with the high cost of long-term care than their parents are today. Most observers now acknowledge that private insurance should play a much larger role in financing long-term care in the future than it has in the past.⁵⁸ To date, however, only a small percentage of seniors have purchased private long-term care insurance and virtually none of the critical baby-boom generation have made this investment.

Why does private insurance play such a small role in financing long-term care?

It is easy to become confused about the growth of the long-term care insurance market. In one sense, market growth has been rapid for many years. According to the Health Insurance Association of America: "By December 31, 1996, 120 companies had sold close to 5 million long-term care insurance policies. The number of policies purchased increased by more than 600,000 in 1996 alone. This is the largest number ever of long-term care policies sold in one year. The market has grown an average of 22 percent between 1987 and 1996."⁵⁹ The problem

⁵⁸ "The Medicaid program could save \$28 billion, or 21 percent, of total Medicaid nursing home expenditures as a result of increased ownership of long-term care insurance." Janemarie Mulvey and Barbara Stucki, *Who Will Pay for the Baby Boomers' Long-Term Care Needs?: Expanding the Role of Long-Term Care Insurance*, American Council of Life Insurance, Washington, D.C., April 1998, p. 10.

Congresspersons Chris Shays and Nancy Johnson of Connecticut and numerous co-sponsors have introduced a "sense of Congress" resolution which states in part: "[T]he Federal Government should take all appropriate steps not only to encourage employers to offer private long-term care insurance coverage to employees, but also to encourage both working-aged people and older citizens to obtain long-term care insurance either through their employers or on their own...." 106th Congress, 1st Session, H. Con. Res. 8, expressing the sense of Congress with respect to promoting coverage of individuals under long-term care insurance.

"If you are among the 90% of the over-65 crowd who do not yet own insurance against the cost of a nursing home, pay attention. You should give serious thought to buying one of these policies." Carolyn T. Geer, "Shopper's Guide to Nursing Home Insurance," *Forbes Magazine*, June 15, 1998.

"The adoption of long-term care insurance would substantially decrease the price of formally provided long-term care to consumers." John A. Nyman, "The Private Demand for Nursing Home Care," *Journal of Health Economics*, Vol. 8, No. 2, June 1989, p. 210.

⁵⁹ Susan Coronel, *Long-Term Care Insurance in 1996*, Health Insurance Association of America, Washington, D.C., 1998, p. 5.

with this assessment is that the seemingly robust growth has come off a base of almost nothing. Also, the data for 1996 reflect a “fire sale” spike caused by the grandfathering of all policies sold by the end of that year as “tax qualified.”⁶⁰ A more recent and sobering appraisal of the market was published in the May 10, 1999 issue of *National Underwriter*.

Individual long-term care insurance sales were generally lack-luster in 1998 and down considerably from 1997 levels, say industry executives. This has happened even though the industry has been expecting sales to increase as baby boomers approach retirement age, and despite the fact that insurers have added many new consumer-friendly features to LTC policies in recent years. And it has happened in spite of government tax breaks that now make premium payments deductible in some instances and benefits on certain plans exempt from federal income tax.⁶¹

Given the obvious need for this product, why do so few people purchase long-term care insurance? Over the years, analysts have offered many plausible answers to this question. Before the collapse of the Clinton health plan, many scholars advocated full public financing for long-term care. They criticized long-term care insurance and other private financing options mercilessly. As confidence in America’s social insurance programs continues to decline, however, fewer and fewer people expect the government to contribute significantly to their retirement security, much less to their long-term care expenses. Most Americans, especially the young, have come to question whether Social Security, Medicare, and Medicaid will be there for them when they need help.⁶² Yet, most people still do not buy long-term care insurance.

Ten years ago, private long-term care insurance had a bad reputation. People said it was too expensive...that it did not cover the right services...that it would not pay legitimate claims...that agents were fear-mongering elderly prospects. *Consumer Reports* accused the

⁶⁰ All policies in place by the end of calendar 1996 were deemed “tax qualified” under provisions of the Health Insurance Portability and Accountability Act of 1996. Therefore, long-term care insurance companies rushed to market, and consumers hurried to buy before the end of that year.

⁶¹ Hal Stucker, “LTC Insurance Is Still a Tough Sell Despite Many New Features,” *National Underwriter*, Vol. 103, No. 19, May 10, 1999, p. 7.

⁶² “Social Security doesn’t seem so secure, despite politicians’ promises. Only 14% of those polled expect Social Security to pay the same benefits as it does today when they retire. A surprising 29% don’t think it will pay benefits at all, and 37% expect reduced benefits; the remainder aren’t sure or are already retired. Among those under 35, nearly half don’t expect any Social Security benefits; 9% expect benefits at today’s levels.” *Wall Street Journal*, March 10, 1995, p. A1.

“The majority of nonretired respondents (71%) believe Medicare will provide a lower level of benefits when they retire than it does today.” EBRI (Employee Benefits Research Institute), “Public Attitudes on Social Security,” cited in *Older Americans Report*, June 21, 1991, emphasis in the original, p. 248.

Recent polls have shown that younger people are more likely to believe that a professional wrestler could be President or that UFOs exist than that they will receive the full Social Security and Medicare benefits they have been promised: “A famous 1994 poll sponsored by Third Millennium, a group that promotes awareness of national issues affecting post-Baby Boomers, reported that more adults 18 to 34-years-old believed UFOs exist (46 percent) than believed Social Security will exist when they retire (28 percent). That was no fluke. In Third Millennium’s 1999 survey, conducted last January, more adults believed a pro wrestler would be elected president (52 percent) than that they would collect all the Social Security money to which they were ‘entitled’ (39 percent)....” Carl Close, “The Anti-Entitlement Revolution,” *The Independent Review: A Journal of Political Economy*, May 24, 1999.

insurance industry of playing “Gotcha!” with their clients.⁶³ These criticisms have largely subsided. Today, most experts acknowledge that long-term care insurance is vastly improved,⁶⁴ that excellent products are readily available,⁶⁵ and that premiums are gradually declining.⁶⁶ Even

⁶³ “Long-term-care insurance promises to pay the bills if you need to enter a nursing home or be cared for at your own home. But our study raises serious questions about its ability to make good on that promise.” _____, “Gotcha! The Traps in Long Term Care Insurance: An Empty Promise to the Elderly?,” *Consumer Reports*, Vol. 56, No. 6, June 1991, p. 425.

⁶⁴ “An increasingly popular alternative...is long-term-care insurance policies.... Today many policies (and most certainly the ones you want) are structured to provide a source of cash that can be used to cover at-home care as well as nursing-home care.” *SmartMoney*, October 1997, p. 134.

“Satisfied Customers: People who have filed long term care insurance claims are generally satisfied with the service they are receiving, suggests data reported by Marc Cohen of LifePlans during the 13th Private Long-Term Care Insurance Conference held in Florida in mid-February. Here’s what claimants had to say: Satisfied with LTC policies: 87%; No difficulty in understanding coverage: 75%; Easy to claim benefits: 70%; No disagreement with carrier: 87%. Source: LifePlans” Cited in *Contemporary Long Term Care*, Vol. 22, No. 5, May, 1999, p. 8.

“Buyers in 1994 were more likely to view long-term care insurance products positively than were buyers in 1990.... Even among non-buyers, an increasing number of people believe the insurance industry offers policies with adequate coverage.” [p. 2] “Average annual premiums for policies selling in the market were \$1,500 in 1994; this compares to an average premium of about \$1,100 in 1991.... The expected increase in premiums given the changes in policy design total 53 percent, whereas actual average premiums have increased by 41 percent. Thus, the increase in net value to the consumer for these policy changes is 29 percent. Put simply, buyers today are receiving more value for the premium dollar than they did just four years ago.” [p. 3] LifePlans, Inc., *Who Buys Long-Term Care Insurance?: 1994-95 Profiles and Innovations in a Dynamic Market*, Health Insurance Association of America, 1995, p. 2.

Even Medicaid estate planning attorneys are recommending private insurance these days: “Long-term care insurance, if available and affordable, is becoming more and more attractive so that our clients have ongoing access to the maximum number of nursing homes in one’s community. Note that these policies increasingly offer home care coverage, as well.” Michael Gilfix, “Medicaid NH Evictions: Not in California,” *Gilfix Elderlaw Newsalert*, February/March 1998, p. 9.

⁶⁵ The Health Insurance Association of America reports annually on the features and characteristics of the most common long-term care insurance policies. According to their 1998 report covering policies sold in 1996: “As in previous years, the long-term care insurance market remained highly concentrated among a relatively small number of sellers. Twelve sellers represent approximately 80 percent of all individual and group association policies sold in 1996. HIAA conducted an in-depth look at the top sellers’ latest policies and found that insurers offer policies with a wide range of benefit options and design flexibility at moderately priced premiums. Key findings follow:

- All companies offer plans that cover nursing home, home health care, adult day care, respite care, and alternate care services. Hospice care was specifically covered by 10 insurers and a separate assisted living facility benefit was offered by 10 of the top sellers.
- Other common benefits include: care coordination or case management services, homemaker or chore services, restoration of benefits, bed reservation reimbursements, medical equipment coverage, spousal discounts, survivorship benefits, and caregiver training.
- Benefit eligibility criteria used are deficiency in performing Activities of Daily Living (ADLs) and determination of cognitive impairment.
- All plans are guaranteed renewable, have a 30-day “free look” period, cover Alzheimer’s disease, have a waiver of premium provision, and offer unlimited or lifetime nursing home maximum periods.
- Whereas in previous years most companies used a 6-month preexisting condition limitation, 9 of the 12 sellers now waive their preexisting condition limitation as long as pertinent medical conditions are disclosed at the time of application.
- Age limits for purchasing are also expanding. Companies now offer individual policies to people as young as 18 and as old as 99 years.
- All plans offer the NAIC Model Act and Regulation inflation protection requirement of benefits increasing at an annual 5 percent compounded rate, funded with a level premium.
- All companies offer plans that have a nonforfeiture benefit, with a shortened benefit period or a return of premium as the most common types.” Susan Coronel, *Long-Term Care Insurance in 1996*, Health Insurance Association of America, Washington, D.C., 1998, pps. 5-6.

⁶⁶ “HIAA [Health Insurance Association of America] analysis reveals that the average premiums reported by the leading sellers have been decreasing over time. The average premiums in 1996 decreased an average of 5 percent

Consumer Reports has come around.⁶⁷ Yet, most people still do not buy long-term care insurance.

If you ask a long-term care insurance agent or executive why the product does not sell better, you will always get the same answer: “Denial.” They will say that prospects insist: “It won’t happen to me...I’d never go to a nursing home...I’d shoot myself first.” Of course, insurance people know the reality—that most people will need some form of long-term care someday at considerable expense. Agents do not hesitate to tell their doubting prospects about the frightening evidence that substantiates the reality of long-term care risk and costs. Good long-term care insurance agents can and do rebut any and all objections presented by prospects who are financially and physically qualified to purchase coverage. Yet, most people still do not buy long-term care insurance.

Clearly, most of the credible reasons for failing to protect oneself against the financial risk of long-term care have fallen by the wayside over the years. Only one plausible objection remains and it is omnipresent in the popular and academic literature: “Long-term care insurance is unaffordable!” This alleged fact is almost a mantra among advocates of taxpayer-financed long-term care benefits. It is a cliché in the media. It is an unquestioned assumption for most long-term care insurance prospects. But is it true?

What do others say about the affordability of private long-term care insurance?

A large and distinguished literature exists on the question of long-term care insurance affordability. It boils down to this: advocates of public financing for long-term care conclude that private insurance is affordable by only ten or 20 percent of the elderly.⁶⁸ Advocates of

when compared to the average premiums for the leading sellers in 1995.” Susan Coronel, *Long-Term Care Insurance in 1996*, Health Insurance Association of America, Washington, D.C., 1998, p. 6.

⁶⁷ “Anyone in the LTC industry who has followed *CR*’s treatment of long-term care insurance in the past will be surprised and pleased to see the magazine’s approving acknowledgement ‘that consumers are turning to insurance to cover the cost of nursing homes,’ that ‘...many consumers need to consider the protection this insurance can offer,’ and that ‘there were fewer high-pressure tactics than we’ve experienced in the past.’ Even more unexpected, however, is their frank admission of why and how the periodical finally recognizes [the long-term care insurance] product’s legitimacy: ‘Some members of Congress are reluctant to see private long-term-care insurance take root lest it become the *de facto* substitute for universal coverage. That’s too bad. Universal insurance (even though desirable) is not on the horizon.’” Stephen Moses, “From Bear Trap to Benediction,” *LTC News & Comment*, Vol. 8, No. 3, November 1997, p. 2 reporting on _____, “Long-Term-Care Insurance Special Report: How Will You Pay for Your Old Age?,” *Consumer Reports*, Vol. 62, No. 10, October 1997.

⁶⁸ “The high price of long-term care insurance explains much of why so few people have policies and why the expansion of this coverage has limited potential for saving Medicaid dollars...Most studies have found that only 10 to 20 percent of the elderly can afford private long-term care insurance. Thus, long-term care policies are affordable mostly by people who would not spend down to Medicaid without the insurance.” Joshua M. Wiener and David G. Stevenson, “Long-Term Care for the Elderly and State Health Policy,” *New Federalism: Issues and Options for States*, Series A, No. A-17, Urban Institute, Washington, D.C., November 1997, p. 4.

“A Study by the Brookings Institution showed that, from 1986 to 1990, 79 to 90 percent of people age 67 or older were not able to afford long-term care insurance. To obtain these estimates, the researchers assumed that people age 67 or older with \$10,000 or more in nonhousing assets could spend up to 5 percent of their income on this insurance A second study conducted by the Families USA Foundation and the United Seniors Health Cooperative in 1990 showed that 84 percent of people between age 65 and 79 could not afford to pay the average cost of basic long-term care insurance policies from nine leading companies.” United States General Accounting Office, *Long-Term Care*

private financing conclude that 50 percent or more of people over the age of 65 can afford the coverage, if you first exclude everyone already eligible for Medicaid nursing home benefits.⁶⁹ Insurance industry representatives push the percentage who can afford long-term care insurance to over 60 percent by targeting younger age groups for whom premiums are lower and incomes are often higher.⁷⁰

Most of these affordability studies are based on the assumption that people will spend some arbitrary percentage of their income, usually five or ten percent, for insurance to protect their assets from the risk of excessive long-term care expenses. Most analysts, whether they prefer public or private financing options, assume that the primary purpose of insurance is to protect assets. Therefore, they rarely include a spend down of private assets in the base of resources available to pay for private insurance premiums. Interestingly, however, research on the characteristics of buyers and non-buyers of long-term care insurance indicates that buyers purchase the coverage more often to preserve their independence and personal control than merely to protect their assets.⁷¹ This research also shows that some people with relatively low incomes do purchase long-term care insurance, which implies they are either drawing some of the premiums from assets or they are receiving financial assistance from some other source.⁷² Consumers who purchase assisted living have recently been shown to display similar behavior. Many of them have much lower incomes and assets than was previously believed.⁷³

Insurance: Better Controls Needed in Sales to People With Limited Financial Resources, GAO/HRD-92-66, Washington, D.C., March 1992, p. 9.

“Only about 10 to 20 percent of the elderly can afford long-term care insurance.” _____, “How Will You Pay for Your Old Age?,” *Consumer Reports*, October 1997, p. 46.

⁶⁹ “It is suggested by these findings that the private capacity to finance long-term care is higher than once thought. It has been demonstrated that in varying degrees, these programs [including long-term care insurance] are potentially affordable to many elders. Across all ages and marital status groups, more than half of all elderly can afford at least one of these options by devoting 10% of their discretionary resources to a purchase.” Marc A. Cohen, *et al.*, “The Financial Capacity of the Elderly to Insure for Long-Term Care,” *The Gerontologist*, Vol. 27, No. 4, 1987, p. 501.

⁷⁰ “Indeed, about three-quarters of individuals ages 35 to 44 could afford a policy if they spend 2 percent or less of their income on private insurance.... Under these criteria, almost half (46 percent) of those ages 35 to 44 would be able to afford a five-year policy, while the rest could purchase a two-year policy. Similarly, 58 percent of individuals ages 45 to 49 could afford a five-year policy.” Janemarie Mulvey and Barbara Stucki, *Who Will Pay for the Baby Boomers’ Long-Term Care Needs?: Expanding the Role of Long-Term Care Insurance*, American Council of Life Insurance, Washington, D.C., April 1998, p. 14.

⁷¹ “Respondents were then asked to choose the single most important reason behind their purchase decision. The reason cited most frequently (30 percent) was to avoid depending on others. The remaining reasons—cited by at least 5 percent of purchasers—concerned minimizing financial exposure and protecting family resources.” Marc A. Cohen, Nanda Kumar, and Stanley S. Wallack, “Who Buys Long-Term Care Insurance?,” *Health Affairs*, Spring 1992, p. 215.

⁷² “Data from both the 1990 and the 1994 studies indicate that the majority of the market consists of persons with annual incomes less than \$35,000. Close to one-third also have assets valued at less than \$30,000. These individuals are purchasing policies that would cover a substantial part of their care were they to need services in the near future. Thus long-term care insurance presents a viable financing option for a growing number of retiring middle-class elders.” LifePlans, Inc., *Who Buys Long-Term Care Insurance?: 1994-95 Profiles and Innovations in a Dynamic Market*, Health Insurance Association of America, 1995, p. 3.

⁷³ “The reported incomes and net worth of the residents in assisted living communities are substantially lower than is currently presumed by feasibility standards and industry benchmarks.... About two-thirds (64 percent) of the residents reporting their income (including savings interest, dividends, and social security) said it was \$25,000 per year or less. (A virtually identical percentage listed their net worth as \$100,000 or less.) Yet, the average monthly fee charged by the communities was found to be \$67 per day or \$24,433 per year, which makes the average fee near

These facts—that long-term care insurance buyers are concerned about more than just asset protection and that purchasers of assisted living have much lower incomes than previously expected—have important ramifications. They suggest that asset protection may be less important to consumers as a reason to purchase long-term care insurance than access to quality care at the appropriate level in the private marketplace. More fundamentally, they suggest that affordability of long-term care insurance is a very complicated and slippery concept.

Is long-term care insurance affordable?

Affordability is relative. If you offer me a Hershey bar for \$50, I'll say "I can't afford that kind of money for a chocolate treat." If you offer me the same bar for \$.05, I might buy it just to give it away. For \$5.00, I'd have to be feeling very hungry or very rich. But for \$.50, a reasonable market price, I'd make the decision based on how much I need or want the candy bar. In other words, affordability is a function of three variables: price, ability to pay and perceived need. To decide whether or not long-term care insurance is affordable, we must answer three questions: (1) How much does it cost?, (2) Do potential buyers have enough money to pay the premiums?, and (3) How badly do people feel the need to purchase long-term care insurance?

How much does long-term care insurance cost?

This question is like asking how much a car costs without specifying the make, model and year. We need to delineate some parameters. The Health Insurance Association of America has published average annual premiums for a long-term care insurance policy that pays four years after a 20-day elimination period at \$100 per day for nursing home care/assisted living and \$50 per day for home health care with inflation protection that compounds these benefits by five percent each year.⁷⁴ The premiums for such a policy would be \$589 at age 40, \$802 at age 50, \$1,829 at age 65, and \$5,592 at age 79.⁷⁵ Like buying a car, however, long-term care insurance offers many additional options from which to choose. To insure for the full average cost of nursing home care nationally (\$130 to \$140 per day as of 1999), for example, you would have to pay an additional thirty or forty percent in premiums. For every bell and whistle you add—such

or above 100% of the average resident's income.... This evidence suggests that the industry, at least on the basis of financial eligibility, could potentially be three times as large as currently presumed in feasibility standards and industry benchmarks. Most feasibility studies dictate that the resident must have \$25,000 per year or greater income, yet only one-third of the residents surveyed in this study did." Margaret A. Wylde, *National Survey of Assisted Living Residents: Who is the Customer?*, National Investment Conference for the Senior Living and Long Term Care Industries, Annapolis, Maryland, 1998, pps. vii-viii.

⁷⁴ The following prices for long-term care insurance are taken from Table 5 "Average Annual Premiums for Leading Individual and Group Association Long-Term Care Sellers in 1996" in Susan Coronel, *Long-Term Care Insurance in 1996*, Health Insurance Association of America, Washington, D.C., 1998, p. 28.

⁷⁵ For comparison, the following are premiums for an actual long-term care insurance policy offered by one of the 12 carriers who represent 80 percent of all individual and group policies sold in 1996. The policy pays up to \$100 per day for four years of nursing home care, assisted living, or congregate care and \$50 for home health care with five percent compound inflation protection and a 30-day (rather than 20-day which is not available for this product) elimination period. Premiums are \$500 at age 40, \$692 at age 50, \$1,529 at age 65, and \$5,105 at age 79. A ten percent spousal discount is available.

as longer coverage, or a non-forfeiture benefit that assures you will get something back even if the insurable event does not occur, or the right to use your insurance benefits to pay a relative to take care of you—you must expect to pay even more. On the other hand, you could pare back the level of benefits and the duration of coverage, drop the inflation protection, increase the elimination period, or take advantage of a spousal discount in order to reduce the cost of coverage. Therefore, for our purposes, let us use these industry-provided premium levels as a general guideline for the cost of long-term care insurance.

Do potential buyers have enough money to pay the premiums?

According to the U.S. Census Bureau⁷⁶ (see the following table), there were 96,468,000 households in the United States in 1993, the most recent year for which these data are available.⁷⁷ Of these households, one-fifth had monthly incomes of \$1,071 or less; one-fifth, of \$1,963 or less; one-fifth of \$2,995 or less; one-fifth of \$4,635 or less; and one-fifth had incomes in excess of \$4,635. Those in the bottom quintile of income had negligible assets across all age groups and would not be promising candidates for long-term care insurance. These are the people for whom we should attempt to save the publicly financed programs. The others might, at least conceivably, aspire to purchase long-term care insurance, especially as their income and assets increase over time. Upward mobility between income quintiles is very common.

Approximately one-quarter of householders are under thirty-five years of age. They are not likely candidates for long-term care insurance, but everyone else might be. If we focus on householders aged 35 to 44 and 45 to 54—approximately 40 percent of the total householders—we find that they have disproportionately higher incomes as compared to the averages for all ages, with 87 percent and 88 percent of them in the top four income quintiles respectively. Fully 73 percent of the 35- to 54-year-olds had incomes in excess of \$1,963 per month and 53 percent of them had incomes over \$2,995 per month. Because of their youth, these age groups also qualify for the lowest long-term care insurance premiums, averaging \$589 (35 to 44) and \$802 (45 to 54) per year. Assuming that they spend six percent of their income for long-term care insurance,⁷⁸ 72 percent of the 35- to 44-year-old households (those with incomes over \$1,963 per month) could afford two long-term care insurance policies, one for each spouse.⁷⁹ Likewise,

⁷⁶ Extracted May 11, 1999 from <http://www.census.gov/hhes/www/wealth/wlth93d.html>.

⁷⁷ The age of this data should be taken into account in analyzing the ability of seniors to afford long-term care insurance. The incomes of elderly people have been increasing faster than those of other population cohorts for many years: “Between 1969 and 1996 the median household income of married couples with a householder aged 65 and over increased 57%, more than that of any other age group. Married couples with a householder less than 40 years old saw a 34% increase. The same increase in median income was experienced by couples with a householder aged 40 to 64. Topping the list of gainers are senior one-person households (male or female) with a 63% growth in median income. [Source: “Changes in Median Household Income: 1969 to 1996,” U.S. Bureau of the Census, P23-196, July 1998.]” Cited in _____, “Older Adults’ Incomes Increase Considerably More than Others,” *LTC News & Comment*, November 1998, Vol. 9, No. 3, p. 9.

See also “LTC Bullet #29: Seniors’ Income Gains Dwarf Others” in the “Appendix” of this report.

⁷⁸ “On average, purchasers spent 6 percent of their annual household income on their long-term care insurance policy.” LifePlans, Inc., *Who Buys Long-Term Care Insurance?: 1994-95 Profiles and Innovations in a Dynamic Market*, Health Insurance Association of America, 1995, p. 2.

⁷⁹ Six percent of \$1,963 (the upper limit of the second quintile) is \$118 per month or \$1,413 per year, more than enough to purchase long-term care policies for two 40-year-olds at \$589 each.

over 56 percent of the 45 to 54-year olds (those with incomes over \$2,995 per month) could afford two policies.⁸⁰ Clearly, these groups are the most promising prospects for long-term care insurance from the standpoint of affordability. Because they have accumulated relatively few assets to protect,⁸¹ however, and because the insurable event seems such a long time in the future for them, these younger groups have been reluctant to spend on long-term care insurance, although group- and employer-sponsored coverage has made some inroads in this market.

