



## Long-Term Care: Who Should Pay?

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**KONDRACKE:** Hello. I'm Morton Kondracke. Welcome to SAGE Crossroads. Our debate today is going to be about the long-term care crisis facing the United States in the long term—somewhat in the short term, as well.

Our guests are Stephen Moses, who is president of the Center for Long-Term Care Financing in Seattle, Washington, and Josh Wiener, who is a long-term health care researcher and senior fellow at RTI International. Welcome to you both.

Stephen Moses, why don't you begin by describing what the problem is and what your proposed solution is?

**MOSES:** Happy to do it. Well, our topic today is "Long-term care: who should pay?"

If that's the question, the average person will answer, "Anybody but me." Denial is not a river in Egypt.

Next best, they'll say, "Everyone should pay." And that leads to the tendency to pass the financing burden on to government.

Finally, if nothing else works, most people will prepare to pay for their own care. That's when they turn to private insurance. Winston Churchill said, "You can trust the Americans to do the right thing, but only after they try everything else first."

So let's ask, what have we tried already in long-term care? And who does pay for long-term care?

**KONDRACKE:** Could I just stop you for a second? Would you define what long-term care is

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so people know what we are talking about here?

**MOSES:** Certainly. Long-term care is assistance that people need who are unable to carry out the normal activities of daily living. It may be necessary because of old age and frailty or chronic illness or an accident, but they need help. Often, it is only custodial care—assistance going to the bathroom or eating.

But sometimes it is highly skilled medical care, as well.

**KONDRACKE:** But overwhelmingly, the people who need long-term care are the aged.

**MOSES:** In large part, and certainly they are among the most expensive people in need of long-term care.

**KONDRACKE:** Go ahead and proceed. I'm sorry to interrupt you.

**MOSES:** Well, the answer to who pays for long-term care now is certainly government. Although Medicaid pays one half the dollars for nursing home care, it covers two-thirds of nursing home residents, and touches nearly 80 percent of all patient days with its dismally low reimbursement rates.

Even the so-called out-of-pocket costs for nursing home care, which are actually down from 39 percent fifteen years ago to 25 percent today, come mostly out of Social Security—another government program in which Medicaid recipients have to contribute toward their cost of care while they are on assistance.

At 13 percent, Medicare is a much larger payer for long-term care than most people realize for nursing home care.

For home care, only 18 percent of the costs are paid by patients. The rest comes primarily from Medicare and Medicaid.

Now, what this heavy dependency on public financing for long-term care has achieved, is that we have a severely dysfunctional welfare-financed nursing-home-based long-term care system that serves no one well, least of all the poor. Long-term care today is plagued by institutional bias, too little home- and community-based care, bankruptcies, inadequate revenue, a dearth of capital, staff shortages, access and quality problems, huge tort liability, unaffordable liability insurance, too few full-pay private payers, and too many low-pay Medicaid recipients.

Well, how in the world did we get into this mess? I think it's critical to understand what caused it.

In 1965, Medicaid came along and started paying for nursing home care. The nursing home industry saw a huge opportunity, a great new financing source, and began to build facilities as

fast as they could raise the walls.

The public saw that nursing home care was free and so decided, “Why pay out-of-pocket for home care or why buy insurance?” That’s how institutional bias began, and that’s why a market for home-care-assisted living and private long-term care insurance did not develop until decades later.

Before long, of course, Medicaid nursing home care exploded in costs, and figuring they can’t charge us for a bed that doesn’t exist, the government capped the supply of nursing home beds by requiring certificates of need.

But capping supply only drove up the price as nursing homes raised their rates to compensate. So Medicaid capped what it would pay for nursing home care. In turn, nursing homes raised rates for private payers to make up the difference. That was the origin of the cost shifting from Medicaid to private payers.

Over time, Medicaid nursing home censuses grew and private pay censuses declined as fewer people could afford the higher private pay rates, and Medicaid eligibility became easier and easier to obtain.

A new practice of law called Medicaid estate planning evolved to impoverish people artificially so that they could qualify for Medicaid without spending down for their own care.

But the average person, in terms of income and assets, could qualify for Medicaid even without such legal machinations, because of the program’s very generous eligibility criteria.

With supply and price capped and eligibility easier and easier to obtain, nursing homes could fill their beds by accepting Medicaid’s low reimbursement rate no matter what quality of care they offered. Thus arose the access and quality problems that led to heavy government regulation of nursing facilities.

Today, nursing homes are caught between the rock of inadequate reimbursement and the hard place of quality regulation.

One industry executive expressed it this way: the government expects Ritz Carlton care for Motel 6 rates, while imposing a regulatory jihad.

In the meantime, both Medicaid and Medicare have played a growing role in financing home care, which most people prefer, but which those programs cannot afford.

The end result is that the public has been anaesthetized to the risk of long-term care, and estate and federal coffers have been emptied by government’s efforts to help.

It’s the same old story: good intentions led to unforeseen consequences.

Well, that brings us to the most important question to ask and that is, “Who will pay for long-term care in the future?” Certainly not government. That well is dry. No one is so naive any more as to expect a new publicly financed long-term care system to come along. More and more, the hard reality is true. If you want access to quality long-term care at home or in the community, you must be able to pay for it privately.