As we get into the older age groups, 55 to 64 and 65 plus, the number of households with incomes above the lowest quintile declines to 82 percent and 66 percent respectively. While 63 percent of the 55- to 64-year-olds had incomes over \$1,963 per month, only 37 percent of the 65 plus age group exceeded that income level and this percentage dropped to 28 percent for the 75 plus sub-group. For these older households, incomes are lower and long-term care premiums would be higher, rising from \$1,829 at age 65 to \$5,592 at age 79. To purchase a long-term care insurance policy with only six percent of household income, a 65-year-old would need \$30,483 per year and a 79-year-old would need \$93,200 per year of income. Unfortunately, only 27 percent of 65- to 69-year olds have incomes over \$35,940 (third quintile upper limit) and only five percent of householders 75 years and older have incomes over \$55,620 (fourth quintile upper limit). Because they have much larger assets to protect,⁸² however, and because they are much closer in time to the insurable event, their need for and their awareness of long-term care insurance is much greater. Therefore, the industry has traditionally marketed the product most aggressively to these age groups. Like any kind of insurance, however, the more you need long-term care coverage, the harder it is to qualify for the protection and the more it is going to cost. Consequently, market penetration in these older age groups has also fallen short of the industry's hopes and expectations.

⁸⁰ Six percent of \$2,995 (the upper limit of the third quintile) is \$180 per month or \$2,156 per year, more than enough to purchase long-term care policies for two 50-year-olds at \$802 each.

⁸¹ Net worth for the 35 to 44-year-olds was only \$29,202 and for the 45 to 54-year-olds, \$57,755.

⁸² For example 28.9 percent of people over the age of 65 (those in the second income quintile) have a median net worth of \$80,975; 17.7 percent (third quintile) have a median net worth of \$138,554; 11.4 percent (fourth quintile) have a median net worth of \$199,581; and 8.0 percent (fifth quintile) have a median net worth of \$354,781.

Asset Ownership of Households: 1993 Source: Census Bureau at http://www.census.gov/hhes/www/wealth/wlth93d.html									
Table D. Median Net Worth by Age of Householder and Monthly Household Income Quintile: 1993 (Excludes group quarters)									
65 years and over									
Monthly household income 1993	Total	Less than 35 years	35 to 44 years	45 to 54 years	55 to 64 years	Total	65 to 69 years	70 to 74 years	75 years and over
All households (thousands)	96,468	24,361	22,790	16,258	12,291	20,768	6,132	5,504	9,131
Median net worth (dollars)	37,587	5,786	29,202	57,755	91,481	86,324	92,500	95,748	77,654
Excluding home equity	9,505	3,297	8,219	14,499	25,108	20,642	23,650	23,054	18,125
Net Worth by Income Quintile ¹									
Lowest quintile:									
Households (thousands)	19,327	5,154	2,911	1,972	2,231	7,059	1,560	1,600	3,899
Median net worth (dollars)	4,249	478	970	3,875	16,900	30,400	34,413	24,373	32,149
Excluding home equity	949	100	499	550	1,900	2,993	2,499	2,142	3,499
Second quintile:									
Households (thousands)	19,306	5,201	3,516	2,272	2,310	6,006	1,692	1,674	2,641
Median net worth (dollars)	20,230	2,837	4,742	15,524	57,075	80,975	72,587	83,848	84,633
Excluding home equity	4,999	1,595	1,975	3,100	11,805	20,624	16,742	20,691	22,883
Third quintile:									
Households (thousands)	19,279	5,659	4,795	2,847	2,306	3,672	1,244	1,076	1,352
Median net worth (dollars)	30,788	6,993	17,315	37,413	86,405	138,554	116,589	147,230	156,499
Excluding home equity	8,283	4,057	5,325	7,475	23,099	53,870	44,410	53,675	67,049
Fourth quintile:									
Households (thousands)	19,304	5,096	5,723	3,686	2,429	2,370	934	682	754
Median net worth (dollars)	50,000	15,872	40,857	62,031	122,278	199,581	182,861	173,664	232,105
Excluding home equity	15,088	7,700	12,305	16,732	38,800	93,196	85,633	83,755	106,650
Highest quintile:									
Households (thousands)	19,252	3,251	5,846	5,480	3,014	1,660	702	472	486
Median net worth (dollars)	118,996	38,449	91,349	133,525	210,741	354,781	316,751	351,739	475,498
Excluding home equity	45,392	17,467	35,200	51,162	101,389	215,335	184,760	213,863	273,500
1/Quintile upper limits for 1993 were: lowest quintile - \$1,071; second quintile - \$1,963; third quintile - \$2,995; fourth quintile - \$4,635.									

How badly do people feel the need to purchase long-term care insurance?

The foregoing analysis shows that the key issue regarding affordability of long-term care insurance is the question of how badly people feel the need to own it. Younger people are more able to pay the premiums, but feel less need for the product. Older people are less able to pay the premiums, but feel a greater need for it. Therefore, the challenge of identifying and enhancing both the perceived and the objective affordability of long-term care insurance is twofold. Younger people must be convinced that they need the protection and older people must be shown how to find the extra money to pay the premiums. Before we can tackle these issues, however, we need to answer two profoundly troubling questions: why do younger people not recognize such an obvious need as long-term care insurance and why do older people not seek ways to afford the coverage more creatively. In other words:

Why is the demand for certain kinds of insurance, including long-term care insurance, so low?

Consumers only buy insurance to protect against real risk. Life insurance is commonplace because people know they will die and that no one will indemnify their families if they die early and uninsured. On the other hand, flood insurance is very unpopular. People have many reasons for not buying it. For example: “My home-owners’ policy will protect me,” “The water could never reach me here in a hundred years,” “Flood insurance is too expensive.” Local officials and bankers frequently bend the rules to approve building permits and bank loans without the technically required flood insurance. No one says “I’m not going to buy flood insurance, because the government will pay if the worst happens.” Nevertheless, vaguely and evasively, everyone knows this is true. The insurable event may not occur, but if it does, every politician within a radius of 500 miles will promise public support for the uninsured victims of any natural catastrophe. That is why so many victims rebuild on flood plains and why so few people purchase private insurance coverage to protect against the flood risk.

Long-term care insurance is much more like flood insurance than life insurance in this respect. People have many reasons for not buying it: “Our Medicare supplement policy will cover us,” “It won’t happen to me; I’m too healthy,” “My family always dies young,” “Long-term care insurance costs too much.” Elder law attorneys and Medicaid eligibility workers often bend the rules to qualify prosperous people for the welfare program’s nursing home benefit. No one says: “I’m not going to buy insurance, because the government will pay if the worst happens.” But, subconsciously, everybody knows this is true. The reality is that if nursing home care becomes necessary, someone else usually pays. Most people do not know, care or ask who pays until after the insurable event occurs. Then it is too late to seek help anywhere except from the publicly financed programs including Medicaid for long-term nursing home care and Medicare for long-term home health care. Like flood insurance, fewer people buy long-term care insurance than need it and can afford it, because, if the insurable event occurs, the government routinely pays.

How do the middle class elderly end up in nursing homes on welfare?

Medicaid is a means-tested public assistance program, *i.e.*, welfare. How do people who possess significant income and assets qualify? The following hypothetical, but stereotypical, example is a good way to answer that question.

John and Mary Smith were born in 1915 when life expectancy was approximately 51 years for men and 53 years for women.⁸³ They married in 1935, began payments on a home, and started a family. Theirs was the American dream—happiness and prosperity—until the late 1990s. At age 80, with an actuarial life expectancy of 8 years remaining, John was stricken by Alzheimer’s Disease. After a gradual onset, he began to require almost full-time care. Even with daily help from a home health aide and frequent visits by the adult children, in their late 50s themselves, the responsibility finally overwhelmed Mary. By 1999, the family concluded that institutionalization could no longer be postponed.

Robert, the couple’s 58-year old son, did some research. He located several excellent long-term care facilities, but was alarmed to learn that they charge from \$40,000 to \$70,000 per year. His dad could easily live several more years. With his mom getting frailer every day, their combined care costs could consume the family’s entire net worth (a \$300,000 home owned free and clear and \$275,000 in certificates of deposit) very rapidly. Even their monthly income of \$3,200—John’s Social Security and retirement pension plus the interest on their joint savings—would not go far. “But wait a minute,” Bob thought, “the folks have had Medicare for 20 years. It does not cover everything, but surely it will ease the burden.”

When Bob visited the local Social Security office, however, he learned that Medicare does not cover custodial long-term care. He checked his parents’ Medicare supplemental insurance policies and found that they were no help either. Furthermore, the couple had not purchased a special long-term care insurance policy, which would have covered custodial long-term care.

As he began really to worry, Bob got some advice from a friend who had been through the same wringer. “Talk to the people at the Department of Public Assistance about Medicaid,” she said. “It has its shortcomings, but Medicaid can be a big help.” Somewhat abashed, Bob arranged an appointment with a Medicaid eligibility worker. After a long wait in a seedy anteroom, he learned that his dad could have no more than \$2,000 in assets and \$500 per month of income and still qualify for Medicaid. Although the family home would be exempt, John’s share of the couple’s savings would make him ineligible indefinitely. “Spend down to the income and asset limits,” said the eligibility worker, “and then come back to fill out an application.”

At this point, Bob started to despair. Then he read an article in a national magazine about legal planning for disability.⁸⁴ He took the article’s advice and called the local free legal services

⁸³ American Council of Life Insurance, *Life Insurance Fact Book: 1998*, American Council of Life Insurance, Washington, D.C., 1998, “Table 10.3: Life Expectancy at Birth in the United States (years),” p. 154.

⁸⁴ Two typical examples of Medicaid planning advice to be found in the mass media follow. Both of these articles were published after Congress and the President attempted to criminalize Medicaid asset transfers and Medicaid

office. They referred him to a private attorney who specializes in “elder law.” This attorney advised him that the draconian eligibility requirements quoted by the Medicaid eligibility worker were only for non-institutionalized people who need acute care. The rules are completely different for people who need nursing home care. His father’s excess income would present no problem. Up to \$2,049 per month could be applied to his mother’s needs. The rest would go toward the cost of his dad’s care under “medically needy” income spend-down rules. As for the assets, up to \$81,960 could be deducted as Mary’s share. The remaining \$200 thousand would be technically disqualifying resources, but that problem could be handled in several ways. For instance, John and Mary might decide to remodel or buy a more expensive home. They could invest in other exempt assets such as a new car or home furnishings. More exotic options such as trusts, annuities, legal transfers, life estates, relocation, or even divorce could be explored if necessary.⁸⁵ In any case, Medicaid nursing home eligibility would be no problem to achieve and attorney’s fees would not exceed \$2,000.⁸⁶

estate planning advice in the Health Insurance Portability and Accountability Act of 1996 and the Balanced Budget Act of 1997, respectively:

(1) “Q: Can my parents give away a part of their life savings and still qualify for Medicaid? A: Yes. The law lets people give a portion of their savings to children or others to protect those funds from being tabulated as assets. Giving away money can help your parents reduce their funds to a level that makes them eligible for Medicaid. Q: How else can my parents protect part of their life savings? A: Here are three of the most popular planning strategies. ...1. Put money into exemptions [*i.e.* home improvements, a new car, etc.]. ...2. Create specialized trusts. Medicaid permits the creation of a variety of specialized trusts that preserve assets. Your parents might transfer their home to an irrevocable Medicaid trust, which allows them to live at home for life, obtain Medicaid coverage if they must enter a nursing home, pass the residence to heirs at death, and avoid capital-gains taxes. ...3. Purchase an immediate Medicaid annuity or promissory note. Let’s return to the example of your parents with \$100,000 in assets when dad enters a nursing home. Your mom takes \$50,000 of that and buys (in her name) an immediate Medicaid-qualified annuity from an insurance company. ...Dad qualifies for Medicaid immediately, and Mom remains financially secure because she keeps all the income. She may even save and accumulate the annuity payments without jeopardizing her husband’s Medicaid coverage.” Armond Budish writing in *Family Circle*, November 1, 1997, p. 46.

(2) “The real goal, though, is to work with your parents on an asset-shifting plan that will allow them to have Medicaid pick up the tab for their long-term care if need be.... The most common means of transferring assets—the ‘half a loaf’ method—is designed to exploit this principle without breaking any rules, explains Boston attorney Harry Margolis.... Planners also suggest shrinking the total assets your parents have to begin with. One way to do this is by turning assets that aren’t exempt from Medicaid into those that are. Money in the bank or a certificate of deposit could be spent on a prepaid funeral or a more extravagant engagement ring, for example; both are exempt assets.... If your parents live in a state that doesn’t limit income for Medicaid recipients or their spouses, fixed annuities are another useful tool. Whichever of these solutions you choose to implement, planners say, it’s important to pay privately for a good six months if you can swing it.” *SmartMoney*, October 1997, pps. 134-136.

⁸⁵ The scholarly literature on elder law is full of articles on Medicaid estate planning of which this excerpt is a typical example: “[T]he term ‘Medicaid Planning’ is used in this article to mean the process of lawfully rearranging an individual’s assets so that the individual qualifies for Medicaid under the law while the assets are sheltered for use by a spouse, children or others.... These techniques...include: divesting assets generally, transferring assets between spouses, transferring assets to trusts, converting assets, and divorcing a spouse.... [T]he couple may avoid a claim by the state to recover the Medicaid payments by transferring all spousal assets to the sole ownership of the community spouse after the institutionalized spouse’s application for benefits has been approved.... Another sheltering strategy is to convert available, countable assets into noncountable exempt assets. For example, money in checking or savings accounts may be used, without creating a period of ineligibility, to purchase or improve a home, pay off a mortgage, buy a cemetery lot, pre-pay funeral services, pre-pay residence-related taxes and insurance, or even pay outstanding bills, including legal fees.... Divorce is one of the more extreme Medicaid planning strategies. A successful divorce, in which both parties are represented by independent counsel, and containing an agreement in which most or all of the couple’s assets are given to the community spouse, can result in almost immediate Medicaid eligibility for an institutionalized spouse.... The mere fact that Congress and the states have enacted statutes and

Before Bob left, the attorney gave him two more pieces of advice, which he immediately acted upon. First, his dad should enter the nursing home of choice as a private-pay patient for several months before converting to Medicaid. He might have trouble getting into a desirable facility as a public assistance recipient.⁸⁷ Second, John and Mary's home, exempt now because of Mary's residence, could become nonexempt if Mary died or needed institutionalization herself. The State might also recover the home's value from John or Mary's estate. Bob's dad should transfer his equity to his mom and then have her hold the property in joint tenancy with the family. That puts the home out of the state's reach for estate recoveries (unless the state has adopted, as few have, an expanded definition of "estate" as authorized by the Omnibus Budget Reconciliation Act of 1993).⁸⁸

"Heck of a way to run a railroad," Bob thought. "Had we known, we could have transferred all the assets three years ago when dad first got sick and avoided these complications. Better yet, had we planned ahead, we could have helped the folks buy long-term care insurance to protect against the risk. All I know for sure—it's a damn good thing Dad's too sick to recognize that he's spending the rest of his life on welfare."⁸⁹

regulations expressly permitting and endorsing Medicaid planning is clearly an expression of the public policy to allow such planning." Hal Fliegelman and Debora C. Fliegelman, "Giving Guardians the Power to Do Medicaid Planning," *Wake Forest Law Review*, Vol. 32, No. 2, Summer 1997, pps. 341-2, 359, 362-4, 373.

⁸⁶ How much money do Medicaid planners make for artificially impoverishing their clients? "Hourly rates for elder law work range from \$85 charged by a practitioner in the rural South to \$275 asked by a Manhattan attorney. [p. 2] "Practitioners say the cost of planning for Medicaid eligibility is difficult to predict. 'In the past year,' Westerman [a Medicaid estate planner] notes, 'the price for the package has ranged from \$700 to \$1,100.' 'I will almost never charge under \$2,000 on a Medicaid plan any more,' says Kuhn [another Medicaid planner]." [p. 3] "Net income ranged from \$15,000 in the case of a sole practitioner who recently set up a practice in the rural South, to \$240,000 (in a good year) for a principal in a six-person firm in the West." [p. 4] Kenneth M. Coughlin, "The Billing Practices of Elder Law Attorneys," *The ElderLaw Report*, Vol. 5, No. 5, December 1993.

⁸⁷ One of the most tragic consequences of Medicaid estate planning is that the affluent clients artificially impoverished by Medicaid planners end up occupying the scarce supply of Medicaid beds in the better nursing homes, while the needy, whom Medicaid is supposed to serve, struggle with the access and quality problems documented elsewhere in this report. The following quote is typical of the advice commonly rendered by elder law attorneys to this day: "It is substantially easier to obtain placement of a patient in a well regarded nursing home if the patient is or appears to be able to pay privately for six months to a year, than if a patient is unable to do so. Therefore, the goal of financial planning may be to leave the potential patient with adequate funds to pay privately for at least six months." Charles M. Delbaum, "Financial Planning for Nursing Home Care: Medicaid Eligibility Considerations," *Ohio State Bar Association Report*, Volume 57, Number 14, April 2, 1984, p. 373.

⁸⁸ Other techniques to evade estate recovery as mandated by the Omnibus Budget Reconciliation Act of 1993 include:

"A transfer of the home with reserved special powers of appointment can provide the best of all possible worlds. It can completely protect the home from the reach of Medicaid after the applicable waiting period while allowing the powerholder to retain control of the property and preserve all desirable tax benefits with no exposure to estate recovery." Alexander Bove, *ElderLaw Report*, February 1996, p. 3.

"The chart at the end of these materials labeled 'The Home in Medicaid Planning'...contains a matrix with 10 rows and 8 columns. Each row contains a method of protecting the family home from Medicaid estate recovery. Each column contains a Medicaid or tax issue which must be considered when selecting a method of protecting the family home." National Academy of Elder Law Attorneys National Conference Materials, 1996, Session 7, p. 1.

⁸⁹ An earlier version of this story by Stephen Moses was published in *Medicaid Estate Recoveries*, Office of Inspector General, Department of Health and Human Services, OAI-09-86-00078, June 1988. For the current version, Medicaid income and asset limits have been increased to reflect 1999 levels.

Postscript:

In the eleven years since this vignette was first written, long-term care service delivery and financing has begun to change in very significant ways. One of the most important changes has been the explosive growth of “assisted living” as a privately financed alternative to nursing home care. Assisted living facilities emphasize independence, homelike surroundings and supportive services for residents instead of the loss of control, institutionalization, and medical emphasis that seniors frequently associate with the “dreaded event” of nursing home placement.

Because assisted living is so desirable and nursing home care is so undesirable in the public’s mind, the dilemma faced by John and Mary’s son Bob in the foregoing story has become more complicated and ethically charged than ever before. Today, Bob and his siblings are faced with a difficult choice between admitting their father to an assisted living facility for which the family will have to pay out of pocket or taking advantage of the option of qualifying him for Medicaid nursing home benefits as outlined in the story. Which alternative they choose may have very serious consequences for their father *and* their mother.

Many elder law attorneys argue that transferring and sheltering income and assets to achieve Medicaid eligibility is no more objectionable (or difficult) than using legal deductions to minimize income tax liability.⁹⁰ From a purely legal standpoint, they may be right. It is very important, however, to consider this decision from another point of view. While the infirm father retains his life’s savings, all care options remain available to him including home care, adult day care, assisted living, and top quality private nursing facility care. After he has been

⁹⁰ For example: “Just as there is no illegality or fraud involved in taking maximum legitimate tax deductions, there is not illegality or fraud in maximizing governmental benefits. For example, giving away property to qualify for Medicaid benefits easily can be analogized to making gifts in contemplation of death to reduce estate tax. Neither is an ethical question necessarily raised by taking steps, short of illegality, to maximize benefits. The comprehensive literature on the subject rarely raises the issue of the appropriateness of this type of planning.” Robin Herman, “Planning for Incompetency and the Aging Client: Professional Responsibility Issues,” *Tax Management Estates, Gifts and Trusts Journal*, Vol. 15, No. 4, July 12, 1990, p. 152.

“The cornerstone of estate tax and long-term care planning is gifting. There are generally two reasons individuals desire to make gifts. The first is to remove assets from their taxable estates, and the second is to remove ‘countable’ assets from their names to plan for long-term care eligibility under the Medicaid program. The primary motive for gifting in either estate tax or long-term care planning is to maximize the amount of assets that are available to pass on to the transferor’s heirs... This article will...concentrate on gifts used in planning for Medicaid eligibility. This article is intended to guide the lawyer in advising clients how to make gifts to ensure those gifts will not be contested and, therefore, deemed to be available for Medicaid qualification purposes. This article will also discuss the types of gifts frequently used in long-term care planning and will include recommendations as to how to document and structure gifts to ensure the client’s intended results are met... Clients often choose to make a ‘disguised’ gift. The disguised gift is intended to keep the assets in one ‘pot,’ to be distributed among the intended donees after the donor’s death... The reason for the use of the disguised gift is for the donor to ensure that the gifted funds will be available if the donor needs them in the future. Then, an unrequired but voluntary retransfer could be made. Care must be taken to ensure the transferred assets are not deemed to be an available resource which may affect the individual’s eligibility for Medicaid benefits. Reserving too many ‘controls’ or retained interests in a gifted asset or premature disposition or use of the gifted asset by the donee after it has been transferred may cause the gift to be ineffective. Care must also be taken to avoid a transfer that is deemed fraudulent... The more control the transferor retains over the gifted asset, the more likely the government agency administering the Medicaid program will treat the asset as an available resource.” Baird Brown, “The Art of Gifting,” *NAELA Quarterly*, Vol. 11, No. 3, Fall 1998, pps. 21-23.

artificially impoverished to qualify for Medicaid, however, he is vulnerable to the access and quality problems so often associated with Medicaid's low reimbursement rates.

On the other hand, to the extent the parents' resources are depleted to pay for the father's privately financed assisted living, how will the mother manage financially? Should Medicaid be responsible for preserving these joint assets beyond the statutorily protected Community Spouse Resource Allowance of up to \$81,960? Where is the equity in using Medicaid to support financially savvy seniors while the poor and near poor cannot afford assisted living and quickly lose their moderate savings, because they do not know how to find the loopholes? These are the kinds of wrenching questions that arise when so many people end up in need of long-term care without having saved or insured in advance.

Why do people purchase private insurance?

The purpose of insurance is to replace the small risk of a catastrophic loss with the certainty of an affordable premium.⁹¹ Insurance companies help people achieve this objective by spreading and pricing risk. For example, if there is one chance in a million that I will be hit by a truck resulting in a \$1 million loss, that event—unlikely as it might be—would devastate me financially as an individual. I would gladly pay \$2 to make such a risk disappear. So would millions of other people. Therefore, an insurance company can sell this protection to me and to 999,999 others, make a nice profit, and perform a valuable public service in the process. That is spreading risk.

But what if five of the insurance company's million beneficiaries are hit by trucks instead of just one? Then the company would have collected only \$2 million in premiums, but would owe \$5 million in claims, a \$3 million loss. To know what to charge for insurance protection, companies must measure, record and analyze extensive (actuarial) data on the incidence and frequency of the insurable event. They must answer the question: What is the probability that the insurable event will occur and what will be the cost if it does? That is pricing the risk.

Both spreading risk *and* pricing risk are critical economic functions. One of the main differences between social insurance and private insurance is that, although both spread risk, only private insurance prices risk in a meaningful way. Private insurers have a legal and fiduciary responsibility to their insureds. They must price insurance coverage at a level sufficient to accumulate reserves adequate to pay carefully anticipated claims rates. Private policyholders possess legal contracts, enforceable in a court of law, that assure them recourse in case of dispute, malfeasance or insolvency by the insurance company.

Social insurance, on the other hand, offers none of these protections. Social Security and Medicare, for example, are notorious for growing exponentially beyond their original cost

⁹¹ Citizens for a Sound Economy Foundation (206-783-3870 or 1-888-564-6273) publishes an excellent guide to the principles of private insurance entitled "Making Sense of Insurance: A Consumer Guide to Regulatory Reform." Anyone who thinks insurance is "unaffordable" or who laments the fact that it does not pay a benefit unless the insurable event occurs should read this brochure. It is very important to understand what is reasonable and what is unreasonable to expect from a private insurance product.

projections. Socially insured people have no legal recourse or protection against increases in premiums (payroll taxes), decreases in benefits (program cutbacks), or the imposition of means tests (welfarization). Indeed, a majority of Americans now believe that these bulwarks of traditional social insurance will not be there in full when they need them in the future.⁹² Serendipitously, as confidence in social insurance declines, the private market economy is booming and consumer confidence is at an all time high.

In America's mixed economy, social insurance is usually considered a safety net and not a first line of financial defense. When savings, investment, pensions and private insurance prove inadequate, we look to social insurance to pick up the slack. Unfortunately, however, the very existence of compulsory social insurance may debilitate the effectiveness of private financing vehicles. People purchase insurance if they *perceive* they are vulnerable to a large financial loss. What matters is their *perception*, not the magnitude or reality of the risk. Real risk, if unperceived, will not impel people to insure. Real or not, perceived risk, may cause people to insure.

Social insurance creates a perception of low risk thereby reducing the demand for private insurance protection.⁹³ Private insurance marketing struggles to create a perception of risk, but to the extent the risk is not real, the task is daunting and unproductive. The worst of all possibilities is when social insurance or welfare has desensitized the public to a risk against which the private insurance industry is trying to sell protection (*i.e.*, loss of assets), while another greater risk (*i.e.*, access to quality care) goes unperceived and uninsured by either social insurance or private insurance. That is precisely the situation with long-term care.

How do long-term care insurance companies market the product and why haven't their methods been more effective?

"Mr. and Mrs. Jones, if you don't buy this long-term care insurance policy from me, you could lose your whole life savings to the catastrophic costs of a long-term nursing home stay."

Long-term care insurance agents repeat that sentence with only minor variations thousands of times every day throughout the United States. But this traditional sales pitch has two major flaws: it is untrue and it usually fails!

⁹² "Both twentysomethings and boomers are highly skeptical that the government will fund their retirement. A vast majority of both generations—more than 80% of twentysomethings and more than 70% of boomers—believe Social Security won't be available to support their retirement." *Wall Street Journal*, June 15, 1995, pps. C1, C20; Roper Starch Worldwide, Inc. poll.

⁹³ Compare Lyndon Johnson's promise for Medicare with the outcome: "No longer will older Americans be denied the healing miracle of modern medicine. No longer will illness crush and destroy the savings they have so carefully put away over a lifetime so that they might enjoy dignity in their later years. No longer will young families see their own incomes, and their own hopes, eaten away simply because they are carrying out their deep moral obligations." Lyndon B. Johnson at the signing of the Medicare legislation in July 1965, cited in Dallek, 1996, p. 1. Outcome: "Elderly Americans are spending more than twice as much on health care, even after accounting for inflation, as they were before the government established Medicare, according to a new report [by Families USA]...from \$1,589 in 1961 to \$3,305 in 1991...out-of-pocket health expenses currently consume an average of 17.1% of an elderly family's after-tax income, compared with 10.6% in 1961." *Wall Street Journal*, February 26, 1992, p. B-3.

Private long-term care insurance will not capture much more than its current 7% of the senior market until insurance executives, brokers and agents discard the myth of long-term care financing and confront the reality.

The myth is that millions of middle-class Americans spend down their life savings on nursing home care until they impoverish themselves and qualify for Medicaid benefits. If this were true, people *would* eagerly purchase private long-term care insurance to avoid such a catastrophe.

The reality is that most seniors qualify easily for Medicaid nursing home benefits and almost anyone, regardless of income or assets, can qualify quickly without spending down. Because this is true, most people hesitate to pay long-term care insurance premiums for protection that the government is giving away.

Consider these little-known truths:

- Medicaid pays for 73.7% of all nursing home patient days in the United States even though only 12% of the elderly are poor.⁹⁴
- Direct and indirect government payments by Medicaid, Social Security,⁹⁵ Medicare and the Department of Veterans Affairs account for almost 80% of all nursing home costs nationally.
- Dozens of recent academic studies prove that only 10% to 25% of Medicaid nursing home recipients began as private payers, instead of 50% to 75% as previously thought.⁹⁶
- Even those few who “spend down” to qualify for Medicaid may have impoverished themselves artificially instead of paying for long-term care out of pocket.
- Most state Medicaid programs place no limit on how much income recipients can receive as long as their medical expenses (including nursing home care) are high enough.⁹⁷
- Even states that limit income to \$1500 per month allow people to siphon any excess income into “Miller” trusts so they can qualify immediately.⁹⁸
- The often-quoted limit on assets of \$2,000 is meaningless because Medicaid recipients can also retain a home, business, car, personal property and many other assets of practically unlimited value.
- Married recipients can also shift up to \$2,049 per month of income and \$81,960 in assets (much more if they know a simple trick)⁹⁹ to a spouse at home and still remain eligible.¹⁰⁰

⁹⁴ “For all nursing homes nationwide, Medicaid days accounted for 73.7 percent of all patient days in 1992, an increase of more than 2.5 percentage points since 1990.” *The Guide to the Nursing Home Industry, 1992*, HCIA and Arthur Andersen & Co., Baltimore, Maryland, 1992, p. xvi.

⁹⁵ See footnote 37 for an explanation of how Social Security contributes to long-term care financing.

⁹⁶ These so-called “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. None of these studies actually measured spend-down. They only measured payment status at admission and at discharge. Not one of the studies took into account the possibility that a private-pay admission could “spend down” to Medicaid eligibility by divesting or sheltering assets instead of paying for care.

⁹⁷ Approximately 30 states use this “medically needy” method for determining income eligibility.

⁹⁸ Approximately 20 states use this “income cap” method for determining income eligibility.

Thus, the average person who needs nursing home care has no trouble qualifying for Medicaid benefits immediately. But, what about people with hundreds of thousands of dollars?

All the rich folks need to do is retain good legal advice. Medicaid estate planners specialize in divesting or diverting income and assets to qualify the well-to-do for Medicaid, often virtually overnight. Popular Medicaid planning techniques recommended by private attorneys and mass-market how-to books include:

- Purchase exempt assets such as an expensive home or car
- Set up a Medicaid trust
- Transfer a home while retaining a life estate
- Pay children for their help
- Get a divorce

For example, at a Medicaid planners' conference in Cambridge, Massachusetts, three nationally prominent attorneys portrayed their techniques for divesting an older couple's \$652,550 estate in a humorous skit. To a packed auditorium, these experts explained how to make non-exempt assets disappear including a vacation home in Florida, \$150,000 worth of stocks, another \$150,000 in savings, and \$20,000 of cash-value life insurance. They took full advantage of exempt assets such as a \$200,000 house, home furnishings of \$40,000, and a \$15,000 car. The couple's \$3,158 monthly income barely warranted discussion, as it presented no significant obstacle to Medicaid eligibility. Legal fees for these services were quoted at \$275 per hour.¹⁰¹

⁹⁹ The simple trick frequently recommended in the elder law literature as a means to shelter up to hundreds of thousands of dollars: "A potential planning technique would be for the community spouse to reallocate his or her assets into forms that pay less income. For example, money market funds could be used to buy zero coupon bonds, gold, or growth stocks, all of which pay no income at all. The community spouse could then legitimately argue that he or she requires a larger allocation of income up to the Monthly Maintenance Needs Allowance." Gregory Wilcox, "Another Strategy to Increase the CSRA," *The ElderLaw Report*, Vol. II, No. 8, March 1991, p. 12. Another variation: "If a couple has a second vacation home, consider having the couple rent that home and then claim the rental income as necessary for maintaining the community spouse's minimum monthly maintenance needs allowance. If the vacation home is considered necessary for this purpose, it is no longer a countable resource." John J. Regan, *Tax, Estate & Financial Planning for the Elderly*, Matthew Bender, New York, 1993 update, p. 10-68.

¹⁰⁰ The monthly maintenance needs allowance was set at \$1,500 per month in the Medicare Catastrophic Coverage Act of 1988 (MCCA '88) and it increased with inflation to \$2,049 as of 1999. The community spouse resource allowance was set at \$60,000 in MCCA '88 and it has increased with inflation to \$81,960 as of 1999.

¹⁰¹ How to divest and divert \$652,550 while qualifying quickly for Medicaid nursing home benefits: "As a practical matter, if your wife needs nursing home care in the future you may want to privately pay the nursing home (three months up front) for purposes of expediting your wife's placement in a nursing home, unless she is eligible for Medicare benefits. Once your wife is in the nursing home and eligible for Medicaid, you should immediately proceed to file for Medicaid Nursing Home Care.... Since your assets are in excess of the CSRA at the time your wife files a medicaid application for nursing home care, then it is critical that you submit a 'Spousal Refusal' to contribute your assets to pay for her care, or else she will be denied Medicaid.... We are available to assist you in the preparation and filing of Medicaid applications and the coordination of Medicaid coverage, including monthly budgeting.... If you receive a denial of benefits...[o]ur firm is available to assist you with regard to any Medicare claims and appeals.... [S]hould your wife require such care, you can obtain Medicaid eligibility for her by transferring assets into your name and your utilization of spousal refusal.... Another alternative would be for you to purchase an annuity with the assets in excess of the CSRA.... This approach will allow your wife to qualify for nursing home care without a transfer penalty and without spousal refusal.... Your wife can transfer her assets into a

Bottom line: In America today, people can and do ignore the risk of long-term care, avoid private insurance premiums, wait to see if they ever need institutional long-term care, and transfer any catastrophic long-term care costs to the tax payers if and when the dreaded event occurs. In a nutshell, we already have de facto National Health Insurance for nursing home care.¹⁰² This is the real reason why so few Americans plan ahead and purchase long-term care insurance in the private marketplace.¹⁰³

Advocates of public financing for long-term care and enemies of private financing might reasonably ask: “So what’s the problem. Why not build up Medicaid instead of promoting private insurance?” The answer to this question is the crux of the long-term care financing problem and the key to its solution.

Medicaid is a means-tested public assistance program. It is welfare. Medicaid was originally intended to assure access to mainstream health care for the poor, but it has gradually evolved into the primary third-party payer of nursing home care for most Americans. The program has a dismal reputation for access, quality, reimbursement, discrimination, and institutional bias. According to the United Seniors Health Cooperative, Medicaid pays nursing homes less than the cost of providing the care. Consequently, good nursing homes have to attract full-pay private residents and Medicaid recipients often face long waiting lists even for inferior facilities. For the home and community-based services that seniors prefer, Medicaid financing is usually inadequate or unavailable altogether.¹⁰⁴

Despite these deficiencies, Medicaid costs have increased so sharply in recent years that the program now consumes over 20% of state budgets, up from 10% only a few years ago. Today, the program rivals education for consumption of state tax revenues. For many years, the

trust for your sole benefit. This transfer would not subject her to a Medicaid period of ineligibility.... [T]he CSRA should be enhanced to \$200,000 from \$76,740.... If the consultation exceeds the one-half hour, then you will be charged based upon my hourly rate of \$275 and my legal assistant’s rate is \$100.” National Academy of Elder Law Attorneys, 1996 National Conference, Session 9, pps. 34-38, 46 of the conference materials.

¹⁰² Fabrizio, McLaughlin & Associates conducted focus groups among consumers and opinion leaders regarding long-term care financing. They found that: “What some consumers are not aware of, or what they are unwilling to believe, is that Medicaid is welfare. To these people, Medicaid is their long term health care. Trying to convince them that Medicaid was welfare was unsuccessful.” [p. 2] “Among some consumers there is a perception that they are already covered, whether it is by Medicare or Medicaid, and that the government is going to pay for their long term care, therefore change cannot be for their benefit.” [p. 3] Laura Fenwick, “Survey Finds Boomers Headed for Financial Disaster in Golden Years: Older Women Particularly Hard Hit,” American Health Care Association press release, Washington, D.C., April 7, 1999.

¹⁰³ “An important finding with implications for policymakers is that changes in Medicaid policy can affect the decisions of consumers regarding the acquisition of private LTC policies as well as the level of protection they choose. The presence of Medicaid does dampen the demand for insurance, even among individuals who, based on their income and asset profile, would not likely qualify for benefits. This supports other evidence that suggests that such individuals have alternative means of potential access to Medicaid benefits, such as divesting themselves of assets (Burwell 1991). Clearly, what occurs in the public LTC protection market (Medicaid) influences developments in the private LTC protection market (LTC insurance).” [p. 672] “Individuals living in states that have general estate recovery programs do purchase more coverage than individuals in states with more limited or no programs.” [p. 670] Nanda Kumar, *et al.*, “Understanding the Factors Behind the decision to Purchase Varying Coverage Amounts of Long-Term Care Insurance,” *Health Services Research*, Vol. 29, No. 6, February 1995.

¹⁰⁴ These facts are already thoroughly documented in earlier footnotes.

program has failed to cover two-thirds of the elderly poor and half of all poor children even for acute or emergency care.¹⁰⁵ Soon, states may have to cut back on program benefits even more than they have in the past.

As Medicaid slides down a slippery slope of insolvency, throngs of legal and financial advisers still counsel healthy, middle-class seniors to plan for its dubious benefits. Such advisers are not limited to high-priced attorneys profiteering on the unwary. They also include insurance agents who sell low-cost, three-year policies on the grounds that “you can save premium dollars, transfer your assets when you enter a nursing home, and legally get Medicaid to pay when your insurance runs out.” This is terrible advice. Obviously, no clear-thinking person in possession of all the facts would deliberately coordinate benefits with a welfare program that is going bankrupt.

Make no mistake. Seniors are not planning consciously to rely on Medicaid instead of buying insurance. But the Medicaid safety net has protected middle-class families for over thirty years from the financial consequences of long-term nursing home stays. This protection has enabled the denial that *is* the immediate cause of their failure to plan ahead and insure. Every long-term care insurance agent has heard the refrain: “It won’t happen to me. I’ll never go to one of those places. I’d shoot myself first.” When the time comes to enter a nursing home, however, the infirm elder is usually cognitively impaired and unable to make independent decisions. Tragically, this is precisely the time when heirs, who have a major conflict of interest, make all of the health care and financial decisions. “Shall I use Dad’s money to buy red-carpet access to top-quality private care for him or shall I retain the services of a Medicaid estate planner and preserve my inheritance by putting him in a welfare home?”

The solution to this problem is simple. We have to give Medicaid back to the poor people it was originally intended to serve. We also have to give the middle-class a genuine incentive to plan ahead, purchase insurance, and pay privately for long-term care. Simply to drop the middle class from Medicaid, however, is neither desirable nor politically feasible. The answer is to convert Medicaid from a grant to a loan for the middle class. When they know they will have to pay every penny back to Medicaid from the estate before it passes to heirs, both seniors and their heirs will pull together, plan ahead, insure privately,¹⁰⁶ and stay off welfare.¹⁰⁷

¹⁰⁵ “The most recent [census data] indicate that only approximately one-third of poor aged and adult individuals and slightly less than one-half of all poor children are actually enrolled in the Medicaid program.” John F. Holahan and Joel W. Cohen, *Medicaid: The Trade-off Between Cost Containment and Access to Care*, The Urban Institute Press, Washington, D.C., 1986, p. 47.

“The medical ‘safety net’ that the giant Medicaid program provides to the nation’s poor is full of holes, a study commission created by the Kaiser Family Foundation has concluded.... In 1990, 47 percent of the poor under 65 were covered, and only 30 percent of the poor 65 or older.” Spencer Rich, *The Washington Post*, November 14, 1991.

¹⁰⁶ “Nonbuyers [of long-term care insurance] are most likely to believe that either government programs or their current insurance plans will pay for most long-term care costs.” [p. 55] “The fact that so many people believe that they already are covered for long-term care or simply do not know may explain why the market for long-term care insurance has developed somewhat more slowly than industry analysts, policymakers, and researchers expected.” [p. 55] Marc A. Cohen and A.K. Nanda Kumar, “The Changing Face of Long-Term Care Insurance in 1994: Profiles and Innovations in a Dynamic Market,” *Inquiry*, Vol. 34, Spring 1997.

¹⁰⁷ This section was based on an article entitled “Researcher: Medicaid Stifles LTC Insurance Purchases,” published by Stephen A. Moses in *National Underwriter* on August 5, 1996.

How widespread is Medicaid planning and does it really influence whether or not people purchase private long-term care insurance?

First of all, egregious Medicaid planning—millionaires jettisoning huge estates—is not a big problem. Only 19 percent of elderly households have median net worths in excess of \$200,000¹⁰⁸ that they could divest. Although abuse of welfare by the wealthy does occur and it is an important source of revenue to Medicaid estate planning attorneys,¹⁰⁹ it is not the major public policy problem impacting the market for long-term care insurance.

The most important problem is that most elderly Americans who need long-term care qualify for Medicaid nursing home benefits or extended Medicare home health benefits without having to spend down their own resources significantly. As explained above, Medicaid nursing home eligibility rules are very generous and extremely flexible. Medicare, of course, has no means test at all. The median elderly person in terms of income and assets who needs long-term care can qualify for public benefits without any elaborate Medicaid planning. This fact reduces the general public's sense of urgency about long-term care financing and explains the absence of stronger demand for private services and insurance.

The impact of Medicaid estate planning comes to bear most heavily among the elderly who fall between the well-to-do—who could easily afford their own long-term care expenses—and the middle class—who easily qualify for public benefits without divesting or sheltering significant income and assets. The best and most recent summation of what we know about the incidence and frequency of Medicaid estate planning was published recently in *The Gerontologist*. We provide an extended excerpt from this source in the following footnote as evidence of an objective third party's assessment of Medicaid planning.¹¹⁰ More briefly:

¹⁰⁸ U.S. Census Bureau, Asset Ownership of Households: 1993, Table D, Median Net Worth by Age of Householder and Monthly Household Income Quintile: 1993. Extracted May 11, 1999 from <http://www.census.gov/hhes/www/wealth/wlth93d.html>.

¹⁰⁹ See, for example, "LTC Bullet #71: Medi-Cal (California Medicaid) is for Everyone?" in the "Appendix" of this report. It describes NAELA Medicaid planner Zoran Basich's web site in which he claims, among other things, that "you don't need to pay anything out of pocket" for long-term care.

¹¹⁰ The following excerpt is from Leslie Walker, Cynthia Gruman and Julie Robison, "Medicaid Eligibility Workers Discuss Medicaid Estate Planning for Nursing Home Care," *The Gerontologist*, Vol. 39, No. 2, 1999, p. 202.

"Medicaid Estate Planning

"Persons applying for Medicaid benefits must satisfy state-specific program criteria, including strict tests on income and assets. Medicaid estate planning (MEP) employs a range of legal and financial approaches for the purpose of establishing eligibility for Medicaid coverage for nursing home care (see Walker, Robison, & Gruman, 1998, for a more detailed description of MEP). There is great diversity in the level and nature of MEP activities across states; one of the most significant contributors is the variability of state-specific Medicaid regulations, policies, and enforcement procedures (Burwell, 1991).

"Despite the vigorous debate and keen interest in understanding MEP and its impact on Medicaid expenditures, few empirical studies have been conducted to quantify its magnitude. The majority of work has been supported by the General Accounting Office (GAO) and the Office of the Inspector General (OIG). A 1988 study conducted by the OIG surveyed all 50 state Medicaid programs regarding policies, practices on transfer of assets, liens, and estate recovery. The study found very weak enforcement of asset transfer restrictions and that an estimated \$589 million annually passed on to heirs of Medicaid recipients (OIG, 1988). A 1989 study by the OIG

“Formal public policy and actual practices regarding Medicaid financing of long-term care are inconsistent. Although the current Medicaid program uses a means-tested approach to resource distribution, regulations have facilitated broader access to Medicaid benefits for long-term care coverage.”¹¹¹

Other studies corroborate the judgment that Medicaid estate planning is very common. For example, the Minnesota Department of Human Services Quality Initiatives Division studied a sample of 445 Medicaid nursing home cases in December 1994 and concluded “approximately 1 in 4 cases with non-excluded assets over \$2,500 involved a transfer of assets...,” “one of every 5 cases involved improper transfers...,” and “nine of every 10 transfers were improper...”¹¹² The study concluded that “Our findings support the hypothesis that LTCF [long-term care facility] clients with assets close to the MA [medical assistance or Medicaid] allowable limit of \$3,000 are able to transfer assets prior to and during their receipt of MA without affecting eligibility.”¹¹³

A series of state-specific “Magic Bullet” studies by the author has also documented considerable evidence of widespread Medicaid estate planning. For example, in the New Jersey study, Medicaid eligibility workers reported that:

We see Medicaid planning every day...Ninety-five percent of our cases involve some form of Medicaid planning... The vast majority of our cases with excess

indicated that persons denied and subsequently approved for Medicaid over a one-year period in Washington state had \$27.5 million in assets at the time of denial (OIG, 1989).

“In 1989, the GAO published a study on estate recovery programs among 200 randomly selected nursing home cases in Oregon and seven other states. Findings indicated that Oregon recovered approximately \$10 for every \$1 spent administering its recovery program. The report estimated that \$85 million passed on to heirs in six states (GAO, 1989). Perhaps the most widely cited GAO study was published in 1993. A review of 403 Medicaid applications in Massachusetts was conducted to determine whether assets had been converted from countable to exempt or transferred. The study found that 54% of applicants had converted assets (typically into a burial account) and 13% had transferred assets within 30 months of filing the application, with an average asset amount of approximately \$46,000 (GAO, 1993).

“Qualitative approaches have been used by Brian Burwell and his colleagues (Burwell, 1991; Burwell, 1993; Burwell & Crown, 1995). Their most recent study consisted of case studies in four purposefully selected states (Massachusetts, California, New York, and Florida) to assess the magnitude and nature of MEP. Although there was variation across the states, most eligibility workers estimated that 5%-10% of single applicants purposefully diverted assets prior to applying for Medicaid and that 20%-25% of married applicants did so. A series of studies conducted in Connecticut found that Medicaid workers, elder law attorneys, and certified financial planners differed substantially in their perceptions of the nature and magnitude of MEP (Walker, Robison, & Gruman, 1998). Medicaid workers estimated that 47% of applicants who transfer assets have less than \$1,000 in monthly income, and that 31% transfer less than \$25,000. Elder law attorneys estimated that 28% of those transferring assets have incomes lower than \$1,000 per month, and that 15% transfer less than \$25,000. Finally financial planners reported that only 3% of clients transferring assets had monthly incomes below \$1,000, and that only 7% transfer less than \$25,000.”

¹¹¹ *Ibid.*, p. 208. An earlier *Gerontologist* article by the same authors entitled “Medicaid Estate Planning: Practices and Perceptions of Medicaid Workers, Elder Law Attorneys, and Certified Financial Planners” is cited and synopsised in “LTC Bullet #28: Widespread Medicaid Planning Confirmed...Again” in the “Appendix” of this report.

¹¹² Quality Initiatives Division, “Medical Assistance Quality Control: Long Term Care Client Asset Review, Phase 1,” Minnesota Department of Human Services, St. Paul, Minnesota, February 1996, pps. i-ii.

¹¹³ *Ibid.*, p. iii.

assets do some form of Medicaid planning... We give them all the information they should need to know to be able to protect the assets. Without telling them to go buy an oriental rug, we tell them what they need to know. We hold nothing back.¹¹⁴

In the Illinois study, Medicaid eligibility workers reported that:

I don't identify myself as a public aid worker, but only as a state worker. Once someone finds out where I work, they all have an aunt or a parent or someone who needs to qualify for Medicaid, and they insist on asking questions about how to get on.¹¹⁵

[The] average caseworker would routinely tell [Medicaid applicants] how to get rid of assets. As long as the applicant gets rid of the assets, the case is easier to handle for the worker, because [we] do not have to set up a spenddown program.¹¹⁶

The Florida study¹¹⁷ contained these examples of nearly universally practiced Medicaid planning techniques:

In practice, many eligibility workers follow a policy similar to the military's "don't ask, don't tell, don't pursue." According to one respondent who trains eligibility workers: "The \$2,000 limit is rarely used. Even though we know the house is full of antiques, we ignore them." Most workers use "negative interviewing techniques" concerning household goods. For example: "You don't have anything of value in your home do you?" This issue may seem insignificant. On the other hand, a popular self-help book on Medicaid estate planning which has sold more than one million copies nationally contains this advice: "If the person is married, household goods, a car and personal effects are protected without regard to their value!....For example, oriental rugs or paintings that appreciate in value may be worthwhile investments that add beauty and hide assets at the same time....Here's another loophole that a nursing-home resident may want to consider. He or she could buy a brand-new—and expensive—ring right before going into a nursing home. After all, the law doesn't limit this exclusion to rings purchased at the time of a wedding or engagement."¹¹⁸

¹¹⁴ Stephen A. Moses, *The Jersey Share: How to Pay for Long-Term Care with Less Federal Money, A Case Study in New Jersey*, LTC, Incorporated, Seattle, Washington, 1996, p. 19.

¹¹⁵ Stephen A. Moses, *The Magic Bullet: How to Pay for Universal Long-Term Care, A Case Study in Illinois*, LTC, Incorporated, Seattle, Washington, 1995, p. 22.

¹¹⁶ *Ibid.*, p. 22.

¹¹⁷ Stephen A. Moses, *The Florida Fulcrum: A Cost-Saving Strategy to Pay for Long-Term Care*, LTC, Incorporated, Seattle, Washington, 1994.

¹¹⁸ Armond D. Budish, *Avoiding the Medicaid Trap: How to Beat the Catastrophic Costs of Nursing-Home Care*, Henry Holt, New York, 1989, p. 39 cited in Stephen A. Moses, *The Florida Fulcrum: A Cost-Saving Strategy to Pay for Long-Term Care*, LTC, Incorporated, Seattle, Washington, 1994, p. 29.