As publicly financed long-term care continues to deteriorate, more and more people will turn to their home equity as the only way to pay for acceptable care.

Eighty percent of seniors own their homes, and 73 percent of those own them free and clear. There is nearly \$2 trillion available and easily accessible through home equity conversion, while still retaining use of the home.

As soon as the only choice is languish in welfare-financed long-term care or spend-down your home equity to get quality care, more people will turn to private insurance as a viable alternative.

With more people insured and paying privately at market rates, care choices and quality will improve for everyone, rich and poor alike. With fewer people dependent on Medicaid, the welfare program will be better able to provide a wider range of higher quality care to the genuinely needy.

We will get to that point by default by staying on the current course, but a lot of people will suffer.

Or we can remove the perverse incentives in public policy that currently trap people in nursing homes on Medicaid. The single most important step to take is to stop using Medicaid as inheritance insurance for the baby boom generation. We need to tighten eligibility, require spend-down of a liquid home equity as a condition of Medicaid eligibility and enforce estate recovery requirements.

When the choice is pay me now or pay me later, like in that old Fram Oil Filter commercial, most people will save, invest, or insure for long-term care and everyone will be better off.

**KONDRACK:** OK. Thank you. Josh?

**WIENER:** Thank you. I think the basic problem is that unlike acute care where older people, and some younger people with disabilities, have health insurance through Medicare, with long-term care the vast majority of people do not have any kind of insurance. Only perhaps 8 or 9 percent of the elderly population have any kind of private, long-term care insurance.

What that means is that they face very high out-of-pocket costs, catastrophic expenses. The average cost of a year in a nursing home is about \$60,000. Most people don't have that kind of expense. It means that they have to impoverish themselves and they end up on welfare.

As Steve alluded to, we have a situation where the vast majority of people in nursing homes and using long-term care have to depend on welfare. I mean, it ought to be a clue to us that when we have a situation where it's the vast majority of people, that's a sign that the welfare strategy is the wrong one.

When we usually think about welfare, such as welfare for families with children, we only expect a small percentage of the population to financially qualify; yet when it comes to long-term care, the vast majority of people do qualify.

So we have those problems. As Steve alluded to, we have an institutional bias. People will get most of their care in nursing homes and other kinds of institutions rather than at home where they prefer to get it.

We have problems of quality. Long-term care is really the system we love to hate. With the aging of the population, it's going to get much larger. If we just kept the same nursing-home-resident population ratio the same, then in 2050 we could have three times as many people in nursing homes as we do today.

So those are the problems. Steve is a big fan of private sector initiatives and I certainly believe that with private insurance, reverse mortgages will grow. But I've done a lot of research in this area. What my research shows is that it will remain a very small niche product.

For private long-term care insurance, even with very generous assumptions about the willingness and ability of people to buy products twenty, thirty years from now, only about 10 to 20 percent of the elderly population will be able to afford private long-term care insurance.

From a policy perspective, the question is, "What about that 80 percent of the population that can't afford it?"

Reverse mortgages is an interesting idea, and I think it's likely to grow. But only about 100,000 people have any kind of reverse mortgages. Only a small fraction of those are geared toward any kind of health problem.

If you look at eighty-five-year-old disabled widows, which is really the population we are talking about for long-term care, their median home equity is only about \$60,000 or \$70,000. A substantial portion of that population doesn't have any home equity at all.

So that's \$60,000 or \$70,000—but when you have a year in a nursing home costing \$60,000 or, in the Washington area, \$85,000, that doesn't take you very far.

My view on private sector things is that they are going to grow. They should grow. But it's going to remain a relatively marginal part of long-term care financing.

If we are serious about addressing those problems that I discussed at the beginning, then I think we need to look at public sector programs, trying to reform Medicaid, trying to expand Medicare, or other kinds of social insurance for long-term care.

Because it seems to me, especially trying to do something with Medicare, that's the only way we are going to deal with that 80 percent of the population. That's the only way we are going to get universal coverage. If we do that, then we are going to be able to reduce the amount of catastrophic costs that people have, we are going to be able to reduce the dependency on welfare, we are going to be able, by deliberate public policy, to expand home- and community-based services that people want, and we are going to be putting additional money into the system, which I agree with Steve, would improve the quality of care, which desperately needs to be done, especially in nursing homes.

**KONDRACKE:** So your solution is to make long-term care a Medicare benefit?

**WIENER:** Well, we can debate whether it would actually be with Medicare but—

**KONDRACKE:** (Inaudible.)

**WIENER:** The notion though is a social insurance program. Although, I think, given the nature of long-term care, I would really have the states be much more involved because they are closer to people in the communities and know what kind of services they need and are better able to tailor it to individual—

**KONDRACKE:** OK. So if Congress just passed a Medicare prescription drug benefit, which costs \$535 billion over a ten-year period, what would it cost government, whether it is federal or state, to give a long-term-care insurance benefit? Or a long-term care benefit, I mean?