One shelter in particular is devastating to Florida's Medicaid budget. It is almost ghoulish to have to mention the state's policy on burial accounts, burial savings, and burial funds; prepaid burial trusts; funeral plans; burial-designated automobiles; life insurance equity exempted for burial; cremation contracts; cemetery plots; and mausoleum vaults. Bottom line: elderly Floridians who need nursing home care can bury virtually unlimited assets in prepaid funeral expenses. Individual cases have protected \$10,000, \$20,000, even \$35,000 in this manner although workers agree it averages only \$4,500 per case. In addition, each recipient can—and most do—designate another \$2,500 of resources for burial over and above the \$2,000 in otherwise exempt assets mentioned earlier. **One worker told me that 65 percent of Medicaid nursing home recipients shelter assets from long-term care expenses by this means; another said 75 percent; a third said 90 percent.** [Emphasis added.] Consensus was closer to the higher than the lower estimate.... If only three-fourths of these people have prepaid for burials (\$4,500) and set aside resources or an automobile for burial costs (\$2,500), then \$244,067,250 has been made unavailable to pay for their long-term care costs. Medicaid pays instead.¹¹⁹

For more information on the “Magic Bullet” studies from which these examples were taken, see the “Annotated Bibliography” of this report.

With regard to the question of whether or not widespread Medicaid planning influences the marketability of private long-term care insurance, Walker, Gruman and Robison leave no room for doubt: “MEP [Medicaid estate planning] also has policy implications for the private arena, because the ability to access Medicaid coverage while retaining assets may have a negative impact on the demand for private long-term care insurance. In addition, penalty rules for asset transfers may influence the type of coverage chosen if a long-term care insurance policy is purchased. If the penalty period is 36 months, for example, there is no incentive to purchase more than 36 months of coverage because the policy holder can transfer all assets with the assurance of accessing Medicaid when the 36-month policy is exhausted.”¹²⁰ Over a decade ago, long-term care insurance scholar and advocate Mark Meiners expressed the same point this way: “Medicaid cannot afford to act as inheritance insurance for heirs, and a private LTC insurance market cannot fully develop if Medicaid plays this role.”¹²¹

If Medicaid nursing home benefits are so easy to obtain, why do so many people say Medicaid requires impoverishment?

In most states, there is no limit to how much income people can have and still qualify for Medicaid nursing home benefits as long as their total medical and health insurance expenses, including long-term care, approximate or exceed their income. In the remaining states, the

¹¹⁹ Stephen A. Moses, *The Florida Fulcrum, op. cit.*, p. 30.

¹²⁰ Leslie Walker, Cynthia Gruman and Julie Robison, “Medicaid Eligibility Workers Discuss Medicaid Estate Planning for Nursing Home Care,” *The Gerontologist*, Vol. 39, No. 2, 1999, p. 207.

¹²¹ Mark R. Meiners, “Reforming Long-Term Care Financing through Insurance,” *Health Care Financing Review: 1988 Annual Supplement on Post-Acute and Long-Term Care*, Health Care Financing Administration, Baltimore, Maryland, December, 1988, p. 111.

monthly income cap of \$1,500 can easily be avoided by channeling excess income into “Miller Trusts.” Assets worth hundreds of thousands of dollars are easily (1) converted to exempt status (such as a home, business and automobile), (2) sheltered in annuities or special trusts, and (3) divested by means of creative strategies that evade anti-asset-transfer laws and regulations.¹²² Obviously, Medicaid nursing home eligibility does not require impoverishment in any meaningful sense of the term.¹²³

Nevertheless, the popular and academic literature on long-term care financing is full of unsubstantiated and unsubstantiable statements to the effect that Medicaid *does* require impoverishment and that people throughout America are spending down into penury because of the high cost of nursing home care. Here are some examples:

- “*Medicaid*, a program for the poor, pays for...nursing home care, but only for people who have spent almost all their assets and become impoverished.”¹²⁴
- “To receive Medicaid assistance, you must meet federal poverty guidelines for income and assets and may have to ‘spend down’ or use up most of your assets on health care.”¹²⁵
- “Many people who begin paying for nursing home care find that their savings are not enough to cover lengthy confinements. If they become impoverished after entering a nursing home, they turn to Medicaid to pay the bills.”¹²⁶
- “[I]ndividuals must spend virtually all of their savings before they qualify for Medicaid.” [p. 118] “[T]he cost of Medicaid (spending down assets and income to the poverty level) can very well be catastrophic.” [p. 119]¹²⁷

¹²² “The objective of Medicaid estate planning is to avoid using private wealth to pay for nursing home care, and letting taxpayers pay for it instead.... State Medicaid officials believe Medicaid estate planning is growing rapidly and has become a serious policy problem. Many attorneys are developing specialty practices in ‘elder law’ to provide counsel on how the elderly can protect their wealth and still qualify for Medicaid.... Medicaid laws which prohibit persons from divesting of their assets for the sole purpose of qualifying for Medicaid have limited impact on actually preventing this practice.... Medicaid estate planning creates severe inequities in the distribution of Medicaid benefits. Middle and upper class elderly, and their heirs, are receiving public benefits, while many truly poor elderly, families and children in the community do not have access to Medicaid because States can’t afford to extend coverage to them.” Brian O. Burwell, *Middle-Class Welfare: Medicaid Estate Planning for Long-Term Care Coverage*, Systemetrics/McGraw-Hill, Lexington, MA, September 1991, p. 1.

¹²³ For detailed, state-specific evidence of these facts and information about how Medicaid eligibility is actually determined, see the “Magic Bullet” studies listed and described in the “Annotated Bibliography” of this report. See especially: *The Magic Bullet: How to Pay for Universal Long-Term Care, A Case Study in Illinois*; *The Jersey Share: How to Pay for Long-Term Care with Less Federal Money, A Case Study in New Jersey*; *The Long-Term Care Financing Crisis: Danger or Opportunity?, A Case Study in Maryland*, and *The Florida Fulcrum: A Cost-Saving Strategy to Pay for Long-Term Care*.

¹²⁴ American Health Care Association, “What Consumers Need to Know About Private Long Term Care Insurance,” Washington, D.C., undated, p. 4.

¹²⁵ National Association of Insurance Commissioners, “A Shopper’s Guide to Long-Term Care Insurance,” Kansas City, Missouri, 1996, p. 5.

¹²⁶ Health Insurance Association of America, “Guide to Long-Term Care Insurance,” Washington, D.C., 1997.

¹²⁷ Mark R. Meiners, “Public-Private Partnerships in Long-Term Care,” in Leslie C. Walker, Elizabeth H. Bradley, and Terrie Wetle, editors, *Public and Private Responsibilities in Long-Term Care, Finding the Balance*, The Johns Hopkins University Press, Baltimore, 1998.

- “Many baby boomers are unaware that the Medicaid program requires people with disabilities to impoverish themselves before they are eligible for public assistance. As a result, middle-income families have few options but to use their own income and assets to pay for their long-term care needs.”¹²⁸
- “The disabled elderly must rely on their own resources or, when these are depleted, turn to Medicaid or state-funded programs to pay for their long-term care.”¹²⁹

A consumer survey¹³⁰ asked the question: “People have to spend all or almost all of their assets to get Medicaid benefits. True or false?” The response was: “Only about half know that ‘people have to spend all or almost all of their assets to get Medicaid benefits’ (51%) and that ‘nursing home residents are often forced onto welfare in the first year’ (48%).” Ironically, the surveyors got the answer wrong and half the respondents got it right. The truth is that, even without the help of a Medicaid planner, people can and usually do protect at least some, and frequently very substantial, income and assets while qualifying for the program’s nursing home benefits.¹³¹

Why does this “Fallacy of Impoverishment”¹³² persist after all these years in spite of the facts? Many long-term care interest groups benefit, or believe they benefit, from the fallacy of impoverishment. Senior advocates may think they have a better chance to attract government financing to long-term care if policy makers perceive that widespread catastrophic spend-down is occurring. Pundits, policy makers and politicians routinely pander to the supposed need for more taxpayer-financed long-term care. Medicaid planners certainly profit abundantly by disproving the fallacy of impoverishment, on a case-by-case basis, for their well-heeled clients. Long-term care providers may hope to increase their declining Medicaid and Medicare reimbursement rates by pleading about the plight of their publicly financed patients. Finally, the insurance industry depends on the perception of widespread spend-down to market the asset protection benefit of the long-term care product.

¹²⁸ Janemarie Mulvey and Barbara Stucki, American Council of Life Insurance, *Who Will Pay for the Baby Boomers’ Long-Term Care Needs?: Expanding the Role of Long-Term Care Insurance*, Washington, D.C., 1998, p. 12.

¹²⁹ Joshua M. Wiener and David G. Stevenson, “State Policy on Long-Term Care for the Elderly,” *Health Affairs*, Vol. 17, No. 3, May/June 1998, p. 81.

¹³⁰ Consumer surveys about long-term care services and financing often demonstrate widespread ignorance and confusion. The public seems to understand the risk and acknowledge failure to prepare, but still neglects to take action. For an explanation of this phenomenon, see “LTC Bullet #88: Aging Anomalies Analyzed” in the “Appendix” of this report.

¹³¹ Mathew Greenwald & Associates, Inc., “The John Hancock/NCOA Long-Term Care Survey Report of Findings,” Washington, D.C., April 1996. The report on which the surveyors based their question and mistaken answer was *Long-Term Care and Personal Impoverishment: Seven in Ten Elderly Living Alone Are at Risk, Committee Print, House Select Committee on Aging*, 100 Congress, I Session, July 1985. This widely publicized report was based on research conducted by Laurence Branch, then of Harvard. Branch took for granted that people spend down their assets before applying for Medicaid and concluded that, therefore, most people would spend down within a year’s time. Several years after Branch’s original work, numerous empirical “spend-down” studies were conducted that showed that a much smaller proportion of nursing home residents converted from private pay to Medicaid than was previously thought. (See footnote 96 for more information on the “spend-down” studies.)

¹³² Stephen A. Moses, “The Fallacy of Impoverishment,” *The Gerontologist*, Vol. 30, No. 1, 1990.

Everyone seems to gain from this commonplace illusion in the short term. Until we cut through the misperceptions and confront the reality of long-term care financing, however, little progress will be made toward solving the real problem. The real problem is that publicly financing long-term care after the insurable event occurs anesthetizes the public to the risk of long-term care and causes their failure to plan, save and insure against this risk before it is too late.

Why doesn't the government clamp down on escalating Medicaid nursing home costs and program abuse?

Actually, the government has tried to discourage Medicaid estate planning very diligently. Three Presidents and eight Congresses have struggled to target Medicaid nursing home benefits to the genuinely needy and to discourage the practice of Medicaid estate planning. The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA '82) authorized transfer of assets restrictions, liens and estate recoveries to discourage Medicaid financial abuse. The Omnibus Budget Reconciliation Act of 1985 (OBRA '85) attempted to clamp down on the misuse of trusts to hide assets. The Medicare Catastrophic Coverage Act of 1988 (MCCA '88) made transfer of assets restrictions longer and stronger while implementing spousal impoverishment protections to eliminate any genuine need for Medicaid planning altogether. The Omnibus Budget Reconciliation Act of 1993 (OBRA '93) closed some key eligibility loopholes, made estate recovery mandatory, and sent the strongest message yet that aggressive Medicaid planning for upper middle class people will not be tolerated.¹³³

None of these legislative initiatives had any appreciable effect. The Medicaid planning bar just became more creative and aggressive. For every loophole Congress closed, private sector Medicaid planners and their allies in the publicly financed legal services bar poked open a dozen new ones. Finally, President Clinton and a Democratic Congress became completely exasperated. In the Health Insurance Portability and Accountability Act of 1996 (HIPAA '96),

¹³³ Burwell and Crown proposed some excellent enhancements to the OBRA '93 legislation that have not yet been enacted: "Should the Congress decide to enact further reforms to tighten the Medicaid eligibility system for long-term care coverage, and to pursue estate recovery efforts more aggressively, there are additional options available that were not addressed in OBRA '93. These options include: ...Amend Federal law to limit transfers from the community spouse to a third party 'for the sole benefit of the community spouse...'; Address the 'half a loaf' strategy by changing the date on which the transfer of asset penalty period begins...; Amend Federal law to clarify that transfer of asset penalties will be applied to transfers that are done for the purpose of establishing eligibility for Medicaid **or to avoid estate recovery**...; Amend Federal Medicaid law to clarify the circumstances under which an institutionalized spouse in long-term care should be deemed eligible for Medicaid when the community spouse 'refuses to support' the institutionalized spouse...; Clarify the rights of Medicaid estate recovery programs to recover from the estates of surviving spouses of deceased Medicaid recipients...; Clarify Federal law in regard to the 'income first' rule for raising the CSRA...; Clarify Federal law in regard to the use of court orders to increase the CSRA for the community spouse...; Allow/require Medicaid applicants to provide copies of Federal tax returns as documentation of their financial situation in the Medicaid eligibility process...Examples of options that would reflect a more aggressive shift in Federal policy might include: (1) requiring states to impose liens on real property as part of their estate recovery programs; (2) pooling the income as well as the assets of married couples in determining Medicaid eligibility for the institutionalized spouse; and/or (3) modifying the 'intent to return' rule such that homes would only remain an exempt resource as long as there is a medically-certified likelihood that a Medicaid recipient will be discharged from nursing home care." Brian Burwell and William H. Crown, *Medicaid Estate Planning in the Aftermath of OBRA '93*, The MEDSTAT Group, Cambridge, MA, 1995, pps. 44-47. [Emphasis in the original.]

they criminalized certain kinds of Medicaid planning and later, in the Balanced Budget Act of 1997 (BBA '97), they targeted this criminal penalty toward the Medicaid planning attorneys themselves. Even this drastic measure could not stop the Medicaid planners, however. The National Academy of Elder Law Attorneys successfully urged a New York court and Attorney General Janet Reno to conclude that the criminalization statute was unenforceable.¹³⁴ According to a recently published chapter in an elder law publication, “the heat is off elder law practitioners who advise their clients to make transfers in anticipation of applying for Medicaid assistance.” Consequently, the heat is also off potential clients to purchase private long-term care insurance.

Does this mean the situation is hopeless? Is there no way to control Medicaid estate planning abuses? Are we doomed to see this nearly bankrupt welfare program deplete the market for long-term care insurance by paying readily, albeit inadequately, for long-term care *after* the insurable event has occurred? No! All this history means is that America has tried a lot of ways to control Medicaid planning that did not work. In the process, we have learned a lot about what should, could and would work.

What should government do to make long-term care more attractive, available and affordable for all Americans, rich and poor alike?

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, compute the family's¹³⁵ 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 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 private customers. Consumers return to the market place: someone else may pay a portion of the monthly bill, but it all comes out of the family's estate in

¹³⁴ NAELA published a “Legislative Alert to All NAELA Members” on April 3, 1998 detailing the organization's “leadership and advocacy in support of its members relating to the draconian measures...that attempted to criminalize legal services and counsel by NAELA members of their clients regarding asset preservation and Medicaid planning.” Among other efforts, NAELA “authorized funding to support intensified efforts to seek repeal,” “dedicated countless hours working with members of Congress to fix the language of the ‘Granny's Advisor Goes to Jail’ amendment,” and “organized necessary funding for class action support and identified a team that would steer litigation to its hopeful result.”

¹³⁵ The term “family” as used in this section refers to the infirm individual and his or her spouse, not to the extended family that would include adult children, unless so specified.

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.¹³⁶ 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.

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.¹³⁷ 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

¹³⁶ See, for example, "LTC Bullet #40: Money Magazine Recommends Boomers Protect Parents" in the "Appendix" of this report.

¹³⁷ 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 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 market.

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-improvement 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 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.¹³⁸

Are the long-term care insurance “partnerships” a workable solution?

The Long-Term Care Partnership Program, implemented in Connecticut, New York and several other states, was a great idea scuttled by one bad assumption. The Program’s founding hypothesis—that consumers would buy a lot more long-term care insurance if they did not have to worry so much about Medicaid spend-down liability—was mistaken. In the first place, most people were not worried about Medicaid spend-down because their elderly friends and relatives usually qualified for Medicaid nursing home benefits without spending down. In the second place, the prospect of going on welfare and dying in a nursing home was not a consummation most people wanted to include as part of their long-term care planning.

To reinvigorate the Partnership Program, it may be necessary to sever its ties with Medicaid. This can be done by establishing a strong Medicaid spend-down liability mitigated by a new program to empower seniors to spend down gradually by means of a line of credit on their estates. With this new incentive in place to take the risk and cost of long-term care seriously, the public will be much more receptive to the long-term care partnerships’ educational efforts and much more likely to purchase their approved and certified long-term care insurance policies. In other words, the optimal solution is to merge the long-term care partnership program with the **LTC Choice** proposal discussed in the preceding section and elsewhere.¹³⁹

¹³⁸ This section was taken from the Center for Long-Term Care Financing’s 1998 white paper entitled “LTC Choice: A Simple, Cost-Free Solution to the Long-Term Care Financing Puzzle.” For more information, visit the Center’s web site at www.centerltc.com.

¹³⁹ For more information on this proposal and how to implement it, the reader may consult “LTC Choice: A Simple, Cost-Free Solution to the Long-Term Care Financing Puzzle,” which is a chapter by the author in Ken Dychtwald’s new anthology *Healthy Aging*. The same material is available in a report of the same name published by the Center for Long-Term Care Financing in Seattle, Washington. For details, see www.centerltc.com.

How can people increase their ability to afford the cost of long-term care insurance?

The Center for Long-Term Care Financing's *LTC Choice* plan will bring the public face-to-face with the true risk of long-term care and the options they have to prepare for the risk, before it is too late. Once consumers recognize the real need for long-term care insurance, *i.e.* not just asset protection, but access to quality care at the appropriate level, they will have many strategies and techniques from which to choose that can enhance their ability to afford the protection. For example:

- **Buy young when premiums are lower.** The average policy referenced above costs \$589 per year at age 40, but \$5,592, at age 79. The immediate benefit of buying young is self-evident. What may be less obvious is that total premiums paid for a long-term care policy purchased at age 55 and held to age 85 will be less than one-third the total premiums paid for similar coverage purchased at age 75 and held for only ten years.¹⁴⁰ A good strategy is to buy what you can afford when you are young and “stack” on additional coverage if you still qualify later as your financial condition improves. “Learn about long-term care insurance in your forties and own it by 50” is very sound advice.
- **Look to home equity for cash flow.** Approximately, 77 percent of seniors own their homes and 82 percent of these own them free and clear.¹⁴¹ More than \$1.5 trillion lies untapped in seniors' home equity that could be freed up by means of home equity conversion tools such as reverse annuity mortgages¹⁴² to enhance the incomes of older people.¹⁴³ This extra

¹⁴⁰ Assume, for example, that someone purchases a four-year, zero-day elimination, “pool of money” policy that pays up to \$100 per day for nursing home, assisted living, or home care. At age 55, one could pay \$860 per year for a policy with five percent simple benefit increase protection that is actually offered by one of the 12 carriers who represented 80 percent of all individual and group policies sold in 1996. Holding this policy for twenty years, one would pay \$17,200 in premiums, and its benefit value would increase to \$200 per day (*i.e.*, \$100 plus five percent simple inflation for 20 years). Now, assume that someone waited until age 75 to buy the same policy with a benefit of \$200 per day. The premiums at age 75 would be \$8,400 per year or \$84,000 for the ten years from the 75th to the 85th birthday. In the meantime, by age 85, the 55-year-old purchaser has paid another ten years of premiums making a total of \$25,800. Therefore, the 55-year-old has paid less than one-third the total premiums paid by the 75-year-old purchaser (\$25,800 as compared to \$84,000) and has been protected by coverage for twenty years longer. (Note that it is true that the 75-year-old purchaser will have more coverage at age 85 than the 55-year-old purchaser [\$300 per day instead of \$250 per day], because the simple five percent inflation increase on \$200 worth of coverage is greater than the increase on \$100 worth of coverage. To end up with \$300 of coverage at age 85, the 55-year-old purchaser would have had to have purchased \$120 worth of coverage originally, instead of \$100. This would have required \$30,960 in premiums over 30 years, still only 37 percent of the total premiums paid by the 75-year-old purchaser for twenty years less coverage.)

¹⁴¹ Of 20,438 occupied housing units with an elderly householder, 15,767 or 77.1 percent are owner-occupied. Of these, 12,873 or 81.6 percent are owned free and clear. Bureau of the Census, *American Housing Survey for the United States in 1993*, Current Housing Reports #H150/93, issued February 1995, Table 7-13 (p. 340) and Table 7-15 (p. 348).

¹⁴² “Reverse annuity mortgages allow homeowners to use their housing equity to secure a loan that is made available to the borrower either as a line of credit or an annuity. The value of the house is the lender's guarantee against repayment of the accumulated debt, with repayment due only after the residents die or sell the house. The reverse mortgage is a non-recourse loan, so the lender may not attach other assets even if the outstanding loan eventually exceeds the dwelling's value. The borrower has the right to reside in the house until he or she decides to sell or until death.” Barbara A. Morgan, Isaac F. Megbolugbe and David W. Rasmussen, “Reverse Mortgages and the Economic Status of Elderly Women,” *Gerontologist*, Vol. 36, No. 3, 1996, p. 401.

income would empower many more people to buy long-term care insurance or to purchase home and community-based services. According to one expert: “Estimates reveal that 57% of all homeowners could pay the premium of the prototype LTC policy with their RM [reverse mortgage] disbursement.”¹⁴⁴ New, “premium-less” long-term care insurance policies could be developed funded entirely by home equity.

- **Buy Chevrolet, not Cadillac coverage.** Consumers can decrease the cost of long-term care insurance drastically by reducing the length, breadth, and depth of coverage. For example, why would someone purchase a two-year, inflation-less, facility-only policy with a 90-day elimination period? If that is all a 79-year-old can afford, such a policy at least assures the policyholder highly competitive access to a quality nursing home as a private payer and improves the chances of remaining there should conversion to Medicaid occur later. Instead of paying \$5,592 per year for the “average” policy cited above, a 79-year old purchasing this shorter-term, facility-only plan (which includes assisted living coverage) could pay \$1,704 per year.¹⁴⁵
- **Self-insure for some of the risk to reduce premiums.** Long-term care insurance need not cover the entire cost of care. Over 90 percent of seniors receive Social Security benefits; approximately one-third have pension income; many receive interest or appreciation on their savings or investments. When someone enters an assisted living facility or a nursing home, his or her income, previously spent on food and lodging in the community, becomes available to offset the cost of facility care. Home equity conversion could also generate

“Government-backed ‘reverse’ mortgages are now available in 47 states, and homeowners 62 and over can get more money from the equity in their homes in more states due to lower interest rates and a growing federal insurance program.... The loan is fully insured by the federal government, and no repayment is required until she dies, sells her home or permanently moves....” National Center Home Equity Conversion (Ken Scholen, Director, 612-953-4474) cited in *Aging News Alert*, January 12, 1994.

¹⁴³ “The homeownership rate steadily declined from almost 80 percent for householders between ages 65 and 69 to 62 percent for those in their nineties or older.... It was quite common for elderly owners to have lived in their home for at least 30 years.... Just over one-half of them had lived at their current residence for 3 decades or more; over 90 percent of these homes were single-family detached houses.... Just because an elderly homeowner had a low income didn’t necessarily mean that their home had a low value. To illustrate, there were more than 600,000 elderly home owners who had incomes of \$20,000 or less but owned a home free and clear that was valued at \$100,000 or more. About half of these owners were aged 75 or older. Reverse annuity mortgages make their homes a potential source of income.” U.S. Bureau of the Census, “Statistical Brief: Housing of the Elderly,” SB/94-33, Washington, D.C., January 1995.

¹⁴⁴ Aldo A. Benejam, “Home Equity Conversions as Alternatives to Health Care Financing,” *Medicine and Law*, Vol. 6, No. 4, May 1987, p. 340.

Note also that public policy clearly expects home equity to be used to finance long-term care: “The Congress intends that all assets, including home equity, available to Medicaid nursing home residents be used to help pay for their care.” General Accounting Office, “Recoveries from Nursing Home Residents’ Estates Could Offset Program Costs,” GAO/HRD-89-56, March 1989, p. 3. 3.

According to legislative history, the intent of Congress in the Tax Equity and Fiscal Responsibility Act of 1982 was “to assure that all of the resources available to an institutionalized individual, including equity in a home, which are not needed for the support of a spouse or dependent children will be used to defray the cost of supporting the individual in the institution.” United States Code, Congressional and Administrative News, 97th Congress—Second Session—1982, Legislative History (Public Laws 97-146 to 97-248) Volume 2, St. Paul, Minnesota, West Publishing Company, p. 814.

¹⁴⁵ This premium is based on an actual long-term care insurance policy offered by one of the 12 carriers who represent 80 percent of all individual and group policies sold in 1996.

additional income to supplement the long-term care insurance benefits whether or not a surviving spouse remains in the home. Furthermore, many policies waive premium payments at some point after benefits begin.

- **Invite heirs to contribute toward premiums.**¹⁴⁶ After all, who should insure the heirs' potential inheritance against the risk of depletion by long-term care expenses? Is it the responsibility of the generation that struggled through the Depression, fought World War II, and scrimped and saved to accumulate the estate? Or should their baby-boomer heirs—who are about to inherit a \$10.4 trillion windfall from their parents and who are now in their peak earnings years—pay the price to protect the estate and their parents' access to quality long-term care?¹⁴⁷ This is more than common sense; it is common decency. Nevertheless, a survey of “Who Buys Long-Term Care Insurance” found: “When asked if children help to pay for long-term care insurance premiums, 98 percent indicated that they paid for premiums without help from their children.”¹⁴⁸ Worse yet, adult children are the driving force behind the artificial impoverishment of the elderly by means of Medicaid estate planning.¹⁴⁹
- **Reconfigure assets to find premium dollars.** Older people often have large sums of money tied up in low-yielding financial instruments such as bank accounts and certificates of deposit. Conversion of these assets into higher-yielding limited-risk instruments such as annuities or bonds can help to bridge the gap between available income and premium costs. Furthermore, by linking the income from a fixed-income asset to payment of a long-term care insurance premium, the policyholder reduces the risk of accidentally lapsing the policy for failure to pay the premium on time.
- **Mine the Med-Sup Policy.** A fundamental principle of insurance is that one should insure against catastrophic risk first. Nursing home costs account for over 80 percent of seniors' out-of-pocket expenditures that exceed \$2,000 per year.¹⁵⁰ Yet most of the elderly are unprotected against this risk while 70 percent or more have “Medi-Gap” policies that cover routine, first-dollar acute care. Many seniors still pay \$1,500 to \$2,500 annually for Medicare Supplemental or Medi-Gap insurance policies. While it could be unwise¹⁵¹ to drop this traditional coverage in favor of the low-cost or “free” Medicare wraparound protection

¹⁴⁶ See “LTC Bullet #40: Money Magazine Recommends Boomers Protect Parents” in the “Appendix” of this report.

¹⁴⁷ “Boomers will inherit some \$10.4 trillion from 1990 to 2040—for a mean inheritance of some \$90,000, according to Robert B. Avery and Michael S. Rendall, professors of consumer economics and housing at Cornell University.” *Business Week*, September 12, 1994, p. 64.

¹⁴⁸ LifePlans, Inc., *Who Buys Long-Term Care Insurance?: 1994-95 Profiles and Innovations in a Dynamic Market*, Health Insurance Association of America, 1995, p. 2.

¹⁴⁹ “[...]it seems fair to say that middle-aged children have much less concern about propriety than their elderly parents. The funds are there, at least for the moment, the planning is legal, and the stakes are high...once people become frail and ‘old-old’ it is much easier to do paperwork on their behalf and without their realizing the full impact of being on Medicaid.” Joel C. Dobris, “Medicaid Asset Planning by the Elderly: A Policy View of Expectations, Entitlement and Inheritance,” *Real Property, Probate and Trust Journal*, Vol. 24, No. 1, Spring 1989, p. 22.

¹⁵⁰ Thomas Rice and Jon Gabel, “Protecting the Elderly Against High Health Care Costs,” *Health Affairs*, Vol. 5, No. 4, Winter 1986, p. 17.

¹⁵¹ Possibly unwise because seniors are rebelling against perceived access and quality problems in such managed care programs.

offered by many health maintenance organizations, it may make sense to reduce Medi-Gap premiums drastically. A true catastrophic-only Medi-Gap policy, available for \$600 or \$700 per year, could often free up \$1,000 or more annually to apply toward long-term care insurance premiums.

- **Look to life insurance for help.** It is very important to match insurance coverage to your stage of life and to your financial goals. Many older people have significant assets frozen in whole life policies that could be freed up to finance long-term care insurance. Middle-aged people may find that by age 55 they need long-term care insurance more than they need their old term-life policy for which the premiums have increased over time to equal what a long-term care policy would cost now.¹⁵² Single-premium and other equity-based life insurance policies that will also pay for long-term care are a good option for people with sufficient assets available to fund them. Finally, viatication, or sale of the rights to the benefits of an insurance policy is a viable care financing option for people with shortened life expectancies.

The truth is that if you recognize the need for long-term care insurance and if you give this kind of coverage a high enough priority in your financial plan, the probability is very high that you will find the product affordable at one stage of life or another. If it is out of reach when you are young, low paid and building a family, perhaps you will be able to afford protection when you are older, even if the premiums are higher, if you look creatively for optional financing sources such as heirs, home equity, and efficient asset management.

Who should purchase long-term care insurance?

Senior advocates and financial planners often advise people not to buy long-term care insurance unless they possess certain minimum levels of income and assets. For example, according to the well-respected United Seniors Health Cooperative (USHC) of Washington, D.C.: “[E]ach member of your household should have at least \$30,000 in annual income and \$75,000 in assets, excluding your home and car, before thinking of buying long-term care insurance.”¹⁵³ Why these limits and not others either higher or lower? In the USHC’s own words: “[I]f you have few assets, you do not need insurance because Medicaid can help absorb nursing home costs.” In other words, their advice is: “If you can qualify for Medicaid nursing home benefits, then you don’t need long-term care insurance.”¹⁵⁴ As we have shown above and

¹⁵² “The State Farm Insurance company charges a nonsmoking male in good health \$350 a year for a \$100,000 policy at age 50, \$920 at age 60, and \$2,504 at age 70.... Mr. Feld [a CPA] maintains that people in their 50’s who have not taken a second look at the cost and compared it with their needs should do so. ‘You can usually eliminate term insurance as soon as your kids are out of college,’ he said.” *New York Times*, October 9, 1993.

¹⁵³ United Seniors Health Cooperative, *Long-Term Care Planning: A Dollar and Sense Guide*, Washington, D.C., March 1997, p. 66.

¹⁵⁴ Other examples in the same vein: “People with limited financial resources generally should not purchase long-term care insurance because they (1) cannot afford adequate coverage, (2) may quickly ‘spend down’ to Medicaid’s eligibility level, or (3) may already be covered by Medicaid.” General Accounting Office, *Long-Term Care Insurance: Better Controls Needed in Sales to People with Limited Financial Resources*, GAO/HRD-92-66, Washington, D.C., March 1992, p. 2.

“Does long-term-care insurance make financial sense for you or for your parents? Not necessarily. Certainly not for those who qualify for Medicaid or for those who would qualify soon after entering a nursing home.” _____, “How Will You Pay for Your Old Age?,” *Consumer Reports*, October 1997, p. 36.

elsewhere, however, virtually anyone can qualify for Medicaid nursing home benefits regardless of income or assets. Certainly, \$30,000 in income, \$75,000 in nonexempt assets, a \$250,000 home owned free and clear, and a brand new Lexus all combined present no significant obstacle to qualifying quickly for Medicaid without spending down for care.

It follows almost syllogistically, therefore, that *no one* needs long-term care insurance. That is precisely the logical conclusion that most consumers reach, although few of them identify the reasoning behind their decision so precisely. Most of them just listen to the nice long-term care insurance agent's presentation, offer courteous thanks, explain they "have to think it over," and usher the poor, befuddled salesperson out the door. This would not happen so often if consumers understood that long-term care insurance is not only, or even primarily, for asset protection. At least under current public policy, the main reason to buy long-term care insurance is to assure access to quality care at the appropriate level within the competitive private marketplace.

Eve Tahmincioglu, writing in *Kiplinger's Personal Finance Magazine*, sets a similarly high threshold for purchasing long-term care insurance: "[U]nless you're a couple with assets above \$100,000 (not including a house) or a single person with assets of more than \$40,000 or \$50,000, long-term-care insurance isn't for you."¹⁵⁵ That standard would certainly leave out a lot of high-income, upwardly mobile, under-saving baby boomers who definitely ought to be purchasing long-term care insurance.¹⁵⁶ What if you are a young couple who have not yet accumulated a lot of savings, but who want to take advantage of the low premiums available to people who purchase coverage at an earlier age? If you follow guidelines like these that are commonplace in the financial planning literature, you will miss one of the best opportunities in a lifetime to acquire long-term care insurance.

The National Association of Insurance Commissioners (NAIC) proposes a guideline for the purchase of long-term care insurance that seems at first to make more sense than either of those above: "[Y]ou should not buy a policy if you can't afford the premiums or cannot reasonably predict that you will be able to pay the premium for the rest of your life."¹⁵⁷ That sounds reasonable, but... What if you have loving adult children who are willing to pay the premiums for a long-term care insurance policy on your behalf so that they will have the satisfaction of knowing that you will be able to purchase quality long-term care *and* that their inheritance will remain intact? What if, like many seniors, you are cash poor, but house rich, and you could easily pay the premiums for a long-term care insurance policy by supplementing your income with the proceeds of a reverse annuity mortgage? What if your ability to pay the premiums indefinitely is dubious, but you would like to have long-term care insurance protection

"Of course, no demand for private LTC insurance would be expected from the population that is both income- and asset-eligible for Medicaid upon admission to a nursing home." William H. Crown, John Capitman, and Walter N. Leutz, "Economic Rationality, the Affordability of Private Long-Term Care Insurance, and the Role for Public Policy," *The Gerontologist*, Vol. 32, No. 4, 1992, p. 479.

¹⁵⁵ Eve Tahmincioglu, "The Catch-22 of Long-Term Care Insurance," *Kiplinger's Personal Finance Magazine*, May 1997, p. 98.

¹⁵⁶ Barbara Stucki of the American Council of Life Insurance (ACLI) suggested this insight.

¹⁵⁷ National Association of Insurance Commissioners, *A Shopper's Guide to Long-Term Care Insurance*, Kansas City, Missouri, 1996, p. 6.

now and for as long as possible? The usual “rules of thumb” about who should buy long-term care insurance are usually wrong and often dangerous to the public’s wellbeing.

The correct answer to the question “Who Should Buy Long-Term Care Insurance?” is anyone who (1) correctly identifies the objective risk of needing long-term care, (2) understands the value of avoiding Medicaid dependency and paying privately in order to obtain quality care at the appropriate level, and (3) can find the income or resources to fund the premiums after giving this coverage an appropriate priority among competing spending alternatives. To recommend arbitrary income and asset levels below which people should not insure is unhelpful. Such recommendations would not happen nearly as often if the “experts” understood and fully appreciated the difference between and the complementary nature of long-term care insurance as both asset protection *and*, even more importantly, quality assurance.

How is long-term care insurance changing and how do these changes affect one’s choice of a product to buy?

Two important trends impact the design of long-term care insurance products and affect the decision of what to buy. One trend is the unrelenting pressure from senior advocates for long-term care insurance products to cover more and more services with fewer and fewer obstacles to claiming benefits. This pressure has spawned new generations of products that cover home care, assisted living, and many other services—not just nursing home care. It has led to benefit triggers based on ADL deficiencies and cognitive impairment—not just medical need. These are very positive developments for consumers who can afford the higher premiums necessary to finance the richer benefits.

The other important trend that consumers need to watch is the gradual substitution of nursing homes by assisted living facilities as the principal venue for providing custodial long-term care. If the analysis in this report is correct, the primary reason Americans have received custodial long-term care in nursing homes (instead of less expensively in the home or community) for the past 35 years is that Medicaid paid and consumers did not if, but only if, they chose nursing home care. Over time, Medicaid-financed nursing home care has become strained by serious access, quality and reimbursement problems. Middle-class consumers have been threatened by potential criminal penalties and mandatory estate recovery for relying on Medicaid. Today, many people are finding the option of assisted living more and more attractive even if they have to pay for it out of pocket.

These two trends intersect to impact the design and choice of long-term care insurance products in the following way. Nursing home institutionalization is a “dreaded event.” Most people avoid going to a nursing home as long as possible. To qualify for nursing home care, one must have a very high level of impairment. Hence, on average, someone over the age of 65 has only a nine percent probability of spending five years or more in a nursing home at a cost of \$50,000 per year.¹⁵⁸ This is a relatively small risk of a catastrophic loss. Such a risk is eminently insurable. It can be spread and priced efficiently. As long as claims experience

¹⁵⁸ Peter Kemper and Christopher M. Murtaugh, “Lifetime Use of Nursing Home Care,” *New England Journal of Medicine*, Vol. 324, No. 9, February 28, 1991, p. 597.

corresponds fairly closely with the anticipated actuarial probability, an insurance company can make money selling protection against such a risk.

Consider, however, what happens when home care and assisted living facilities are covered by insurance and become the services of choice among beneficiaries. As more and more Americans live longer and longer, their risk of using some level of long-term care at some point in their lives begins to approach a certainty. Instead of a small risk of a catastrophic loss (long-term nursing home care), we are now confronting a high probability that most of us will need some form of ADL¹⁵⁹ assistance someday. Insurance may not be the most optimal way to protect against a risk that is highly probable or certain to occur. There is no way to spread a certainty. Instead, if we know we are very likely to need something expensive someday, we might save or invest rather than buy insurance.

Over time, long-term care “insurance” products have evolved from primarily pure-insurance policies protecting against the catastrophic risk of a dreaded event to partial-savings vehicles accumulating large reserves to pay for a virtual certainty of extended assisted living. There is nothing wrong with this kind of equity-based insurance. It is more like whole or universal life insurance, while traditional long-term care insurance was more like term life. What is important for the consumer to realize, however, is that the closer insurance comes to pure savings, the more advantageous it may be to save and invest independently. One might be able to get a better rate of return from a well-diversified mutual fund or some other investment. Supplemented by a relatively inexpensive, “facility only,” traditional long-term care insurance policy, this could be the least expensive way to prepare for the eventual need of long-term care. Premiums for a lean policy of this kind may be half or less the premiums for a richer, multi-benefited plan.

On the other hand, the new long-term care insurance policies, that cover a wide range of services including home care and adult day care for a relatively higher premium, may be a wise option for consumers who can afford them. Such consumers can benefit from the savings discipline such a plan imposes and they will reduce the risk to capital that comes from investing independently.

If long-term care insurance is affordable and people need it, why don't they buy it?

Objections to the purchase of long-term care insurance abound. As we explained earlier, however, most of the objections people articulate are not the real reasons they fail to buy the product. The real reason they do not buy is usually that they do not believe they need the coverage. By refocusing the question of need from mere asset protection (available from Medicaid) to excellent access, quality and level of care (available confidently only to private payers), we have shown in this report how to get underneath and behind the commonplace objections in order to discern and remove the real obstacle to the sale. The only unanswerable reason for failing to insure against the risk of long-term care is that a person does not qualify medically or financially for the coverage. If and when that fact is determined, the selling process should end immediately.

¹⁵⁹ ADL stands for “activities of daily living.”

Most long-care insurance agents are able to answer or deflect the common objections that people raise. Readers who are not agents, however, may not know the fallacies behind and the answers to the most common objections. Therefore, it is worth explaining them here.¹⁶⁰

- **Objection #1: “It won’t happen to me.”**

The average senior has four chances in 10 of entering a nursing home as a patient, but most institutional stays are short-term. The need for long-term care insurance arises because some stays are very long and expensive. For example, seniors face one chance in five of staying in a nursing home more than a year, one chance in 12 of a extended sojourn lasting five years or more, and one chance in 50 of remaining over ten years. Women are considerably more likely to enter nursing homes than men. Couples should consider carefully how they will finance long-term care in light of these facts.¹⁶¹

- **Objection #2: “I’m too healthy.”**

Healthy people live longer. The longer people live, the more likely they are to suffer one of the chronic long-term illnesses of old age. Ironically, healthy, vigorous seniors need to plan for long-term care much more carefully than their less healthy peers whose life expectancy may be much shorter.¹⁶²

¹⁶⁰ The following section was adapted from a similar section in Stephen A. Moses, “Health and Long-term Care Insurance,” Chapter 24 in Louis A. Mezzullo and Mark Woopert, editors, *Advising the Elderly Client*, Clark Boardman Callaghan, New York, 1992.

¹⁶¹ “Overall, 27% of decedents age 25 or older were nursing home residents at some point in their lives. The majority of nursing home users (54%) spent less than 1 year in nursing homes. A significant minority, however, had high amounts of lifetime use—12% had between 5 and 10 years of use and 4% had 10 or more years of lifetime use....[pps. 208-209] Women were more likely than men to use nursing homes (34% versus 20%), and whites and others were more likely to use nursing homes than blacks (28% versus 14%).... [p. 209] Not surprisingly, most nursing home users first entered at advanced ages (the mean and median were 78.5 years and 80.0 years, respectively).... [p. 209] Lifetime nursing home use is inversely related to age at first admission. Mean use by persons first admitted before age 65 was more than twice that of persons who entered at age 85 or older.... Among nursing home users, 87% had only a single episode, 11% had two episodes, and 2% had three or more episodes of nursing home care over their lifetimes.... [p. 210] Expected time to admission of nursing home users declined sharply with age. At age 45, those projected to be nursing home residents were not expected to start their stays for 38.6 years. The corresponding figure at age 85, conversely, is 4.1 years for all persons and 5.3 years for community residents.... [p. 211] **Approximately 20% of community residents were projected to exceed 1 year of use, 15% were projected to exceed 2 years of use, 8% were projected to exceed 5 years of use, and 2% were projected to exceed 10 years of use....** [emphasis added] The extreme skewness of the lifetime use distribution is highlighted by the finding that, at most ages, approximately 25% of all remaining use was expected to occur after 5 years of nursing home residence.” [p. 212] Christopher Murtaugh, Peter Kemper, Brenda C. Spillman, and Barbara Lepidus Carlson, “The Amount, Distribution, and Timing of Lifetime Nursing Home Use,” *Medical Care*, Vol. 35, No. 3, 1997, pps. 204-218.

¹⁶² In the July 1998 issue of *The Journals of Gerontology: Series B, Social Sciences*, Sarah B. Laditka’s article “Modeling Lifetime Nursing Home Use Under Assumptions of Better Health” examines the following hypothesis: “If members of the baby boom generation spend a larger percentage of their longer lives in better health, a lower demand for nursing homes is likely to result than if they live a greater proportion of their longer lives in worse health.” [p. S178] Sounds reasonable, but here’s what the study actually found: “In contrast with what was hypothesized, when increased longevity came as a result of better health, the proportion of life spent in a nursing home (*i.e.*, relative nursing home use) did not decrease or change. Second, better health did not appreciably reduce the proportion of the cohorts that used nursing homes.... Better health did result in an increase in the absolute

- **Objection #3: “I’ll never go to one of those places; I’d kill myself first.”**

Quality long-term care in pleasant surroundings is readily available to those who can pay. Unfortunately, many people associate nursing homes with bad smells, dowdy surroundings, and screaming, zombie-like patients. Quality nursing homes and assisted living facilities are pleasant places with enjoyable activities for the able and special care units for the severely disabled. Advisers should encourage clients to check out several local long-term care facilities including all-Medicaid, all-private pay, and mixed facilities for comparison. As for the idea of preventing institutionalization by committing suicide, most nursing home residents are cognitively impaired by Alzheimer’s disease or some other form of dementia.¹⁶³ When the time comes to use it, most people will not remember why they bought the gun!

- **Objection #4: “I want to stay at home.”**

Most seniors strongly prefer to remain at home if and when they need long-term care. Research indicates that people who buy long-term care insurance believe they will need nursing home care more than home care, while non-buyers think the opposite.¹⁶⁴ Advisers should respect the preference for home care, but emphasize the hard facts to clients. Institutionalization is the greatest risk. Home care, beyond a few hours per day, is prohibitively expensive for most people. Round the clock home health or in-home custodial care is not insurable cost-effectively. Without supplemental assistance from family members or voluntary caregivers, people should not plan on home health coverage for extended periods of care. Even with paid helpers, strain on family caregivers can be excessive. The hierarchy of risk principle definitely applies. Cover the risk of institutionalization first. Then, if additional premiums are affordable, add home health coverage to the plan. Such coverage may extend a patient’s ability to remain at home without undue burden on the family.

- **Objection #5: “My kids will take care of me.”**

Many adult children refuse to talk to their parents about long-term care. They are afraid the parents will think they do not love them or that they want to put them “in a home.” But

number of years older persons spent in nursing homes. This result implies that if morbidity improves there will be an increase in the use of long-term care services—an increase above that which researchers should expect from the anticipated larger number of older adults alone.” [pps. S184-85] In other words, the healthier you are, the longer you are likely to live; and the longer you live, the more likely you are to need expensive long-term care. So much for the common objection to long-term care insurance that: “I’m healthy and my family is long-lived so I’ll never need that coverage.” The truth is that healthy people need long-term care protection even more than sick people, who may pass on relatively quickly and inexpensively.

¹⁶³ “For every 1,000 nursing home residents, 674 [67.4 percent] had at least one cognitive disability.” J.F. Van Nostrand, S.E. Furner, and R. Suzman, editors, *Health Data on Older Americans: United States, 1992*, National Center for Health Statistics, Vital Health Stat 3(27), 1993, p. 4.

¹⁶⁴ “Other things being equal, individuals who purchase policies are more likely to assess their risk of incurring a high expense to be greater than those who do not.... Consistent with our expectations, purchasers believe that they are at higher risk for needing nursing home care than do non-purchasers.... Non-purchasers assess their risk for needing nursing home care to be lower than purchasers and are also more likely to believe that if they do incur such expenses, the government will pay.” LifePlans, Inc., *Who Buys Long-Term Care Insurance?*, Health Insurance Association of America, Washington, D.C., 1992.

talking to their parents about long-term care is just as important as talking to their children about sex. The risks of silence are too great. Ten percent of the children of the elderly are elderly themselves and this percentage is growing.¹⁶⁵ Often, they cannot physically perform the heavy lifting required to move and bathe a totally incapacitated person. Other children of frail parents still work, or live elsewhere, or want lives of their own. For one reason or another, taking care of disabled parents is becoming harder and harder for families. Seniors must recognize that disabilities which occasion long-term care are usually severe. They customarily include the need for help with normal activities of daily living, but they may also require incontinence management or control of screaming and abusive behavior incidental to dementia. Such care requires round the clock attention and infinite patience. This letter to Ann Landers speaks volumes: “When my mother was 60 years old, (and in excellent health), she made me promise, with my hand on the family Bible, that I would never put her in a home. Now she is 83, bedridden and incontinent. Her mind is gone, and she screams constantly. I kept my word, but it cost me my marriage. Please tell your readers that they should never make this mistake. It has ruined my life.”¹⁶⁶ Most people, when they realize what it entails, will not want their children to provide their long-term care.

- **Objection #6: “I’m going to wait and see what the government does.”**

The prospect of paying or insuring for long-term care is daunting to most people. When they hear a daily din of advocacy groups demanding and politicians promising universal health insurance, the temptation is strong to wait for further developments. This is dangerous for two reasons. First, government health care expansions are highly doubtful because of inadequate financing sources. If they come at all, new benefits will probably go first to the uninsured rather than to seniors, who are perceived at least to have Medicare. Those few health proposals which include long-term care usually offer little more than enhancements of Medicaid. A further concern of many people, based on the dismal reputations of Medicaid and the Veterans’ hospitals, is what kind of care the government might provide: “National health insurance would give us all the compassion of the IRS and the efficiency of the postal service—at Pentagon prices,” predicted one former federal official. Secondly, any delay in purchasing private long-term care coverage is hazardous for seniors because they are vulnerable in the meantime to an unprotected loss, to a sickness or injury that would preclude future insurability, and to increased premiums which rise with age at purchase. The best advice is to lock in at least some catastrophic coverage as early as possible. Then relax and let the political theatre of health policy making play itself out.

- **Objection #7: “Medicare will pay.”**

Medicare does not pay for custodial nursing home care. It pays only for short-term recuperative care requiring a high level of skilled, medical attention. Surveys still show that most seniors think Medicare will pay their nursing home bills. Until they are disabused of this myth, confusion will linger. The irony is, however, that *Medicaid* *does* pay nursing home bills,

¹⁶⁵ “Already, 10 percent of today’s senior citizens have children who are also senior citizens.” Ken Dychtwald and Joe Flower, *Age Wave: The Challenges and Opportunities of an Aging America*, Jeremy P. Tarcher, Inc., Los Angeles, 1989, p. 238.