**WIENER:** Well, obviously it depends on what benefit you provide.

**KONDRACKE:** Right.

**WIENER:** Calculations that I did quite a while ago suggested that you would need above what we would be spending otherwise in long-term care for Medicaid and Medicare, a payroll tax paid by both employers and employees of somewhere between an additional 1 to 4 percent. In Germ—

**KONDRACKE:** So what are we talking about? What is the cost of this over a ten-year period, would you—

**WIENER:** Oh, I don't know. Over a ten-year period, if we were to have a full-blown system today, it could cost between \$30 and \$50 billion.

**KONDRACKE:** A year?

**WIENER:** A year.

**KONDRACKE:** Uh-huh. OK. So we are talking \$3 to \$4 trillion. Over—

**WIENER:** You said thirty to forty—

**KONDRACKE:** \$300 billion, in addition. So it's less than the prescription drug benefit.

**WIENER:** Well, I don't want to put too fine a point on it. It certainly would be a substantial amount of money. I'm not going to back away from that.

What the exact estimate is would depend on what the design features were. Germany has recently, or ten years ago, adopted a public insurance program for long-term care. They are financing that with basically a 2 percent payroll tax. Japan implemented a public long-term care insurance program in 2000.

All I want to do is really kind of put that kind of issue on the table in terms of thinking about possible options.

**KONDRACKE:** This is the current cost pre-baby boom generation retirement we are talking about. This is what it would take to provide long-term care to the existing population. Do you have any estimates about what 77 million people are—that constitute the baby boom generation—what the cost would rise to if this kind of full-blown program were instituted for them?

**WIENER:** Well, again, it depends on the design.

**KONDRACKE:** Right.

**WIENER:** But previous calculations I did found that it would require a 3 to 5 percent increase in the payroll tax.

**MOSES:** Could I—

**KONDRACKE:** Yes, please, please—

**MOSES:** (Inaudible) a reality check here?

Expanding Medicare to include long-term care, I've got to say that would be a little bit like adding deck chairs to the Titanic, after the little incident with the iceberg.

We are looking at that program becoming insolvent in very few years. We are looking at Social Security facing the same fate. And Social Security currently contributes a huge portion of the

money.

**KONDRACKE:** Could I just stop you there and respond to that? I mean, the actuaries—

**WIENER:** Well, I'd—

**KONDRACKE:** —say that Medicare is headed for ruin. So you are going to add this burden to it?

**WIENER:** If you look at other countries, even a country like Sweden, in which 20 percent of its population is elderly, and they, certainly everyone would agree, provide very generous social benefits to people of all ages, including long-term care, and they are spending about 2.5, maybe 2.75 percent of their GDP for long-term care.

So the notion that we can't afford it is rebutted by the fact that there are countries out there that do it. It's a matter of political will and social choice.

Are we going to do that or are we going to do certain other things?

But what people tend to forget is that the economy will be growing as well, and that long-term care as big a problem as it is, it is a major problem. And it's a major problem for individuals. It is only currently a little over 1 percent of gross domestic product. So if it goes to 2 or 3, that's a strain, but it's not the end of civilization as we know it. It's not the end of democracy in the twenty-first century.

**MOSES:** There is, however, the concept of the straw that broke the camel's back. Everything I've read about Europe and the social insurance programs there suggest that they are draining off the productive capacity of their economies, and that because they are aging even more quickly than we are, and because they are more advanced in their government financing of social programs, they face a bigger challenge than we do even with our crisis in Medicare and Social Security.

Germany and Japan, that you reference, have some interesting approaches to long-term care, but you helped me find some people to talk to in Germany when I visited a year or two ago, and I found that after only a few years they were already running a deficit in that publicly financed program.

So I think we have different circumstances very rapidly approaching. An "age wave" as Morton suggests.

**WIENER:** I don't think they are different circumstances. I think what is different is the political will and the policy preferences cross those countries.

I certainly would agree that the European countries and Japan have a broader social safety net

and have both broader set of social programs than we do.

**KONDRACKE:** Which they are finding difficult to sustain, you will admit.

**WIENER:** They are making the choices to sustain them. I mean, clearly in some areas they are cutting back. But certainly, I know when Steve went to Germany he found that there was very, very strong support for maintaining that program. Everyone that I've talked to about that program has said that they expect to make only fairly minor financial changes in order to return to a surplus in that program.

**MOSES:** But there was also a huge concern about the abuse of the welfare system there, and people transferring assets and using some of the same games that people use—

**KONDRACKE:** Let me stop you both and talk about—

**MOSES:** Sure.

**KONDRACKE:** —where is this on the American political agenda? I mean, we are in a presidential election year. Is either party mentioning long-term care or is it even on the agenda of the AARP, for example, as something that they want something done about.

**WIENER:** Well, it certainly is on the agenda for AARP and has been and—

**KONDRACKE:** Which model are they tending—?

**WIENER:** Well, they have historically been supporting a social insurance approach to long-term care. I think Steve—care insurance.

But Steve is certainly right that it's not the most politically popular idea at the current time.

Neither party has made this a major part of their campaign. But the campaign's not over yet. I suspect that as both parties look for votes in Florida and other areas and try to motivate older voters, that this may come up on the agenda.

**KONDRACKE:** Both parties are proposing to cut the federal deficit in half within the next four years of their administration. So it would be a little difficult to pay for it.

**MOSES:** There is bipartisan agreement that something needs to be done. It just is on the back burner instead of the front burner.