¹⁶⁶ *Seattle Post-Intelligencer*, April 9, 1990.

and as explained in this report, with much less difficulty and spend-down than is commonly thought. Therefore, advisers should warn clients about the access, quality, discrimination and institutional bias problems associated with Medicaid financing and not focus on asset protection alone.¹⁶⁷

- **Objection #8: “I’m a vet.”**

Although the Department of Veterans’ Affairs does provide nursing home care to some veterans, there is no entitlement for this service. Eligibility is means-tested and limited to veterans with service-connected injuries. By the year 2000, three-fifths of elderly men will be veterans.¹⁶⁸ This will place a tremendous burden on the health care system for veterans. Because of worsening financial constraints, the Department plans to provide nursing home care to only 16 percent of the 290,000 veterans who will need it by the turn of the century. The rest will have to fend for themselves.¹⁶⁹

¹⁶⁷ Even Medicaid estate planning attorneys are beginning to recognize the risks of relying on Medicaid. The following warnings come from a former President of the National Academy of Elder Law Attorneys. “*Practice Alert: The escalating cost of the Medicaid program at both the federal and state levels has caused a significant ‘tightening’ of the program, both through legislative change and cutbacks in coverage. These changes have been heavily focused on the category of aged persons who need long-term institutional care. At the federal level this is reflected in the passage of the Medicaid portions of the Omnibus Budget Reconciliation Act of 1993 (OBRA 93). At the state level, there has been proactive elimination of Medicaid coverage. Typical items eliminated from Medicaid nursing home programs in such cutback programs have been eyeglasses, dentures, hearing aids, and disposable adult diapers. At the present time it appears that such cutbacks will not only continue, but will include more essential items. This raises grave quality of care issues, which are important to consider when discussing Medicaid as a potential option for financing costs of long term care. From a planning perspective, this also makes it important to assure that the client will not be ‘wiped out’ and left without the means to provide for himself or herself the needed services and goods no longer provided by Medicaid.*” [p. 16] “Most clients recognize the fact that Medicaid is the only government program which can assist with the cost of long-term care. Thus, it is becoming increasingly common for the older client to want to specifically address the concept of Medicaid planning. Advisers to elderly persons must remember, and help their clients remember, that Medicaid is only one of a number of alternatives to consider. The full range of financial planning tools and alternatives must be considered. Planning only for Medicaid eligibility severely restricts options, and would not be in the best interest of many clients. For example, considerations should be given to the following possible consequences of transferring resources in an effort to meet resource eligibility requirements: (1) Possible loss of autonomy, pride, and dignity; increase in dependence on others; (2) Inability to purchase services not available under Medicare or Medicaid; (3) Reluctance of nursing homes to admit Medicaid as opposed to ‘private pay’ patients; (4) Donees of transferred assets may be or become unwilling to provide financial assistance to the donor when needed; and (5) Resource depletion eliminates the option of obtaining entry to facilities that do not accept Medicaid patients.” [pps. 54-55] William Overman, “Medicaid Program,” Chapter 29 in Louis A. Mezzullo and Mark Woopert, editors, *Advising the Elderly Client*, Clark, Boardman, Callaghan, New York, June 1995.

¹⁶⁸ United States Senate Special Committee on Aging, the American Association of Retired Persons, the Federal Council on the Aging and the United States Administration on Aging, *Aging America: Trends and Projections, 1991 Edition*, Washington, D.C., 1991, p. 25.

¹⁶⁹ “The VA statute allows but does not mandate that the VA provide nursing home coverage.... The VA rations the limited nursing home resources according to a list of priorities which is headed by veterans with service-connected disabilities. Higher income veterans with non-service-connected disabilities are at the bottom of the list. These veterans have access to services ‘[t]o the extent resources and facilities are otherwise available....’ The occupancy rate for VA nursing home facilities is more than 90%, so access can be difficult.... The only VA home care benefits are a hospital-based home care program that does not provide home health or personal care aides and a demonstration project allowing the VA to contract with certified home health agencies to provide services to veterans with service-connected disabilities.... The nursing home coverage is also subject to geographic limitations.... Many states have only one or two VA nursing homes and not every state has a State Home.... Persistent concerns are

- **Objection #9: “Long-term care insurance has a bad reputation.”**

Long-term care insurance receives a lot of bad publicity. Congressional hearings have spotlighted agent abuse; *Consumer Reports* lambasted certain product features; advocates for national health insurance blast insurance companies frequently. Some of this criticism is valid, reflecting the awkward adolescence of a new and experimental industry. Much of it is dubious, displaying ideological bias of the critic more than objective analysis of the products. Most of it is questionable, comparing existing policies with imaginary ideals instead of with real world alternatives. The only fair comparison is between actually available private coverage and the only other alternative, Medicaid, which has far more serious problems. Most experts agree that long-term care insurance has come a long way toward correcting the problems that consumers and their advocates have raised. The experts would also agree that the industry still has a way to go. *Caveat emptor* definitely applies. People should shop carefully and examine several different companies and their policies before buying.

- **Objection #10: “It costs too much.”**

Long-term care insurance is expensive. People who genuinely cannot afford it, should not buy it unless they have financial support from adult children or some other source. In fact, responsible insurance companies will not sell a policy to someone who cannot afford adequate coverage while maintaining a satisfactory lifestyle. On the other hand, people need to be realistic. Fire insurance would not be cheap if every tenth house burned down. The high actuarial probability of a loss puts a floor under long-term care insurance premiums. Therefore, families should be creative about finding ways to pay for protection as suggested above. An inter-generational contract in which adult children help with insurance premiums in exchange for the promise of an inheritance thus secured is a very promising solution for many lower-income older people (many of whom possess substantial assets). Home equity conversion through formal reverse annuity mortgages or informal family arrangements, such as a sale and leaseback, is another way to generate financing for care or premiums.

- **Objection #11: “It will not pay if I have a claim.”**

This worry has several variations. Early generations of long-term care insurance had stringent gate-keeping provisions, such as prior hospitalization requirements or stipulations concerning medical necessity, designed to prevent excessive utilization. These provisions were found sometimes to obstruct appropriate utilization to the detriment of policyholders. New products, carefully chosen, avoid this problem. Even if a claim is paid, however, inflation may have eroded its value. This has the same practical effect for insureds as non-payment. Most long-term care insurance products today, offer one or more approaches to inflation protection for varying levels of additional premium. Finally, the apparent breadth and quality of coverage is moot if the carrier goes out of business or raises premiums beyond affordability in the future. Financial rankings from A.M. Best’s, Moody’s, and Standard and Poor’s should be consulted, but they provide no guarantee. People ought to insist on examining insurance companies’ claims

expressed regarding the quality of care provided in VA facilities.” Anthony Szczygiel, “Long Term Care Coverage: The Role of Advocacy,” *University of Kansas Law Review*, Vol. 44, No. 4, July 1996, pps. 765-9.

payment histories and their record of premium increases if any. Although only a few companies have been in the market for more than ten years, it is important to check their track records no matter how long or short.

Conclusion

Scholars and policy makers understand and anticipate the coming crisis of aging demographics. The media buzzes already with concern and advice. The public is nervous and apprehensive. But public policy has not yet responded adequately to the challenge.

At least, however, discussion and debate have begun regarding Social Security and Medicare—the two biggest social insurance programs. Unfortunately, the thermo-nuclear time bomb of the global aging crisis—long-term care—remains mostly unaddressed politically.

Political intervention in long-term care financing has been a long history of meager support for unwanted services (Medicaid nursing home care) and even less support for desirable services (home and community-based care). President Clinton's latest proposal for a \$1,000 tax credit for caregivers represents more of the same.¹⁷⁰

By paying for long-term care, albeit inadequately through Medicaid and Medicare, the government has anesthetized the public to this substantial financial risk. Consequently, most people fail to place a sufficiently high priority on the need to plan, save and insure against the cost of long-term care.

This false sense of security is the primary cause of the myth of unaffordability—the common notion that most people cannot afford private long-term care insurance. Because most people do not perceive a need to insure privately for long-term care, they think that long-term care insurance coverage is too expensive for the benefit it provides, *i.e.* unaffordable.

This report has demonstrated that when people place a realistic priority on the need for long-term care insurance, based on the objective probability of needing care and on the declining probability that public programs will pay, the vast majority of them can afford private insurance protection.

Younger people may have less income and fewer assets to protect, but their premiums for long-term care insurance are relatively low. Middle-aged people tend to have growing income and assets and their premiums would only be marginally higher. Older people face declining incomes, and increasing premiums, but the assets they need to protect often continue to grow.

Confronted with the stark reality of long-term care financing risk, most Americans (realistically as many as 70 or 80 percent) can afford to purchase the protection of private long-term care insurance at one stage of their life or another. For the young and middle-aged, the challenge is to get their attention. For older people, the challenge is to help them find creative ways to generate the cash flow for premiums.

This report has proposed solutions for both of these challenges. To raise the public's consciousness and sense of urgency concerning long-term care, we propose targeting most public financing of long-term care to the genuinely needy and offering only a line of credit on their

¹⁷⁰ See "LTC Bullet #58: Dr. Feelgood's LTC Prescription" in the "Appendix" of this report.

estates to others if they fail to insure privately.¹⁷¹ With something to lose, many more seniors and their heirs will plan creatively and insure fully for the risk of long-term care. With most Americans privately insured against this risk, Medicaid and Medicare will be better able to provide quality care at the most appropriate level for everyone else.

Unless and until lawmakers show the courage to correct our flawed public policy for long-term care financing, The Myth of Unaffordability will persist and grow in acceptance. If nothing is done, we are heading inexorably toward a demographic train wreck in the United States. The Center for Long-Term Care Financing is raising the alarm. We hope this report contributes toward the objective assessment and timely correction of the long-term care financing problem.

¹⁷¹ For details on this proposal, see “*LTC Choice: A Simple, Cost-Free Solution to the Long-Term Care Financing Puzzle*,” the Center for Long-Term Care Financing’s first white paper, which is described in the body of this report and synopsized in the annotated bibliography immediately below.

Annotated Bibliography of Research Studies and Publications on Related Subjects by Stephen A. Moses

For information on how to obtain copies of the following reports, call or write the Center for Long-Term Care Financing at the location cited on the title page of this report or consult the Center's web site at www.centerltc.com. Studies in the "Magic Bullet" series are indicated by an asterisk in front of the report's title. See the end of this list for David M. Rosenfeld's "Whose Decision Is It Anyway?: Identifying the Medicaid Planning Client," *University of Illinois Elder Law Journal*, Vol. 6, No. 2, 1998, pps. 383-395.

LTC Choice: A Simple, Cost-Free Solution to the Long-Term Care Financing Puzzle, Center for Long-Term Care Financing, Seattle, WA, 1998, 31 pages, \$24.95 (hard copy), \$14.95 (disk)

This study explains for the first time why the government's Medicaid and Medicare programs are hemorrhaging billions of dollars for long-term care while so few elderly people pay privately for home and community-based or nursing home care. Americans face roughly a one in ten chance of spending five or more years in a nursing home after age 65 at a cost of \$30 to \$80 thousand per year, according to the report. Nevertheless, most people fail to save or insure against the high risk of catastrophic long-term care expenses. This fact has been a puzzle to policy analysts until now. According to the *LTC Choice* report, aging Americans and their families have been anesthetized to the risk of long-term care by 33 years of easy access to government-subsidized care. Despite the conventional wisdom that Medicaid requires impoverishment and that Medicare does not pay for long-term care, the truth is that virtually anyone can qualify quickly for Medicaid nursing home benefits regardless of income or assets and Medicare has become a major payer of long-term home health care. "The government spends tens of billions of dollars every year on long-term care for people who could have, should have and would have paid their own way," said Center President Stephen Moses. "We can and must stop this waste by encouraging families to plan ahead while their aging members are still young, healthy and affluent enough to save or insure for the financial risk of a long-term illness." The *LTC Choice* report explains how to save government-financed long-term care programs for the genuinely needy by encouraging prosperous Americans to pay privately or insure for the risk of long-term care.

****The Jersey Share: How to Pay for Long-Term Care with Less Federal Money, A Case Study in New Jersey, LTC, Incorporated, Seattle, Washington, 1996, 104 pages, \$23.95 (hard copy), \$14.95 (disk)***

This study, commissioned by the New Jersey Department of Health and Senior Services, examines the state's long-term care financing crisis, explores the problem of Medicaid estate planning, and warns about the risks of making Medicaid even more attractive to the middle class by facilitating access to publicly financed home and community-based services. The report

offers 46 recommendations, provides an extensive bibliography of related publications, and supplies a model state statute.

****The Heartland Manifesto: How to Finance Long-Term Care for Middle America, LTC, Incorporated, Seattle, Washington, 1996, 67 pages, \$13.95 (hard copy or disk)***

This study applies the Magic Bullet principles and analysis to a sparsely populated Great Plains state and concludes: “South Dakota should not try to solve the long-term care financing problem by denying the succor of medical care to more of her citizens. She should not address these issues by reducing provider reimbursement rates below the minimum required for adequate care. She should not correct the system by plunging ever more of the taxpayers’ money into the black hole of institutional long-term care. The real solution is simple, economically sound and politically feasible. Merely change the incentives in the system so that South Dakotans plan ahead for long-term care, purchase private long-term care insurance, tap the equity in their homes, and utilize private home and community-based services. Divert them from the sorry fate of ending up in nursing homes on welfare prematurely by default. By doing so, the state can save Medicaid for the truly needy who cannot manage without it, relieve the overburdened taxpayers, empower the providers of long-term care with more private payers, and supercharge the financial services and long-term care insurance industries.”

Long-Term Care Public Policy & the Future of Seniors Housing, American Seniors Housing Association, Washington, D.C., 1995, 17 pages, \$14.95 (hard copy only)

This monograph explains why home and community-based services, assisted living, and private long-term care insurance were slow to develop in the United States and predicts explosive growth for these products in the future. Anyone working in long-term care can benefit from this penetrating history and analysis of the long-term care financing marketplace.

****The Magic Bullet: How to Pay for Universal Long-Term Care, A Case Study in Illinois, LTC, Incorporated, Seattle, Washington, 1995, 142 pages, \$29.95 (hard copy), \$17.95 (disk)***

This study, commissioned by the Illinois Department of Public Aid, disproves the idea that Medicaid requires impoverishment, debunks 11 fallacies about Medicaid nursing home eligibility, and provides 88 specific recommendations on how Medicaid can save \$5 billion per year (nationally) while improving access to and quality of care. This widely publicized report, the magnum opus of LTC Inc.’s “Magic Bullet” series, was the basis for a Heritage Foundation \$25 billion, five-year savings proposal to Congress.

****The Long-Term Care Financing Crisis: Danger or Opportunity?—A Case Study in Maryland, LTC, Incorporated, Seattle, Washington, 1995, 51 pages, \$23.95 (hard copy), \$13.95 (disk)***

This study analyzes the Medicaid nursing home cost explosion, offers a practical plan of corrective action and includes a model state statute to expedite long-term care savings and improvements. Legislators, policy-makers and administrators will find this report invaluable in controlling Medicaid expenditures.

The Perils of Medicaid: A New Perspective on Public and Private Long-Term Care Financing, LTC, Incorporated, Kirkland, Washington, 1997, 100+ pages, \$23.95 (hard copy), \$13.95 (disk)

This is the text and reference material for a continuing professional education seminar on the malpractice risks of Medicaid estate planning for attorneys, accountants and financial planners. Topics covered include aging demographics, the long-term care financing crisis, “elder law,” Medicaid planning techniques and their pitfalls, commonly cited deficiencies of Medicaid nursing home care, and the fundamentals of private long-term care insurance. Many pages of quotes from Medicaid planning handbooks, law journal articles, and legal treatises reveal the scope and sophistication of Medicaid estate planning techniques. The report contains a bibliography of over 200 sources and a glossary of 125 terms. Constantly updated with current information and statistics, this book is a treasure chest of quotes and citations for writers and researchers in the field of long-term care.

****The Florida Fulcrum: A Cost-Saving Strategy to Pay for Long-Term Care, LTC, Incorporated, Seattle, Washington, 1994, 181 pages, \$22.95 (hard copy), \$12.95 (disk)***

The Florida State Legislature mandated this study to “develop a proposal to limit resource and asset transfers for the specific purpose of obtaining Medicaid eligibility for long-term care services.” The report concludes that Florida can recover \$2 million dollars per year from recipients’ estates and save another \$160 million annually by closing Medicaid loopholes and encouraging private long-term care financing options. These savings would empower the state to replace its draconian “income cap” with a more generous “medically needy” nursing home eligibility system. The report includes (1) 44 recommendations on how to target Medicaid nursing home benefits to the neediest, (2) the most comprehensive bibliography on Medicaid estate planning theretofore published, and (3) the results of a nationwide survey on state Medicaid asset transfer, lien and estate recovery policies and practices.

****Long-Term Care in Montana: A Blueprint for Cost-Effective Reform, LTC, Incorporated, Kirkland, Washington, 1993, 86 pages, \$19.95 (hard copy), \$12.95 (disk)***

The Montana Department of Social and Rehabilitation Services commissioned this project to learn how “to get the most out of OBRA ‘93.” The purpose of the study was to

develop a long-term care policy for Montana which reduces public assistance expenditures by diverting affluent citizens to privately financed care while simultaneously ensuring access for everyone to high quality home, community-based and nursing-home care. The report contains eight pages of detailed recommendations on how to close Medicaid loopholes, maximize estate recoveries, and divert prosperous people to private long-term care insurance and away from Medicaid.

***Medicaid Estate Recoveries in Maine: Planning to Increase Non-Tax Revenue and Program Fairness*, LTC, Incorporated, Kirkland, Washington, 1993, 7 pages, \$9.95 (hard copy), \$7.95 (disk)**

“Eighty percent of all residents in Maine’s nursing homes are already covered by the Medicaid program. The remaining 20 percent could be on Medicaid within 30 days (days, not months!) if they chose to hire one of the attorneys we interviewed or to buy one of the self-help guides we discussed.” This report explains how Maine can save \$35.5 million per year (20 percent of the state’s Medicaid nursing home budget) by recovering efficiently from estates and encouraging the purchase of private long-term care insurance.

***Medicaid Estate Planning: Analysis of GAO’s Massachusetts Report and Senate/House Conference Language* (presented to the United States Senate Committee on Finance and Special Committee on Aging), LTC, Incorporated, Kirkland, Washington, 1993, 15 pages, \$17.95 (hard copy), \$10.95 (disk)**

Over half of all nursing home eligibility cases studied in Massachusetts transferred or sheltered assets to qualify for public assistance according to a recent General Accounting Office study. Yet, GAO discounted the significance of this finding. This report exposes the errors in GAO’s methodology and explains why they missed the full impact of Medicaid estate planning on state and federal budgets. This report also analyzes the draft statutory language that ultimately became OBRA ‘93 and explains why elder law attorneys lobbied so hard to keep key loopholes open. You cannot understand OBRA ‘93 without this report.

***Medicaid Estate Planning in Kentucky: How to Identify, Measure and Eliminate Legal Excesses*, LTC, Incorporated, Kirkland, Washington, 1993, 27 pages, \$9.95 (hard copy), \$7.95 (disk)**

What are the major “loopholes” in Medicaid nursing home eligibility? How do Medicaid estate planning attorneys take advantage of elasticity in the rules to benefit their affluent clients? What are the best ways to document the frequency and magnitude of these practices? What measures can states take to control Medicaid planning and limit financial expenditures to affordable levels? This report answers these questions succinctly for Kentucky. It applies equally well to other states with generous Medicaid nursing home eligibility rules.

A Minnesota Prospectus for the Senior Financial Security Program, LTC, Incorporated, Kirkland, Washington, 1992, 1992, 5 pages, \$9.95 (hard copy), \$7.95 (disk)

This report summarizes the status of “Medicaid Mining in Minnesota,” draws the comparison to Wisconsin, which has already acted aggressively to control Medicaid planning abuses, enumerates the questions Minnesota must answer before taking action itself, and recommends a quick turnaround study to provide the solutions.

****The Senior Financial Security Program: A Plan for Long-Term Care Reform in Wisconsin, LTC, Incorporated, Kirkland, Washington, 1992, 76 pages, \$19.95 (hard copy), \$10.95 (disk)***

This case study of Medicaid estate planning, commissioned by Wisconsin Governor Tommy Thompson, covers the techniques people use to qualify for Medicaid nursing home benefits without spending down, the status and growth of this practice, the potential impact on the state budget, and methods to control the damage, reverse the process and encourage more responsible long-term care planning. A major finding: “Medicaid nursing home eligibility is so generous in Wisconsin that most seniors who need long-term care qualify financially even without any sophisticated financial planning. Anyone else can qualify quickly, often overnight, by using techniques such as joint accounts, trusts, purchase of exempt assets, or multiple divestment... Wisconsin could save \$106 million per year by diverting ten percent of future nursing home caseloads into private pay status” in accord with the report’s recommendations.

Medicaid Loopholes: A Statutory Analysis with Recommendations (presented to the United States Senate Committee on Finance), LTC, Incorporated, Kirkland, Washington, 1991, 21 pages, \$9.95 (hard copy), \$7.95 (disk)

This report explains the problem of Medicaid loopholes and contains a footnoted copy of the applicable portion of the Social Security Act, a line-by-line analysis of each loophole including recommendations, a sampler of quotations and Medicaid planning techniques from the legal literature on Medicaid estate planning, and a bibliography of articles and books on how to qualify for Medicaid without spending down.

The Myth of Medicaid Spend-Down, LTC, Incorporated, Kirkland, Washington, 1991, 44 pages, \$14.95 (hard copy), \$7.95 (disk)

Conventional wisdom holds that large numbers of elderly Americans spend down their life savings in nursing homes before they qualify for Medicaid. Recent research indicates otherwise; “spend-down” is 15 to 25 percent instead of 50 to 75 percent as previously believed. Even these new, lower estimates include artificial impoverishment by Medicaid planners. Genuine spend down rates are lower still. This monograph demonstrates that most nursing home costs nationally are financed by direct government payments or income, not savings, and most elderly people who need nursing home care can qualify for Medicaid without spending down.

Ramifications for public policy, such as the chilling effect of easy Medicaid eligibility on the marketability of private long-term care insurance, are also discussed.

Medicaid Estate Recoveries in Massachusetts: How to Increase Non-Tax Revenue and Program Fairness, LTC, Incorporated, Kirkland, Washington, 1990, 9 pages, \$9.95 (hard copy), \$7.95 (disk)

This paper reports on a quick turnaround study of divestiture, asset sheltering and estate recoveries in Massachusetts. State eligibility staff reported that “long-term care units are barraged by [Medicaid planning] attorneys...it goes on all day...the system leaks all over the place...the laws and policy set us up for failure...the workers feel intimidated...it gets outrageous...it is morally terrible.” Thirty to 50 percent of Medicaid nursing home cases in the prosperous suburbs of Boston involve the use of divestment or sheltering techniques. Massachusetts could constrict the loopholes and collect an extra \$30 million from estates by implementing 23 “best practices” from other states.

“Rolling Back the Welfare State,” Institute for Objectivist Studies, Poughkeepsie, New York, 1994, audio tape, \$19.95

Today’s welfare state is a derelict structure wobbling on the shaky foundation of altruism. Stephen Moses explains how the Objectivist ethics provide the tools to dismantle the structure and rebuild it on solid ground, replacing welfare programs with private insurance. He discusses concrete strategies for successful political change. Mr. Moses delivered this lecture at the “Objectivism Today 1994” conference in New York City. The professionally recorded audio tape comes in a book-sized plastic binder. Order from the Center for Long-Term Care Financing or directly from The Objectivist Center, 11 Raymond Avenue, Suite 31, Poughkeepsie, New York, 12603; 1-800-374-1776; ios@ios.org

***An asterisk before the title of the reports listed above indicates that the report is part of the “Magic Bullet” series of studies.**

Other Related Publications by Stephen A. Moses

“Chapter 19: Long-Term Care Choice: A Simple, Cost-Free Solution to the Financing Puzzle,” in Ken Dychtwald, editor, *Healthy Aging: Challenges and Solutions*, Aspen Publishers, Gaithersburg, Maryland, 1999, pps. 285-302.

“Planning for Long-Term Care Without Public Assistance,” *Journal of Accountancy*, Vol. 175, No. 2, February 1993, pps. 40-44.

“Health and Long-Term Care Insurance,” chapter in Louis A. Mezzullo and Mark Woolpert, editors, *Advising the Elderly Client*, Clark Boardman Callaghan, New York, 1992.

“The Fallacy of Impoverishment,” *The Gerontologist*, Vol. 30, No. 1, February 1990, pps. 21-25.

Transfer of Assets in the Medicaid Program: A Case Study in Washington State, Office of Inspector General, OAI-09-88-01340, Washington, DC, 1989.

Medicaid Estate Recoveries: A Management Advisory Report, Office of Inspector General, Office of Analysis and Inspections, OAI-09-89-89190, Washington, DC, December 1988.

Medicaid Estate Recoveries, Office of Inspector General, Office of Analysis and Inspections, OAI-09-86-00078, San Francisco, California, June 1988.

The following publication by Center for Long-Term Care Financing Vice President and Chief Counsel David M. Rosenfeld is also available for purchase (bound copies for \$5.00):

"Whose Decision Is It Anyway?: Identifying the Medicaid Planning Client," University of Illinois *Elder Law Journal*, Vol. 6, No. 2, 1998, pps. 383-395.

The Center for Long-Term Care Financing opposes Medicaid planning as dangerous to seniors and counterproductive to genuine long-term care reform. Center Vice President David Rosenfeld's essay explores the added risk to seniors when attorneys fail to protect them in the Medicaid planning setting. Who is the client when an adult child contacts an attorney? Who is the client when an entire family arrives for the initial consultation? Who is the client when a senior insists on family approval of financial decisions? The answer to all of these questions is the same: the senior. Yet too many Medicaid planners try to represent persons in addition to, or even instead of, the senior—ignoring the paramount interests of the senior and the inherent conflict of interest with overzealous relatives and heirs. The essay concludes that individual representation is the only model, which allows for identifying and protecting a senior's best interests in this last and most vulnerable stage of life.

Appendix ***LTC Bullets***

The Center for Long-Term Care Financing publishes *LTC Bullets*—a periodic online news service covering the latest information and trends in long-term care financing.

LTC Bullets are **free of charge**. They arrive as e-mail at your internet address, but they are also archived for your convenience on the Center's web site at www.centerltc.com.

To subscribe, e-mail your request to info@centerltc.com. We will add you immediately to the distribution list.

Should you ever wish to unsubscribe, simply reply to a *Bullet* or send a message to info@centerltc.com indicating that desire and we will immediately delete your name from the distribution list.

Please direct any questions or requests regarding *LTC Bullets* to info@centerltc.com or call the Center for Long-Term Care Financing at 206-447-1340.

A dozen examples of recent *LTC Bullets* follow:

LTC Bullet #28: Widespread Medicaid Planning Confirmed...Again **Thursday, August 27, 1998**

The August 1998 issue of the respected academic journal *The Gerontologist* confirms that Medicaid estate planning—the practice of transferring or sheltering assets and income in order to qualify for taxpayer-financed nursing home care—is a widespread phenomenon. The findings reported in “Medicaid Estate Planning: Practices and Perceptions of Medicaid Workers, Elder Law Attorneys, and Certified Financial Planners” support the results of several previous studies and directly contradict assertions that Medicaid estate planning is a relatively benign and isolated occurrence.

This finding is extremely important because it helps to explain why so few Americans purchase private long-term care insurance despite the risk of catastrophically high long-term care costs. People don't insure against a financial risk that does not exist.

Researchers from the Braceland Center for Mental Health and Aging, supported with a grant from the Robert Wood Johnson Foundation and the State of Connecticut, surveyed Medicaid eligibility workers, elder law attorneys, and certified financial planners to compare their experiences and perceptions on the scope and nature of Medicaid estate planning. The researchers observe that Connecticut is known as a “hotbed of MEP [Medicaid estate planning] activity due to its wealthy population and generous, high-quality, Medicaid-covered nursing home services.”

The survey results confirm that Medicaid estate planning is a commonplace strategy advocated and facilitated by lawyers, financial planners, and even Medicaid eligibility workers to shield their respective clients from responsibility for long-term care costs.

Particularly relevant findings include the following:

*Change in Prevalence Over the Past 6 Years: Eighty percent of Medicaid workers, 60.0 percent of elder law attorneys and 57.7 percent of financial planners reported that asset transfers have increased over the past 6 years. (P. 407)

*Average Value of Transferred Assets: Among financial planners, 51.9 percent reported average transfers over \$200,000. Fifty-five percent of elder law attorneys reported average transfers over \$100,000. Overall, 7.4 percent of respondents reported average transfers over \$200,000. (P. 408)

*Financial Profile of Typical Applicant Executing Transfers: Income: Among financial planners, 51.7 percent reported clients with total monthly incomes between \$2,500-\$4,999 with 17.2 percent reporting clients with monthly incomes above \$5,000. Almost two-thirds (62.5 percent) of elder law attorneys and 48.6 of Medicaid eligibility workers reported clients with monthly incomes between \$1,000-\$2499. Overall, almost 20 percent (19.4) of respondents reported clients with monthly incomes above \$2,500 and 5.0 percent reported clients with incomes over \$5000. (P. 409) Assets: One-hundred percent of financial planners reported clients with more than \$100,000 in total assets; 13.8 percent reported clients with assets of \$200,000-\$349,999; and 72.4 percent reported clients with assets over \$350,000. Among elder law attorneys, 87.8 percent reported clients with more than \$100,000 in total assets; 41.5 percent reported clients with assets of \$200,000-\$349,999; and 19.5 percent reported clients with assets over \$350,000. (P. 409)

*Estimate of Magnitude: Financial planners reported advising 40.8 percent of clients on average about asset transfers. Elder law attorneys reported advising more than half (51.4 percent) of clients about asset transfers. Overall, 81.9 percent of respondents recommended cash gifts; 43.5 percent recommended paying off debt; 58.7 percent recommended converting countable assets into exempt assets; 52.9 percent recommended various financial instruments; and 55.8 percent recommended increasing the Community Spouse Resource Allowance (CSRA). (P. 409)

One area of possible bias in the reported findings is the assertion that “the higher proportion of elder law attorneys reporting that they advise clients who actually divest assets is not surprising given that it is their professional responsibility to provide legal guidance that is in their clients’ best interests.” (P. 410) Advising clients to give up control of their life savings and place themselves at the mercy of a welfare system with a notorious reputation for problems with access, quality, discrimination, reimbursement, and institutional bias is not likely to be in very many clients’ best interests. Unless, of course, the client is an eager heir seeking to protect an early inheritance.

The Braceland Center’s findings confirm those of previous studies conducted by the Office of the Inspector General (“Medicaid Estate Recoveries,” 1988; “Transfer of Assets: A Case Study in Washington State,” 1989) and the General Accounting Office (“Medicaid: Recoveries from Nursing Home Residents’ Estates Could Offset Program Costs,” 1989; “Medicaid Estate Planning,” 1993). Center for Long-Term Care Financing President Stephen Moses directed both OIG studies and consulted on the earlier GAO study in his former position as senior analyst for the Inspector General.

A more recent study not cited by Braceland researchers was the 1996 Minnesota Department of Human Services Quality Initiatives Division’s “Long-term Care Client Asset Review” conducted to assess the extent and impact of Medicaid estate planning. Quality Control staff reviewed 445 cases of clients residing in long-term care facilities as of December 1, 1994 for evidence of improper transfers. The results were troubling: 9 out of every 10 transfers were improper (276 of 297). The total amount of assets improperly transferred was \$1,747,852 vs. \$353,398 in permissible asset transfers.

In the August 1998 issue of *LTC News & Comment*, David Rosenfeld, Chief Counsel of the Center for Long-Term Care Financing, stated that “thousands of Medicaid planning professionals are not prospering on imaginary clients. It just takes some people more time than others to admit this.”

This latest study reported in *The Gerontologist* should help to reveal the truth about Medicaid estate planning.

Source: Leslie Walker, Cynthia Gruman and Julie Robison, “Medicaid Estate Planning: Practices and Perceptions of Medicaid Workers, Elder Law Attorneys, and Certified Financial Planners,” *The Gerontologist*, Vol. 38, No. 4, August 1998, pps. 405-411.

**LTC Bullet #29: Seniors' Income Gains Dwarf Others
Friday, September 4, 1998**

The Washington Post recently analyzed new Census Bureau data showing that seniors' incomes have grown more than for any other demographic group.

The Census Bureau's analysis of household income from 1969-1996 shows a 57 percent rise in real median income for married couples over age 65 compared to a 6.3 percent increase for all households. Incomes for single men and women over age 65 rose 63 percent. The elderly are now the least likely segment of the population to be poor.

According to the article, "the result has been to create a very different profile of retirement and aging...Now most older Americans are able to either live at home or, in a small but growing number of cases, move into retirement communities and assisted living facilities that enable them to live more active lives."

The article points out, however, that circumstances can change dramatically in post-retirement years. "At age 65...many are coming off peak earning years, still live in a home they own, enjoy relatively good health and are sitting on a nest egg. But a decade later, women have lost their husbands, are beginning to suffer from more expensive, debilitating health problems, and are working their way through savings."

Purchasing long-term care insurance during or soon after peak earning years protects seniors from the risk of catastrophic long-term care costs at a time when premiums are most affordable.

Agents often describe husbands who are unwilling to seriously consider insurance despite their wives' worries over caring for themselves when their husbands are gone. The Post article shows how these fears can materialize. Another interesting fact that should give husbands pause: Without the contribution of wives, the 57 percent rise in median income for senior couples would have only been 34 percent.

Source: Barbara Vobejda, "Elderly Lead All in Financial Improvement," Washington Post, September 1, 1998, pg. A03. <http://www.washingtonpost.com/wp-srv/WPlate/1998-09/01/0351-090198-idx.html>

**LTC Bullet #40: Money Magazine Recommends Boomers Protect Parents
Friday, October 16, 1998**

Kelly Smith's article "Wealth Insurance" in the Nov. 1998 issue of Money Magazine profiles Jeff Hooke and Martin Cohen - two boomers who pay their parents' long-term care insurance premiums. According to Smith, "many boomers are realizing that they may ultimately bear the cost of their parents' long-term care, whether in the form of a forgone inheritance or as out-of-pocket outlays."

Others might ask: "Why not rely on Medicaid to pay the bills?" Martin Cohen—the profiled 51-year-old print shop owner who pays his father's LTC insurance premiums—hits it on the head: "With the insurance, I'm much more confident that I will be able to keep [my father] out of a nursing home."

LTC insurance preserves choices. Boomers, who demand choice in their own lives, can help their parents secure the best possible and most appropriate care across the spectrum of care settings.

The following letter-to-the-editor authored by Center President Stephen Moses responds to Ms. Smith's welcome article:

October 15, 1998

Editor
Money Magazine
Rockefeller Center
New York, NY 10020

Dear Editor,

Congratulations and thank you for publishing Kelly Smith's outstanding article, "Wealth Insurance" (November 1998), regarding the importance of long-term care planning.

Ms. Smith's recommendation that adult children pay or subsidize the long-term care insurance premiums for their aging parents is truly wise advice indeed. I have paid the cost of my parents' long-term care coverage for ten years. Why should they pay to protect my inheritance? I have never before seen this practice recommended in a national publication, however.

Good work! Sadly, too many of America's World War II generation are dying in nursing homes on welfare because they and their baby-boomer heirs were unaware of this devastating health and financial risk.

When you publish excellent advice of this kind, you make an important contribution to the wellbeing of our country's social safety net as well as to your readers' estates.

May I offer one important correction and one addition, however? The advice to buy long-term care insurance only if one has more than \$100,000 in assets is unsound, especially when the adult children are willing to pay the premiums. The most important reason to buy private LTC insurance is not asset protection! It is rather to assure access to quality care at the appropriate level in the private marketplace. Someone with low assets and income can easily qualify for Medicaid, i.e. public assistance, but Medicaid rarely pays for the home care or assisted living alternatives that most seniors prefer. As a general rule, Medicaid means nursing home confinement while private insurance means independence and choices with regard to care alternatives. People who want third party financing for the most desirable kinds of long-term care should consider long-term care insurance even if they have no significant estate at risk. Home equity conversion, e.g. reverse annuity mortgages, and financial support from adult children can often make the premiums reasonable under such circumstances.

Finally, Medicaid truly is a trap you should warn your readers to avoid. Because most people do not worry about long-term care until chronic illness strikes, they often find themselves suddenly in need of expensive care when they can no longer qualify to insure privately. (You cannot buy fire insurance when your house is in flames nor LTC insurance when you already have Alzheimer's Disease.) Unfortunately, a large and growing army of private "Medicaid estate planning attorneys" entices the vulnerable elderly and their heirs with a wide array of esoteric techniques to qualify for publicly financed nursing home benefits by means of artificial impoverishment. These lawyers offer the heirs an early inheritance and taxpayer-subsidized nursing home care for the parents. Once they have lost their assets, however, the parents, often frail, infirm, or cognitively impaired by this time, lack the financial wherewithal to remain at home or pay for an assisted living facility in lieu of nursing home care. They become wards of the state, cared for at public expense, while their estates frequently pass unencumbered to legally savvy heirs at the expense of the taxpayers. This is the single most common and egregious example of financial abuse of the elderly in America today. Unfortunately, it is not only legal, but also encouraged by perverse incentives in Medicaid eligibility rules that reward irresponsibility with generous contributions from the public fisc.

The Center for Long-Term Care Financing in Seattle, Washington is dedicated to disclosing and correcting these problems. Thanks again for a timely article that contributed significantly to our mission.

Sincerely,

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

**LTC Bullet #51: Certifiable Suckers?
Thursday, December 10, 1998**

Should Medicaid estate planning attorneys play a role in testing and endorsing the professional competence and ethics of long-term care insurance agents?

That is the question raised and answered in the following article, which will be published in the January 1999 issue of LTC News & Comment.

Certifiable Suckers?

by Stephen A. Moses, President
Center for Long-Term Care Financing

Are long-term care insurance agents certifiable suckers? I don't think so. But NAELA does. And it looks like we are going to find out who is right. Here's the story:

The National Academy of Elder Law Attorneys, the trade association of America's leading Medicaid estate planning lawyers, is co-venturing with one of its founding members, Boston elder law attorney Harley Gordon, to offer a program of professional certification and designation for long-term care insurance agents.

The program, which involves an eight-part training course, a four-hour NAELA-instructed review session, and a four-hour NAELA-proctored exam, is already receiving critical scrutiny by heavyweights in the long-term care insurance industry. They are asking questions like these: should a professional certification program be offered by a for-profit company rather than by an independent, objective organization like the American College of Life Underwriters? Will the program's diffuse scope and its availability to "accountants, attorneys, bank trust officers, financial planners, healthcare professionals, and security brokers" dilute its value for establishing the unique knowledge, credibility and professionalism of long-term care insurance agents? Does the Corporation for Long Term Care Certification's glossy booklet announcing the program, which is strewn with typographical errors, poor grammar, and condescending ethical aspersions toward LTC agents, reveal carelessness and bias against private insurance? Why are early supporters of the program already starting to drop out? I'll let others address these issues. My objective in this article is to challenge the wisdom of partnering professionally with NAELA and the Medicaid estate planning attorneys it represents.

Despite a growing avalanche of information about aging demographics and catastrophic long-term care financing risk, the public remains in denial about the need to insure privately. Why? The answer is simple. Medicaid still finances over two-thirds of all patient days in nursing homes and Medicare pays liberally for long-term home-health care. In the past 10 years, public financing has skyrocketed and private out-of-pocket costs have plummeted as a percentage of total LTC expenditures. After 25 years, the long-term care insurance industry has barely penetrated five percent of the senior market and virtually none of the critical baby-boomer market. Simultaneously, Medicaid and Medicare have come to face a fiscal crisis that threatens their existence. These conditions will not change until public policy rewards the early purchase of private long-term care insurance and allows those who fail to plan ahead responsibly for this risk to encounter serious financial losses as a consequence. For the past 16 years, eight Congresses and three Presidents have tried to do exactly that, but they have been thwarted every step of the way, and to this day, they have been defeated. Who is responsible for blocking these efforts at government reform? Primarily, the culprits are NAELA and the Medicaid estate planning bar.

The history of foiled reform

The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA '82) authorized transfer of assets restrictions, liens and estate recoveries to discourage Medicaid financial abuse. The Omnibus Budget Reconciliation Act of 1985 (OBRA '85) attempted to clamp down on the misuse of trusts to hide assets. The Medicare Catastrophic Coverage Act of 1988 (MCCA '88) made transfer of assets restrictions longer and stronger while implementing spousal impoverishment protections to eliminate the need for Medicaid planning altogether. The Omnibus Budget Reconciliation Act of 1993 (OBRA '93) closed some key eligibility loopholes, made estate recovery mandatory, and

sent the strongest message yet that aggressive Medicaid planning for upper middle class people will not be tolerated. None of this had any appreciable effect. The Medicaid planning bar just became more creative and aggressive. For every loophole Congress closed, private sector Medicaid planners and their allies in the publicly financed legal services bar poked open a dozen new ones. Finally, President Clinton and a Republican Congress became completely exasperated. In the Health Insurance Portability and Accountability Act of 1996 (HIPAA '96), they criminalized certain kinds of Medicaid planning and later, in the Balanced Budget Act of 1997 (BBA '97), they targeted this criminal penalty toward the Medicaid planning attorneys themselves. Even this drastic measure could not stop the Medicaid planners, however. NAELA urged a New York court and Attorney General Janet Reno to conclude that the criminalization statute was unenforceable. According to a recently published chapter in an elder law publication, "the heat is off elder law practitioners who advise their clients to make transfers in anticipation of applying for Medicaid assistance." Consequently, the heat is also off potential clients to purchase private long-term care insurance.

My colleague David Rosenfeld and I attended NAELA's 10th Anniversary Advanced Elder Law Institute in Washington, D.C. from November 20 to 22, 1998. True to past practice, this conference focussed on aggressive techniques to qualify well-to-do seniors for Medicaid-financed long-term care while eliminating or minimizing their spend-down liability. For example, past-NAELA-President Vincent Russo gave a session entitled "Irrevocable Trusts for Asset Protection" to a jam-packed audience in which he explained how to protect half a million dollars while qualifying a client for Medicaid. He concluded: "If an individual requires long term care and has significant assets to protect, then a combination of outright transfers directly to family members and assets being placed in an Irrevocable Living Trust may make sense." In another session, Florida attorneys Nicola Boone and Scott Solkoff recommended the "Personal Care Contract," a legal device whereby adult children promise to take care of an ailing parent in exchange for an early inheritance of his or her life's savings. When and if nursing home care becomes necessary, Medicaid eligibility is obviously no problem because the parent is now indigent. We questioned the ethics of this technique, but a New York attorney in attendance assured us that: "It is not financial abuse of the elderly if the elderly person wants you to do it." A third session, offered by Attorney Victor Finmann, explained how to divert large Individual Retirement Account (IRA) balances from Medicaid spend-down liability, while simultaneously avoiding Federal and State income, estate and excise taxes. According to Finmann's outline, his clients want to "[t]ransfer assets to qualify for Medicaid and thereby avoid [the] 100% 'tax' on assets [that would occur] (by payment of 100% of assets to [a] nursing home or home health care aides.)"

Milking Medicaid

But, for me, this was the final straw: In a program entitled "Nursing Home Litigation Issues," one of the presenters showed a horrific videotape of a terribly mistreated nursing home resident suffering from bone-deep, decubitus ulcers on his legs and shoulders. The audience groaned and gagged. The presenter explained that he sued the responsible nursing home under the False Claims Act and recovered \$600,000 on this case which occurred in a non-profit nursing facility serving 98-percent to 99-percent Medicaid residents. Another presenter at the same session said he spends all of his professional time suing nursing homes; he has seven to ten cases open at all times; and he thinks more and more attorneys should get into the lucrative field of nursing home litigation. "Inadequate staffing is almost always the cause of the awful consequences," he observed. Do you see how the pieces of this puzzle fit together? Medicaid planners make their money in three ways. They help affluent clients avoid income and estate taxes thereby depleting the government's resources. Then, they divest or shelter the same clients' assets to qualify them for publicly financed long-term care without spending down. Finally, when the overburdened, resource-starved Medicaid program can consequently no longer afford adequate reimbursements to assure quality care for a disproportionately heavy Medicaid nursing home caseload, the Medicaid planners sue the welfare-dependent nursing homes for deficient care-giving. If you ever wonder why Americans sometimes end up suffering and dying in tragically inadequate welfare homes in this country, just connect those dots . . . they lead directly to the unbridled practice of Medicaid estate planning. Are these the people who should examine and certify LTC agents' professional ethics and competency?

Medicaid planners see LTC agents as a source of referrals

Why are Medicaid planners suddenly taking an interest in long-term care insurance and agents? The market for Medicaid planning candidates is drying up. The public is gradually becoming aware of Medicaid's access and quality problems. Seniors are flocking to assisted living facilities which private long-term care insurance usually

pays for, but Medicaid rarely does. Seniors want to avoid the kinds of nursing homes that rely predominantly on Medicaid financing. To replenish this dwindling client base, Medicaid planners need referrals. Enter the LTC insurance agent. Medicaid planners seem to offer an easy solution for clients who cannot physically qualify for insurance. Attorneys can wave a magic legal wand and save the clients' assets while qualifying them for Medicaid benefits. Medicaid planners present this option with such seeming compassion and caring that the offer appears extremely seductive. But beware! There are three huge problems. First, an artificially impoverished elder loses the ability to purchase quality care in the private marketplace at the appropriate level. You may be condemning your client to the kind of nursing home care the Medicaid planners are litigating against. Second, Medicaid planners are notorious for failing to reciprocate with referrals from among their clients who can qualify for private long-term care insurance. Every referral they send to a long-term care insurance agent is one less Medicaid planning candidate for them. Finally, as long as Americans can ignore the risk of long-term care, avoid the premiums for private insurance, and qualify easily for government-financed care, they will not sense the urgency and need to buy a long-term care insurance policy. Until that system changes, penetration of the LTC insurance market will remain minimal.

Insurance pros should be certified by insurance experts

A professional designation and certification program for long-term care insurance agents is definitely a good idea. Fortunately, the insurance industry contains independent professional organizations capable of designing and offering a professional certification. They should do so soon. The Center for Long-Term Care Financing will gladly support and assist such an effort. The team approach to protecting seniors by interlacing the professional services of long-term care insurance agents with those of attorneys, accountants, and financial planners is excellent. We have encouraged this strategy in articles and speeches for many years. Hundreds of thousands of responsible financial professionals, who do not practice or condone Medicaid estate planning, are readily available to work cooperatively with long-term care insurance agents. With the constant publicity nowadays about the impending collapse of Social Security, Medicare and Medicaid, these collateral professionals are finally primed to work cooperatively with long-term care insurance agents to help them help their clients avoid the dire consequences of the on-going constriction of government largesse. Agents should catch this wave and ride it to the benefit of your mutual clients. But we should all ignore the siren's call of Medicaid planning advocates which will inevitably sink our hopes for a healthier long-term care system in America.

(Tape recordings of all the NAELA sessions referenced above and others as well are available from ADC Services, 69013 River Bend Drive, Covington, Louisiana, 70433, fax 504-892-9975. In addition, you can order a free tape, "Medicaid Estate Planning: The Smoking Gun," by sending a self-addressed, stamped envelope with at least \$1.01 in postage to The Center for Long-Term Care Financing, 800 Fifth Avenue, Suite 4100, Seattle, WA, 98104-3122).

**LTC Bullet #54: Caregivers Plan for LTC
Wednesday, December 16, 1998**

A recent survey of female baby boomer caregivers conducted by the National Alliance for Caregiving (NAC) reveals the powerful impact of caregiving on caregivers' expectations for their own long-term care. The survey results demonstrate how caregiving motivates caregivers to plan ahead for their own future needs. Thirty-four percent (34%) of respondents expect to purchase LTC insurance.

The following are excerpts from the NAC's survey report entitled, "The Caregiving Boom: Baby Boom Women Giving Care" (1998):

"A vast majority of caregivers, 87% of the respondents, have thought about their future long-term care needs as a result of their caregiving experience.... This may be a hidden benefit of caregiving—it helps motivate consideration of future personal care needs among current caregivers." (p. 20)

"Over one-third of caregivers claim they have taken some specific actions to plan for their own possible future long-term care as a result of their experience caring for someone (37%).... One-third reports obtaining more insurance including health, life, or long-term care policies (36%)." (p. 21)

“While caregiving per se is not sufficient to motivate or create specific areas of consideration for future long-term care needs for the majority of caregivers, it undoubtedly creates a widespread awareness that the global issue of their long-term care needs must be considered.” (p. 21)

“Nearly all of the respondents believe that their own future long-term care will be paid for by one of three means—private long-term care insurance that the respondent purchases (34%), savings and investments (31%) or government insurance such as Medicare and Medicaid (25%). The belief, among some respondents, that Medicare or Medicaid will pay for future long-term care may reflect a lack of knowledge about the financial and medical conditions that must be met to qualify for government insurance coverage of long-term care.” (p. 23)

“Taken together, these results suggest that caregivers are more realistic in their understanding of the limitations of Medicare and other governmental programs in paying for the typical services needed in long-term care, and understand the likely role that insurance and their own resources will play in funding their own caregiving needs.” (pp. 24-25)

The NAC report is especially worthwhile for anyone interested in learning more about the caregiving experience and for those involved in marketing long-term care related products and services. NAC can be reached at 4720 Montgomery Lane, Suite 642, Bethesda, MD 20814. Ph: (301) 718-8444.

Source: “The Caregiving Boom: Baby Boom Women Giving Care,” National Alliance for Caregiving, September 1998.

**LTC Bullet #58: Dr. Feelgood’s LTC Prescription
Friday, January 8, 1999**

Last Monday, President Clinton and Vice President Gore unveiled an “historic long-term care initiative to support family caregivers and help address growing long-term care needs.” All week long, praise for this plan from interest groups and advocates has filled the newswires and airwaves. The Center for Long-Term Care Financing has a different, somewhat contrarian opinion of the proposal. Here it is in the form of an op-ed article. We hope you like it.

Dr. Feelgood’s LTC Prescription
by
Stephen A. Moses, President
Center for Long-Term Care Financing

What if you needed a root canal, but your dentist prescribed novocaine instead? You’d feel better for awhile, but sooner or later you would writhe in agony, lose the tooth and blame the doctor. President Clinton’s new long-term care plan is like that: great short-term politics, but terrible long-term public policy.

The White House correctly diagnosed a huge and growing problem. American families already strain to provide 70 percent of the long-term care that five million of their loved ones need who are unable to perform the normal activities of daily living. As the baby boom generation ages and declines, the emotional and financial cost of providing this care will gradually progress from today’s crisis to a genuine catastrophe in the future.

Does it follow that the best medicine for this problem is a richer transfusion of public financing? No! For decades, government expenditures for long-term care have increased dramatically while the proportion of these costs paid by individuals out of pocket has declined radically. With every good intention, Uncle Sam has anesthetized the public to the risk of long-term care with an overdose of fiscal analgesia.