**WEINER:** I think—

**MOSES:** There are bills in Congress to make long-term care insurance more tax deductible, and to encourage more private financing. But I am dubious that's going to happen.

**KONDRACKE:** Let me just stop you. What is the current state of federal law as to assistance for people in handling their long-term care problem? That is to say, is there a federal tax deduction for long-term care insurance or not?

**MOSES:** There is, but for all intents and purposes it's ineffectual. It doesn't affect that many people, not that many seniors have enough income to deduct their—

**WIENER:** It's basically you can deduct the cost of the premiums in excess of 7.5 percent of your adjusted gross income.

**KONDRACKE:** Which, would probably—your insurance premiums would not amount to 7 percent of your adjusted—

**MOSES:** Not for most people, no.

**KONDRACKE:** Do you accept that—that only 10 to 20 percent of people could afford a private insurance approach to this?

**MOSES:** By no means.

**KONDRACKE:** Let's deal with that.

**MOSES:** I did ask before we came on if it would be all right to share some information.

We've done a report called "The Myth of Unaffordability"—how most Americans could, should and would buy long-term care insurance. I make the case in here, and that's available on our Web site at CenterLTC.org that anywhere from 50 to 75 percent of Americans, if they felt the need, could find the way to afford long-term care insurance.

**KONDRACKE:** So what does a premium cost?

**WIENER:** Well, just—

**KONDRACKE:** Yes. Go ahead.

**WIENER:** You know. I mean, Steve and I have debated this for a long time. But, I did research and published—I didn't bring my two books that I wrote about this, but the two books that I did while I was at the Brookings Institution used a fairly—a very sophisticated computer simulation model to do these projections and to calculate this. And you know, my findings are that if we are talking about the older population—aged sixty-five and older—then you have very modest levels of affordability because a good quality policy right now costs \$2,800 a year.

So for a married couple, at age sixty-five, you are talking about \$5,600 a year. So that's a—by

any—

**KONDRACKE:** Do you accept that?

**MOSES:** The premium rates are correct.

**KONDRACKE:** OK. So what about his point that people over sixty-five would find it difficult? And do you accept, then, that only 10 to 20 percent of the older-than-sixty-five population could afford long-term care insurance?

**MOSES:** No. This is precisely why I gave my opening remarks explaining how we got into this mess.

Josh does wonderful research, well documented, peer reviewed, and it's outstanding. But it starts from the status quo.

We have, for forty years, been paying people to ignore the risk of long-term care and it's no wonder they don't search for ways to purchase long-term care insurance.

Now, that same policy that Josh mentioned that costs \$2,800 at age sixty-five may well cost only \$100 a month when somebody is in their fifties. I personally have catastrophic coverage only because I wanted to keep my premiums low, but it's lifetime coverage, based on \$200 a day for a nursing home, \$120 a day for assisted living after a 90-day deductible, and I pay \$400 a year for myself and \$400 for my wife.

Now, we spend more than that on Starbucks, at least she does.

**KONDRACKE:** And you are how old?

**MOSES:** I'm fifty-eight. I've had it for eight years. I purchased it at fifty and I still pay \$400 a year because it's age-rated level premium.

**KONDRACKE:** What would be wrong with taking the current over-sixty-five population and leaving them to one side for a minute, and encouraging every younger person to buy long-term care insurance, which would be pretty cheap right now, which presumably they would build up, and it would be like—maybe even like a whole-life policy, where they could have term insurance or something like that for themselves as a solution to this problem, instead of burdening the Medicare system for eternity.

And as you know, the Medicare system is not means tested so everybody gets the same benefit, right?

**MOSES:** Well, that's one of the great—

**KONDRACKE:** Well, but that's the way it is, you know? The Democratic Party is determined to keep Medicare not—you know, non-means tested. So this is an enormous cost over a long period of time.

Why not encourage younger people to buy their own long-term care insurance now?

**WIENER:** Well, I think as a kind of personal solution to the financing your own long-term care, buying a high quality policy makes a lot of sense.

But there, I think, are real limits right now in terms of the willingness and ability of people to, at younger ages, to purchase policies.

**KONDRACKE:** How much will it cost for a person who is forty years to purchase one?

**WIENER:** Well, a policy at age fifty, which is the number I looked up for the show, is about \$1,500 a year for a high quality policy. So, again, we are talking \$3,000 for a married couple.

What is it that someone who is forty-five, fifty is concerned about? Well, they are concerned about their mortgage payments, because they haven't paid off their house yet. They are concerned about college education for their children or even daycare for their children.

They are concerned about general retirement. As Steve alluded to, you ask the average person, "Well, have you thought about the last couple of years of your life when you are going to be unable to eat and bathe and dress yourself?" And they will say, "Hey, you know. I am going to die winning the fourth set of tennis of a heart attack. I'd rather die than go into a nursing home."

**KONDRACKE:** Well, there is a difference between the two of you as to the cost of this. You say \$400—

**MOSES:** Well, for a policy—

**KONDRACKE:** Oh, that's for a policy year for catastrophic.

**WIENER:** Right. That's for a catastrophic.

**MOSES:** It's facility only, assisted living or nursing home. It doesn't include home care.

Now, I may well add to that foundation later, with home care benefits, but I wanted to have the basic protection against the potential catastrophic loss.