The new Clinton plan would add \$1.24 billion per year to an already burgeoning government investment in long-term care. From 1990 to 1997, the bill to taxpayers for home health and nursing home care shot up from \$31 billion to \$69 billion, an increase of 123 percent. In the same period, private out of pocket costs for the same services edged up from \$26 billion to \$33 billion, an increase of only 27 percent. Put another way, the proportion of long-term care costs paid by the government jumped from 48 percent to 60 percent while the proportion paid by patients

shrank from 40 percent to 28 percent. As public financing of long-term care increases and private spending decreases, the sense of urgency people feel about the need to plan early and insure fully for the risk of long-term care goes down. Consequently, very few people purchase private long-term care insurance and most Americans sense correctly that the government pays much of the cost of long-term care.

We can find a far better way to meet the long-term care financing challenge. Instead of spending more of our scarce public resources on current consumption, we should invest the money wisely toward a longer-term solution. The Clinton plan acknowledges the wisdom of this approach by targeting \$10 million to educate Medicare beneficiaries about the risk of long-term care and by investing \$15 million to urge Federal employees to buy private long-term care insurance. Unfortunately, the Clinton plan spends the remainder of its \$6.2 billion on tax credits to subsidize immediate spending. It would be much smarter to expend that money on tax credits or true deductibility for private long-term care insurance. This tack would gain the government some real long-term leverage on the problem. As wise as this approach is, however, it would not ameliorate the terrible burden faced by families and caregivers who are already suffering.

The best strategy is to provide a fully collateralized, government-backed line of credit on the estates of all Americans who need long-term care. That would empower them to purchase red-carpet access to top quality home care, assisted living and nursing home care in the private marketplace. The fact that they would have to pay this loan back out of their estates and inheritances would strongly encourage new generations of the aging and their heirs to plan ahead for long-term care and purchase private insurance while they are still young, healthy, and affluent enough to afford it. Getting middle class people to take responsibility for themselves in this way would relieve the currently unupportable burden on Medicare and Medicaid to provide home health and nursing home care for the needy AND the middle class. The Center for Long-Term Care Financing in Seattle, Washington has published a white paper that explains this proposal more fully (“LTC Choice: A Simple, Cost-Free Solution to the Long-Term Care Financing Puzzle”).

Since 1965, the United States government has pumped ever more money into long-term care each year through Medicaid and Medicare. Nevertheless, America’s long-term care service delivery and financing system remains fragmented and dysfunctional. We still face severe and worsening problems of access, quality, reimbursement, discrimination and institutional bias. Under these circumstances, would it be callous to suggest that the government should stanch the hemorrhage in long-term care spending and target our meager public resources more wisely? Only as callous, I think, as the dentist who heals your tooth with an unpleasant surgical procedure instead of injecting an endless stream of painkillers.

The Center’s latest policy report “LTC Choice: A Simple, Cost-Free Solution to the Long-Term Care Financing Puzzle” can be purchased for \$24.95 by contacting Amanda Cooke at 206-447-1340 or by replying to this e-mail with your order.

LTC Bullet #59: LTC is Hot!
Monday, January 11, 1999

We all know public awareness is a critical part of solving the long-term care financing crisis. Thanks to the President’s recent focus on the issue, long-term care is in the news big time these days! That is great news even if the Clinton plan itself is deficient. Here is some of the coverage we think may interest you.

The “New York Times” editorialized today (1/11/99) about the President’s new LTC plan: “President Clinton’s proposal on long-term care will give only modest help to most individuals with debilitating illnesses and family members who are caring for them and no help at all to the very poor. But it might do some good if it puts the long-term care problem on the nation’s political agenda and becomes a starting point for increased Federal involvement. The issue cannot be put off for long as millions of baby boomers begin facing potentially huge long-term care costs for themselves or their parents.” So far so good, but then the Times continues to perpetuate the myth of Medicaid spend-down: “Medicaid...is available only to people with extremely low incomes. Others have to deplete nearly all of their assets before qualifying for Medicaid.” This is ridiculous. New York City residents who need nursing home care can qualify for Medicaid benefits despite having incomes of over \$7,000 per month, more if they are married. Most assets are exempt already or they are easy to divest or convert to exempt status. Evidently, the Times

editorialist forgot what the newspaper said back on April 14, 1996 when it editorialized correctly against “the blatant and often unethical misuse of the [Medicaid] program by well-to-do patients in nursing homes. These patients exploit legal loopholes to transfer their wealth to their children, thus technically impoverishing themselves and providing themselves with inexpensive nursing home care. What was supposed to be a program for the poor has turned into a boondoggle for everyone else.... The system is a scandal.”

The “Investor’s Business Daily” ran a front page story by Laura Litvan today entitled “Long-Term-Care Troubles Loom: Some Fear Taxpayers Will Pick Up Boomers’ Tabs.” This piece comments on the danger of deflating the market for long-term care insurance by providing too much public financing. It cites Center President Stephen Moses to the effect that: “We just keep applying more anesthesia, when what we really need is a root canal.”

The current “National Journal” contains an article entitled “Another Looming Crisis” by Marilyn Werber Serafini. Here the focus is on the hidden crisis of long-term care which is usually overshadowed by the Social Security and Medicare problems. The Center for Long-Term Care Financing was cited at length in this article: “‘It sounds very seductive to take Medicaid and Medicare money, pool it together and manage it and carefully identify people’s levels of need. Keep them at home, then move them to assisted living, and use the nursing homes as a last resort,’ Moses said. ‘But this is suicidal to the Medicaid program. For every person in a nursing home,’ he said, ‘there are two or three with comparable or even more-severe disabilities getting by at home. Half,’ he said, ‘are incontinent, bedridden, or both. If you make publicly financed home care available...if you offer free care at a level that people want—assisted living and home care—people come out of the woodwork. As a result,’ he said, ‘Medicaid could be overwhelmed. It sends the message to the public: “Don’t worry about long-term care. If you ever need it, we’ll be there for you,” and that’s why we’re staring into the abyss as boomers move through Social Security and Medicare to the thermonuclear time bomb of long-term care.’”

Carl Hulse of the “New York Times” Washington Bureau put a column on the wires January 6 entitled “Plan Could Trigger National Dialogue on Long-Term Care.” He says it will be “available to dozens of newspapers” and “will run in many places.” Hulse cites the Center’s criticism of the new Clinton LTC plan: “It treats the symptoms and not the underlying problems.”

Watch for additional coverage based on input from the Center for Long-Term Care Financing forthcoming from ABC News, the New York Times, Consumer’s Research magazine, and McKnight’s Long-Term Care News. Things are poppin’!

**LTC Bullet #62: Good Ink
Friday, January 22, 1999**

This week, Jane Bryant Quinn’s syndicated column (“Tax Credit Not the Best Option for Caregivers”) tackled the new Clinton LTC proposal. She begins “It sounded like a great idea...,” but concludes “A tax credit won’t help the poor...” and “there’s a big risk of fraud.” Furthermore: “Long-term care insurance normally triggers benefits after only two impairments. So the tax credit [which requires three ADLs] is only for the severest cases.” JBQ closes the piece with “Starting a \$5.5 billion program suggests that the government will eventually pay more, says Stephen Moses, head of the Center for Long-Term Care Financing in Seattle. That lessens people’s incentive to plan for themselves...Highlighting caregiving is ‘a good message but bad public policy,’ Moses says. ‘People should be told that they need to save their money or else buy long-term care insurance.’ Unless people use their own resources, the needs of the elderly eventually will crowd out everything else.”

The current issue of Best’s Review (January 1999), the insurance industry trade magazine, contains pictures and blurbs on 33 “People to Watch in the Coming Year” who are “likely to affect the course of the industry.” The list includes billionaire investor Warren Buffet, California Governor Gray Davis, Senators William Frist and Phil Gramm, and the presidents of MetLife, John Hancock, Swiss Re, Consec, Unum, HIAA, and the Center for Long-Term Care Financing. Pretty nice company for your favorite think-tank! The blurb on Center President Steve Moses says “This crusader for sanity in long-term care continues to turn up the heat on elder-law attorneys and financial planners who help affluent people manipulate their assets so they can qualify for Medicaid. If policymakers heed his message, long-term care insurers will have a lot easier time selling their product.”

Steve Moses' op-ed article entitled "LTC Insurance Could Play Role in Solving Medicaid Woes" is published in the current [January 11, 1999] issue of National Underwriter. We have asked the magazine for permission to publish a longer, original version of this piece, entitled "Scary Numbers," as an LTC Bullet. Watch for it. Obviously, the Center for Long-Term Care Financing has been getting a lot of "good ink" lately, which means our message is getting out: the only way to save public financing of long-term care for the needy is to encourage private insurance for everyone else.

**LTC Bullet #71: Medi-Cal (California Medicaid) is for Everyone?
Wednesday, February 10, 1999**

So says Medicaid planner and National Academy of Elder Law Attorneys (NAELA) member Zoran Basich. His web site <http://www.medi-plan.com> promotes his aggressive Medicaid planning services with a potpourri of multi-media hype. He encourages unsuspecting seniors to tap into Medi-Cal's long-term care benefits by impoverishing themselves. Basich's organization is a perfect example of what the long-term care insurance industry and responsible legal and financial planners are up against.

Any advice to plan ahead with long-term care insurance? No way. Mr. Basich dismisses long-term care insurance outright in an on-line video clip that tells a room full of seniors "I personally don't have a lot of confidence in long-term care insurance.... [A]ny of the really good policies are really very expensive." He then goes on to instruct attendees on the creative use of annuities to become eligible for Medi-Cal within one month.

Any warning about Medi-Cal's problems with access, quality and institutional bias? Not a word. Evidently, it's caveat emptor when you buy discounted welfare eligibility from a Medicaid planner.

Is anyone listening to Mr. Basich's seductive message? You bet. According to Basich's web site, his organization has given "hundreds of lectures to the general public, hospital workers, doctors, nurses, social workers and discharge planners throughout the state of California."

Below are excerpts from the text of Mr. Basich's web site that typify Medicaid planners' characteristic sales pitch which responsible citizens find so maddening:

"My husband (wife, parent, grandparent) needs nursing home care and I don't know how I'm going to pay for it."

"We hear these two statements from distraught callers at least a dozen times, every day. The most important thing that we tell them in response is:

"It's all alright. You don't have to lose everything you've worked for. In fact, you don't need to pay anything out of pocket."

"Hard to believe? Let us explain. You can pay privately, out of your own savings. Or, you can let us help you get those nursing home costs paid, at little or no expense to you."

"THE IDEA IS SIMPLE, YOU DO NOT HAVE TO BE POOR OR DESTITUTE TO QUALIFY FOR MEDI-CAL. MOST PEOPLE CAN QUALIFY REGARDLESS OF INCOME OR ASSETS."

"Medi-Cal is a public benefit program, not a welfare program. A public benefit program, such as Medi-Cal, is available to all Americans, including the elderly, who are the most likely group of people to need government assistance at some time during their lives. Medi-Cal is not just for those classified as needy or poor."

“Politicians and others continually perpetuate the myth of the ‘rich senior on public assistance’ because it sounds good to a significant uninformed section of our society.”

“One does not have to be impoverished before applying for desperately-needed Medi-Cal benefits! This is where a competent professional comes in.... [W]e have assisted many elders and their families over the past 20 years. These elders and their families have been economically diverse, i.e., they have ranged from lower middle class to rather well-to-do individuals.... Now, more than ever, it is important to consult with a competent professional before entering long-term care so the proper planning can be done!”

“The asset protection aspect of our services include preparing all documents (will, durable powers of attorney, deeds, etc..) necessary to complete the process and protect the home, savings, pensions, IRA’s, annuities, and a variety of other assets that do not need to be ‘spent down’. With our planning in place, a family can far exceed the \$80,760 limit for married couples set by Medi-Cal. The healthy spouse at home can also keep a monthly income flow of a minimum of \$2,019.00.”

“WITH PROPER PLANNING ANYTHING IS POSSIBLE.”

How can long-term care insurance agents compete with lawyers who offer free coverage after the insurable event occurs? They can’t! Is there any wonder why so little LTC insurance is being sold?

Unfortunately, the more negative publicity the Medicaid planners receive, the more people seek out their services. That’s why Jane Bryant Quinn told us she hates to write on the topic. Even when she excoriates Medicaid planners in her syndicated column, her phone rings off the hook with readers asking for referrals!

When will the long-term care provider and insurance industries get behind efforts to stop these legalistic abuses?

Zoran Basich can be contacted at:

NURSING HOME FINANCIAL SECURITY
1955 West Glenoaks Boulevard
Glendale, CA 91201-1546
TEL- (818) 558-6755
FAX- (818) 558-6756
E-MAIL- mediplan@pacbell.net

**LTC Bullet #80: Center VP Argues Dangers of Medicaid Planning
Tuesday, March 16, 1999**

David Rosenfeld, Vice President and Chief Counsel of the Center for Long-Term Care Financing, has authored a provocative essay on protecting seniors from abusive Medicaid planning. His essay, entitled “Whose Decision Is It Anyway?: Identifying the Medicaid Planning Client,” appears in the current volume of the University of Illinois Elder Law Journal (Vol. 6, No. 2, 1999), the preeminent academic journal devoted to elder law issues.

The Center for Long-Term Care Financing opposes Medicaid planning as dangerous to seniors and counter-productive to genuine long-term care reform. Mr. Rosenfeld’s essay explores the added risk to seniors when attorneys fail to protect them in the Medicaid planning setting.

*Who is the client when an adult child contacts an attorney?

*Who is the client when an entire family arrives for the initial consultation?

*Who is the client when a senior insists on family approval of financial decisions?

The answer to all of these questions is the same: the senior. Yet too many Medicaid planners try to represent persons in addition to, or even instead of, the senior—ignoring the paramount interests of the senior and the inherent conflict of interest with overzealous relatives and heirs. The essay concludes that individual representation is the only model which allows for identifying and protecting a senior's best interests in this last and most vulnerable stage of life.

Bound copies of the essay are available from the Center while supplies last (\$5.00; free to media). Purchase a copy by contacting Nadia Morgen at 206-447-1340 or by replying to this e-mail with your order.

**LTC Bullet #88: Aging Anomalies Analyzed
Friday, April 9, 1999**

Two recent public opinion surveys, one sponsored by the National Council on Aging (NCOA) and John Hancock Mutual Life Insurance Co. and the other by the American Health Care Association (AHCA), produced some fascinating public opinion data on long-term care financing in the United States. Many of the findings are puzzling, however, if everything we hear about the risk of catastrophic long-term care costs reflects reality. It doesn't. Here's the story:

The third iteration of the NCOA/Hancock Long-Term Care Survey, published March 23, 1999, reports a lot of seemingly anomalous responses.

For example, although...

- * 87% of Americans think long-term care is a big problem in the U.S.
- * 69% said they were worried about paying for their own or their spouse's long-term care
- * 79% of older boomers believe long-term care is the greatest risk to their standard of living during retirement
- * 82% of respondents agree that it is irresponsible not to plan for their own long-term care needs

Nevertheless...

- * 73% of the respondents incorrectly said Medicare is the primary funding source for most older people's long-term care costs
- * 7 of 10 respondents failed a 10 question true/false quiz on basic long-term care facts, scoring a "50" or worse
- * Only 29% were familiar with reverse mortgages and 50% with long-term care insurance [fewer than 10% of seniors have purchased LTC insurance]
- * Only 12% feel they have adequately prepared for the risk of long-term care

The American Health Care Association survey, published April 7, 1999, revealed more seemingly anomalous responses.

For example, although...

- * 68% of boomers say they are not financially prepared for long term care should they need it later in life

Nevertheless...

- * Half of all boomers haven't given any thought to how they will pay for their long term care needs
- * 27% of boomers think they are covered by long term care insurance when very few boomers actually carry this coverage
- * 85% of boomers cannot name Medicaid as the primary funding source for the vast majority of nursing home residents
- * Four out of five boomers interviewed do not know how long term care is paid for and 25 percent say they are unwilling to consider paying for any additional insurance to cover these costs
- * While 41 percent of boomers interviewed are willing to pay between \$1-\$49 per month for long term care insurance, less than 6% of boomers are willing to pay \$100 or more per month (According to the American Council of Life Insurance, long term care insurance policies range from approximately \$30-\$440 a month per individual depending upon the age of the policyholder and the level of coverage provided.)

What could possibly explain these findings? Are American consumers ignorant? Illogical? Irrational?

"It's a paradox," according to Nancy Bern, senior vice president, John Hancock, as cited in a March 23, 1999 NCOA press release. "Long-term care is an increasingly familiar and important issue to aging boomers with older parents, and the issue is a growing concern among policymakers in Washington. But still, most Americans don't discuss long-term care with their families and they neglect to plan for it."

"There is definitely a reality gap in how Boomers view their retirement needs," said Tony Fabrizio, partner of Fabrizio, McLaughlin & Associates, one of two firms collaborating on the American Health Care Association (AHCA) study (cited in an April 7, 1999 AHCA press release). "Boomers are completely confused about how health care—specifically long term care—is paid for in retirement.... These findings make us wonder if Boomers are planning for yachts and sunsets at the risk of ignoring their biggest financial burden, long term care."

The data in these two surveys is not as strange as it seems according to Steve Moses, President of the Center for Long-Term Care Financing. He says:

"People only insure against real risks. Despite all the media hype about long-term care costs, the simple fact is that the average senior qualifies for Medicaid nursing home care without fancy financial planning and without spending down assets significantly. Virtually anyone, regardless of income or assets, can qualify for Medicaid long-term care benefits quickly by legally sheltering or divesting assets. Medicare provides generous long-term home health benefits to most medically qualified seniors, although it has been cutting back severely recently.

"Americans verbalize worry about long-term care financing because of the increasing barrage of media coverage on the issue. The vast majority of them are not worried enough, however, to expend the substantial premiums necessary to purchase long-term care insurance. They are not worried enough about long-term care for the simple reason that, when the worst happens and formal care becomes necessary, the government usually pays. Something over 80 percent of all nursing home costs in the United States are paid directly or indirectly by government programs or private income (not assets.) To avoid the anguish and expense of long-term home care, families often turn to Medicaid financing of nursing home care which has contributed to the well-known institutional bias in America's long-term care service delivery system.

"These facts explain why Americans report strong concern and worry about long-term care, but they fail to plan and insure adequately for the risk. They do not know who pays for long-term care, but they assume, correctly, that someone or something must pay. Ironically, the 'soft landing' provided by easily accessible Medicaid and Medicare financing has de-sensitized the public to the risk of financing long-term care. The only way to change this situation and create a stronger market for private long-term care insurance is to establish a real financial risk that cannot be avoided by turning to Medicaid nursing home benefits after the insurable event occurs. The Center for Long-Term

Care Financing has proposed new public policy that would achieve that goal, assure universal access to top-quality long-term care at the appropriate level for all Americans, and save Medicaid and Medicare money in the meantime.

“Our white paper entitled ‘LTC Choice: A Simple, Cost-Free Solution to the Long-Term Care Financing Puzzle’ documents the statements made above about public financing of long-term care, explains why most Americans can be genuinely worried about long-term care financing but still fail to plan or insure adequately, and advocates a method to encourage the early purchase of affordable long-term care insurance while empowering those who fail to insure with the ability to purchase quality home care and assisted living in the private marketplace.”

You can purchase a copy of the Center for Long-Term Care Financing’s “LTC Choice” report for \$24.95 (free to media) by contacting Nadia Morgen at 206-447-1340 or by sending your order in a reply e-mail.

**LTC Bullet #101: HCFA Tells States to Prepare for Looming Crisis
Friday, May 21, 1999**

Earlier this month, Sally Richardson, Director of the Health Care Financing Administration’s (HCFA) Center for Medicaid and State Operations, warned state Medicaid directors that several nursing home chains reporting significant financial difficulties may close or at least withdraw from the Medicare and Medicaid programs.

Ms. Richardson’s May 7, 1999 letter, reprinted below, is more evidence that a growing number of nursing homes are struggling to survive on insufficient public financing. This is not academic. Ms. Richardson’s letter describes quite starkly how states must prepare to protect publicly financed patients from the negative consequences of a nursing home’s closure or financial decline.

Unless public policy changes to promote more private financing of long-term care, nursing homes which rely on inadequate Medicare and Medicaid reimbursement for the bulk of their financing will continue to invite the financial peril Richardson describes.

Ms. Richardson’s letter is reprinted below:

May 7, 1999

Dear State Agency Director:

As you probably know, several national nursing home chains are reporting significant financial difficulties. While we hope that these organizations will see their way through these difficult periods, we are nevertheless concerned that the quality of care residents receive in chain facilities citing financial pressures be protected. Additionally, if financial difficulties persist, it is possible that some facilities may decide to withdraw their participation in the Medicare or Medicaid programs. As you may be aware, a situation like this arose in Texas recently and both HCFA and the State faced a tremendous challenge implementing new management, and virtually simultaneously, helping assure the residents of 13 nursing homes of the continued quality care they deserve.

For these reasons, we are asking that you pay particularly close attention to these situations should they develop. In particular, we want to be sure that resident health and safety are protected despite the financial decline of any nursing home or hospital organization. States should have adequate plans to assure a smooth transition to State receivership or that sufficient other resources exist to care for these residents.

To focus our collective thinking on this issue, we want to remind you of the plans and processes you must have in place and up to date:

- o Contingency plans to handle closures of multiple nursing homes or hospitals in the event they should occur.
- o A process to identify the availability of beds or alternative resources that can be drawn upon should the relocation of residents become necessary.

- o Consideration of the use of revenues from collected civil money penalties to help underwrite transition costs of relocating residents should that become necessary.
- o A review of state receivership laws to better prepare for new facility management should it become necessary to invoke these authorities.
- o Development of plans to assure that any potential changes in facility management occur smoothly. For example, States should be thinking of what measures they might take to assure residents and their families that care will be provided in a manner consistent with residents' health and safety needs.
- o Development of plans to assure that any resident relocation or facility management change is coordinated with the Ombudsman Program.

We greatly appreciate your prompt attention to this matter. Our regional office staff will follow up with the individual state survey agencies to discuss the contingency plans in more detail. I look forward to our continued collaboration as we ensure that our beneficiaries receive the quality of health care they deserve.

Sincerely yours,
Sally K. Richardson
Director

Stephen A. Moses Biographical Profile



Stephen Moses is President of the Center for Long-Term Care Financing in Seattle, Washington. The Center promotes universal access to top-quality long-term care by encouraging private financing and discouraging welfare financing of long-term care for most Americans. Previously, Mr. Moses was Director of Research for LTC, Inc., a Medicaid state representative for the Health Care Financing Administration and a senior analyst for the Inspector General of the U.S. Department of Health and Human Services.

Mr. Moses is widely recognized as an expert and an innovator in the field of long-term care. *McKnight's Long-Term Care NEWS* named him "one of the 100 most influential people in long-term care." *Nursing Homes* magazine reported "there is probably no more articulate spokesperson for privately financed long-term care than Stephen Moses."

Steve Moses has directed numerous national studies for the federal government, state governments, and private organizations on Medicaid nursing home eligibility, asset transfers, estate recoveries and long-term care financing. He specializes in problems associated with "Medicaid estate planning," the practice of artificially impoverishing affluent people to qualify them for public assistance.

Moses is credited with having "forged the framework" for the Omnibus Budget Reconciliation Act of 1993, which attempted to bring Medicaid eligibility loopholes under control. He helps state Medicaid programs curtail Medicaid estate planning and encourage private insurance as an alternative to public welfare financing of long-term care for the middle class.

Mr. Moses' articles appear often in distinguished publications like *The Gerontologist*, *The Journal of Accountancy*, *Contemporary Long-Term Care*, *Best's Review*, *National Underwriter* and *LTC News & Comment*. He is the author of "Health and Long-Term Care Insurance," a chapter in Clark Boardman Callaghan's legal treatise, *Advising the Elderly Client*. He has testified before half of America's state legislatures. He frequently addresses professional conferences in the fields of law, aging and insurance.

Steve Moses' recommendations are quoted regularly in the national media including the "CBS Evening News," PBS's "Frontline" and "The Financial Advisors," CNN, National Public Radio, *The New York Times*, *Newsweek*, *USA Today*, *Forbes*, *The New Republic*, *Smart Money*, *National Journal*, and Jane Bryant Quinn's syndicated column. He appears in a public television documentary entitled "The Aging of America: The Dilemma of Long-Term Care." His talk radio appearances on health care reform are unique, provocative, and increasingly in demand.

Mr. Moses wrote the chapter on long-term care financing for a new anthology entitled *Toward Healthy Aging*, edited by best-selling author Ken Dychtwald of *Age Wave* renown. His chapter for an anthology on the Long-Term Care Partnerships was published in 2001. He is also the author of *LTC Choice: A Simple, Cost-Free Solution to the Long-Term Care Financing Puzzle* and *The Myth of Unaffordability: How Most Americans Should, Could and Would Buy Private Long-Term Care Insurance*.