But you asked, "Why don't we encourage people to buy long-term care insurance?" Well, we do. We give it all kinds of lip service and education six ways to Sunday. What we don't do is promote it through public policy; we do exactly the opposite.

The reality in this country is you can ignore the risk of long-term care, avoid the premiums for private insurance, wait until you get sick, and the government pays. It's been that way for forty years, and as a consequence, we have this nursing-home-based welfare-financed system that institutionalized our whole World War II generation unnecessarily.

**KONDRACKE:** Right.

**MOSES:** We need to change those incentives.

**KONDRACKE:** Now, there are twenty-three states, as I understand it, that give some sort of tax deduction, state tax deduction, and/or credit, for the purchase of long-term care insurance.

**WIENER:** Yes, there are. But I think—maybe Steve—

**MOSES:** Currently twenty-six.

**WIENER:** Maybe Steve might actually agree with me. The amount of that tax benefit is relatively trivial. It's \$100, \$200, and again, if you are talking about a \$2,800 premium that's not going to be enough to really motivate you to purchase a policy.

**MOSES:** Well, I'm all for tax deductions, but the reality is that people don't fail to buy long-term care insurance because it isn't tax deductible. They don't buy it because they don't think they need it. They don't think they need it because the government's paid for it for forty years.

**KONDRACKE:** Except that—

**MOSES:** So until we do something about that, we are not going to break through this denial.

**WIENER:** But I think the important thing to remember, what we really should be talking about, is how to provide the financing for services for people. The issue is not selling insurance. I don't care whether we sell insurance. What I care about, and what I think we all should care about, is providing the funds for people who are disabled, not able to get out of bed without help or not able to eat or bathe themselves—that's really what we are trying to do.

I think too often—

**MOSES:** I absolutely agree on that.

**WIENER:** —we've—the debate gets around, “Well, how can we promote private insurance?” rather than “how can we provide the services to the people who need them?”

**MOSES:** No. What the objective has to be is to save Medicaid, our social safety net for the people who genuinely need it, and the only way we can do that is to change public policy to divert middle class and affluent people who are currently using that system into early planning,

save, invest, or insure, and if they don't, then require them to use their home equity, which is substantial.

**WIENER:** Well, we already basically require that, because—

**MOSES:** No, we do not.

**WIENER:** As you know, Steve, there's an estate recovery program that is a requirement of the Medicaid program and forty-nine of the fifty states—

**KONDRACKE:** I thought that most states exempt your home from—

**WIENER:** While you are alive. But they are required by federal law to recover the costs of the Medicaid after your death.

So if you have any—if you have a house left—

**KONDRACKE:** Let's go back to the beginning. Let's go back to the beginning here.

**MOSES:** I am going to respond.

**KONDRACKE:** —and talk about the way things work right now, and what you think is bad about it. Now, let me just try to repeat what I think I've heard.

Most people, when they get to need long-term care insurance, try to—

**WIENER:** Long-term care or long-term—

**KONDRACKE:** Long-term care. I'm sorry. Long-term care. Try to “impoverish themselves” so that they can fit under the Medicaid rulings state by state—the Medicaid regulations state by state.

**MOSES:** No. That is not what I'm saying! And that gives me a chance to mention another report due out September 7 called, “The Realist's Guide to Medicaid and Long-Term Care Financing.”

What happens is that if you ignore the risk, and then all of a sudden you need expensive long-term care, the conventional wisdom is that Medicaid is welfare and you have to be extremely impoverished to qualify.

The reality is you can have practically unlimited income as long as you don't have enough to pay for nursing-home care, which is very expensive, right? You can have unlimited assets as long as you hold it in an exempt form, such as a home, an all contiguous property, regardless of value, a business including the capital and cash flow of unlimited value, any number of special trusts or annuities, an automobile of unlimited value—

**KONDRACKE:** Automobiles are excluded?

**MOSES:** Yes, as long—are excluded with no limit on the value as long as it's used for the benefit of the recipient.

That gives rise to a technique the Medicaid planners use called, “The Two Mercedes Rule.” If you've got a couple hundred thousand dollars, you want the government to pay for your long-term care—buy a Mercedes. It's exempt. Give it away. It's not a transfer of assets for less than fair market value for the purpose of qualifying for Medicaid because you were eligible before you gave it away. Buy another one and give it away.

Now, that is too egregious. That isn't used. But believe me, the reality is that most people do not have to use any fancy legal machinations to qualify for Medicaid. It's only people with very, very substantial income and assets that need to do that.

That's just the tip of the iceberg.

**KONDRACKE:** So the average person is going on Medicaid and not spending down their—not needing to spend down their—

**MOSES:** The average person, in terms of income and assets, qualifies for Medicaid without significant spend down, and if they have excess assets, they are very, very easy to divert or shelter.

Now, Josh mentioned Medicaid estate recovery, which has been mandatory since 1993. There are three states that completely thumbed their nose at the feds—Michigan, Texas, and Georgia—and most states have not enforced that program aggressively. There are so many exclusions and loopholes and elasticities in the law that the Medicaid planning can evade it altogether.

So the reality is we don't have a system that requires people to pay their own way. As a consequence, people don't take the risks seriously until it's too late. Then the path of least resistance is to find a way to qualify for Medicaid, which is now overwhelmed and unable to provide adequate care for the poor.

**KONDRACKE:** And you agree that this is the accurate description of the system?

**WIENER:** Well, I'm glad that Steve said—just to restate what Steve said—the vast majority of people do not transfer assets.

**MOSES:** That's what I've always said, Josh.

**WIENER:** Not very—well, but it's not the way it gets translated out in the media.

**MOSES:** It gets misrepresented.

**WIENER:** Well, most people do not transfer assets in order to qualify for Medicaid. To be sure—

**KONDRACKE:** What do you mean by that? “Most people don’t transfer assets?”

**WIENER:** The vast majority of people do not go through the kinds of machinations that Steve described in order to appear poor and, therefore, qualify for Medicaid.

**KONDRACKE:** But rather the current law allows them to get Medicaid?

**WIENER:** Will rather they—if they are middle income, they impoverish themselves. They use up all of their income, all of their assets, except for \$2,000 and—

**KONDRACKE:** That’s not what Steve said. Steve said that the average person can—

**MOSES:** That’s was—there is no empirical evidence that that occurs, and you did some of the research on spend down that proved that it doesn’t occur in any kind of catastrophic—

**WIENER:** Well, it depends on what you—how you—to paraphrase Bill Clinton, it depends on how you define spend down. If you mean people who are in the community who are not Medicaid-eligible, who then go into a nursing home, and then they are Medicaid eligible—in fact, a substantial number of people are in that kind of situation, where I agree, absolutely agree with Steve, is that if you look at the financial assets of eighty-five-year-olds, they have about \$20,000 or \$30,000. It’s not a big chunk of money.

You pay off your MasterCard, some other debts, you know, you are down to the \$2,000 or \$3,000 that—

**KONDRACKE:** Is that accurate? That the average Medicaid long-term care—

**WIENER:** That wasn’t Medicaid. That was the total population.

**KONDRACKE:** OK. But a person who is in a long-term care facility and is paying out of their own pocket shouldn’t count here.

We are talking about the Medicaid long-term care client, here. They have a net worth of what?

**MOSES:** To say that people in nursing homes on Medicaid are poor is just a (inaudible). The question is, how did they get there and did they spend down their own money for their long-term care?

The reality is that 80 percent of people own their homes, and that is a very substantial asset.

**WIENER:** But eighty-five-year-olds don't.

**MOSES:** But by the time they get on Medicaid, right, only 15 percent of them own their homes. The big question in long-term care financing is what happened to all that home equity?

**KONDRACKE:** Yeah, what did happen to it?

**MOSES:** Well, I'd like to see somebody like Josh do some research on that, because nobody has ever examined it.

**KONDRACKE:** Well, what do you think happened to it? So the person—

**MOSES:** It has gradually diluted and come into the hands of the next generation early. I did a study recently—

**KONDRACKE:** So in other words, you transfer it—you transfer the ownership of your home—

**MOSES:** Well, let's not—

**KONDRACKE:** —to your heirs in order to impoverish yourself so that you can go on Medicaid?

**MOSES:** Not necessarily. You don't necessarily do it purposefully to qualify for Medicaid.

Let me give you an example. I just finished a study in Nebraska and what we found there is that the younger—the older generation, in their sixties to seventies, will pass to the younger generation the farm, the business, the home. It's just a standard of estate planning practice.

Now, they aren't thinking about long-term care. The folks out there have a pioneering spirit and their attitude is, "We'll take care of our own." But when the time comes and somebody needs twenty-four-hour-a-day long-term care, you know, changing their diapers, helping them eat and so on, then it becomes impossible for the family to cope with it and, ironically here, they are already eligible for Medicaid even without doing any Medicaid planning.

The wealth of the elderly has dissipated long before they need long-term care, and as a consequence, we've handled long-term care for the elderly—

**KONDRACKE:** Do you regard this as the standard practice for elderly people? I mean, you've studied this population group. But is that what most people do? They get rid of their assets?

**MOSES:** I am not prepared to say most people. I think most people just ignore this problem until it's too late. Most people have a level of income that—first of all, the home is exempt. That's their biggest asset, right?

**KONDRACKE:** Right.

**MOSES:** The income—maybe they've got \$20,000 or \$30,000 which is a combination of their Social Security and maybe a little bit of pension or interest on assets. That doesn't make them ineligible because nursing home care costs more than that.

And then finally they have maybe \$80,000, \$100,000, \$200,000 in assets. That is chicken feed.

**WIENER:** They don't have that kind of money.

**MOSES:** Well, a lot of people do, OK.

**WIENER:** Some people.

**MOSES:** The median elderly family has something in the range, I think, of \$100,000.

**WIENER:** Well, not eighty-five-year-olds.

**MOSES:** No, of course not. That's the point! That by the time they get to that age—

**WIENER:** (Inaudible.)

**KONDRACKE:** One at a time. One at a time.

**MOSES:** By the time they get to that age, all that wealth has disappeared. The question is where has it gone, and how can we ensure that it goes for the purchase of quality long-term care for seniors?

**WIENER:** I think we can't forget the thing that Steve said sort of at the beginning of this set of interchanges, which is we should do some research on this. Because we don't really know what—first of all whether all these assets actually exist for people who end up in nursing homes. There is research to suggest the use of nursing home care is disproportionate by lower income and, therefore, lower asset populations. We just, you know, we don't know if it dissipated in the way in which Steve kind of alluded to.

You know, but one good story is not data.

**KONDRACKE:** Right.

**WIENER:** So, I think this is—you know, I'd love to get some research money to do this kind of stuff.

**KONDRACKE:** Well, in the—

**MOSES:** Well, I sure wish you would. I've been waiting for academics who are predominantly predisposed to a government financing solution—

**WIENER:** Oh, Steve—you don't need to say that.

**MOSES:** —and to pooh-poohing private financing. I've been waiting for two decades for people to go out and study this issue.

**WIENER:** I don't think, though, that absent the research and the findings we are unable to conclude logically that people have a lot of money at one point in their life. It's not going for long-term care.

**MOSES:** We don't know that they are—

**KONDRACKE:** OK. Now, what would be wrong with having a system where people were encouraged from their youth on to think about their long-term care, and buy insurance for it, and which they would pay along? If they started at the age of thirty, you know, which most people don't—and would be encouraged to save and then, at the end of the day, means test the solution for those who are genuinely impoverished, and you know, handle that as a public problem.

**WIENER:** The question is why should we do that for long-term care when we don't do it for Social Security, we don't do it for Medicare? If you are “lucky enough,” and I put that in quotes, to get a heart attack, and you end up in the hospital, nobody is going to say to you, “Well, you know, come back to us after you have impoverished yourself.”

There is a stream of benefits because we, as a society, believe that we should provide people who—at least older people who need medical care with those services.

For reasons that, frankly, escape me, if you are unlucky enough to get Alzheimer's disease, then you know, we are—our societal response is basically, you know, “Come back to us after you have impoverished yourself and then, you know, we'll provide you with some financing and some services.”

But, you know, the fundamental issue here, and I think you put your finger on it, is, is this really an issue where it's sort of up to the individual and their family? Or is this a societal concern that we as a society as a whole are going to sort of step forward and say that people who need these kinds of services are going to get them regardless—

**KONDRACKE:** Well, ideologically we have here Sweden and Margaret Thatcher.

*[Laughter]*

**WIENER:** I'm not Sweden. Or George Bush.

**MOSES:** Let me respond to that, though, because I think that is a specious argument and I hear all the time from Medicaid estate planning attorneys who are suddenly trying to morally justify their impoverishment of well-to-do seniors and the billable hours they take from that.

The fact that if you have a heart attack you get medical care through Medicare and if you get Alzheimer's you are unlucky because you have to impoverish yourself—first of all, that's not a correct premise, because there are thousands of people out there who will get you on Medicaid and get you the long-term care without impoverishment.

**WIENER:** But you just said that didn't happen very often.

**MOSES:** But it happens.

**WIENER:** Yes.

**MOSES:** I didn't say it doesn't happen often. I said, "It's only the tip of the iceberg." Because we have people with hundreds of thousands of dollars routinely occupying beds on Medicaid, it is a very serious tipping of the system in the wrong direction.

But—two points. I wanted to respond to this argument that if you have a heart attack, Medicare pays for it. We are going to lose the programs that pay for acute care long before we ever get a public financing program that pays for—

**KONDRACKE:** Because Medicare is going to go broke?

**MOSES:** Absolutely, and because we are devastating Medicaid, which is so heavily dependent on Social Security now, because people on Medicaid have to contribute their Social Security income toward their cost of care.

That's literally half of all of the out-of-pocket expenditures for nursing home care today. When Social Security dries up, then that money won't be there for long-term care. Medicare is really the 800-pound gorilla of social issues that we haven't begun to face yet, as we discussed earlier.

Now, the question of who gets the best care under Medicaid is critical because while the artificial impoverishment is only the tip of the iceberg, the irony is that the wealthier you are the easier it is to qualify for Medicaid and the better care you get under the program. Now, why is that?

**KONDRACKE:** Yeah. Why is that?

**MOSES:** Because—

**WIENER:** But Steve, do you accept that? No!

**MOSES:** I accept the fact that people who have a lot of money are able to have a wide choice of facilities and they go into the more expensive, better—

**KONDRACKE:** Well, that's if they pay out-of-pocket. But he's talking about people who are rich—

**MOSES:** I am talking about a gross inequity in the system. Let me explain it and then we can discuss it.

**KONDRACKE:** OK. Go ahead.

**MOSES:** What happens is that the elder law bar is thoroughly aware that you can't be guaranteed access to quality nursing home care unless you can pay privately for at least a year. It's called key money.

So what they do when they impoverish somebody with half a million dollars is say, "Look, we are going to save out \$50,000. I know all the best nursing homes in the community that have just a few Medicaid beds, and you will get high quality care there. People won't even know who's on Medicaid and who isn't. After you pay privately for a year, we'll flip the switch with our little legal plan and you will convert to Medicaid, and you will get outstanding care."

Now, the tragedy here is that poor people do not have key money. They have to go to those 100 percent Medicaid homes that you read about in the newspaper and it's a shame. It's inequitable. It's one more piece of evidence that Medicaid planning, to the extent that it occurs, is very serious for this system.

**WIENER:** Well, I think Steve has been a master over the years of ferreting out the ways in which Medicaid estate planning can operate. But—

**KONDRACKE:** You don't deny that it goes on?

**WIENER:** No, I don't. Absolutely not.

**KONDRACKE:** (Inaudible.)

**WIENER:** You know, the key question is that this year there will be a million and a half people on Medicaid in nursing homes and a larger number in the community, and the question is how many of them have transferred substantial amounts of assets in order to qualify for Medicaid?

The answer, first of all, is we don't know. That is—

**KONDRACKE:** But you suspect it's a small number.

**WIENER:** I suspect it's a relatively small number, because if you look at the median income of

eighty-five-year-olds, which is basically the median age in nursing homes, their average income is \$16,000 and their—in the community their median amount of financial assets is \$20,000 or \$30,000.

So it's a relatively low income population.

**KONDRACKE:** The question occurs to me that—we can come back to this—why should we not encourage people to do home care as much as conceivably possible and keep people out of nursing homes, where they don't want to be anyway?

Now, does Medicaid pay for home care or not?

In other words, assistance to keep you in your own home?

**WIENER:** Medicaid does pay for home care both through a number of mechanisms. It is largely up to state options, so there is great variation. So if you are in Wisconsin or Washington State, there is a substantial amount of Medicaid home care available.

If you go to other states, there is not very much. So—

**KONDRACKE:** Home care is much cheaper than nursing home care. It's got to be, right?

**WIENER:** Well—

**MOSES:** It's not that simple.

**WIENER:** That's actually quite a complicated issue. There is a large amount of empirical literature on that that's quite rigorous, but old, twenty years old, that basically finds that if you add home care that expenditures go up because it's an add-on service—

*[Break in tape]*

**WIENER:** —or not, there really isn't the empirical evidence to suggest.

**KONDRACKE:** Let me talk about—

**MOSES:** Let me—

**KONDRACKE:** Yes. Go ahead.

**MOSES:** There is still the reality that Medicaid programs do not begin to pay enough for home- and community-based care, and there is the irony that the more they pay for services than people want instead of a nursing home, which they tend not to want, the more attractive it makes Medicaid.

So when you have easy eligibility and you have more and more attractive services, and you have politicians and program administrators trying to convince the public that Medicaid is doing this fine job, it only adds to the anesthesia in the system.

**KONDRACKE:** Well, let me ask you, see if you both agree on this: that the rules for Medicaid eligibility should be tightened up to the point where they are available fundamentally to people who are genuinely poor.

**WIENER:** They are already that way. In order to qualify for Medicaid, excluding the house while you are alive, you have to contribute all of your income toward the cost of care, except for basically one buck a day. So you are going to have to do everything on a kind of personal basis—just let me finish—on one buck a day and you can have, if you are a single individual, which is what 85 percent of people in nursing homes are, basically \$2,000 in non-housing assets, a figure which has not increased since 1984. So, twenty years ago.

**MOSES:** Let me explain the fallacy in that.

You don't have to be poor to get Medicaid. We talked about assets. Put assets aside. Look just at income.

All you need is a cash flow problem, all right? You can have \$5,000 a month in income but if nursing home care costs more in your state than that, you are going to be eligible for Medicaid.

Now, why is that so critical? It means that people with very substantial incomes who, if they liquefied the wealth in their home, which is exempt, would be able to afford nursing home care, are now on Medicaid. Now, why is that—

**KONDRACKE:** But you are at odds here. You are saying that if you have \$2,000—

**WIENER:** In non-housing assets. I agree with Steve—

**KONDRACKE:** And you are saying that you can have \$5,000.

**WIENER:** No, no, no. He was talking about income.

**MOSES:** Income.

**KONDRACKE:** Income.

**WIENER:** Income. And, you know, I absolutely agree with Steve that the critical thing for Medicaid eligibility on the income side is basically if you have a medical expense, like being in a nursing home, that's greater than your income, then you have to take your \$5,000 in income and contribute \$4,965 to the cost of your care and you get to keep your \$35 a month.

**KONDRACKE:** OK. Now, let me just go back here.

**MOSES:** That is devastating to the long-term care system and it's critical that I get this point out.

**KONDRACKE:** OK.

**MOSES:** And that is that this person with \$5,000 in income goes on Medicaid, contributes the income to the cost of care, but the nursing facility only gets the Medicaid rate for long-term care.

Now, that is on average, nationally, 70 percent of the private pay rate, according to BDO Seidman, it's \$4.1 billion short of sufficient to pay for the cost of the care. It's \$11.55 per bed per day that we are underpaying nursing homes.

**KONDRACKE:** And that comes (inaudible) quality.

**MOSES:** That devastates quality of care and because it is the only source of long-term care, available, in essence for free, just with the deductible of your income to people—

**WIENER:** It's hardly for free, then.

**MOSES:** —it creates that institutional bias, the over-emphasis on nursing home care. That is what has contributed to the underdeveloped infrastructure of home community-based services that people don't need to pay privately.

**WIENER:** I want to go back to the point that Steve made earlier, which was that basically he opposes trying to expand Medicaid home- and community-based services, trying to get programs that make it easier to stay out of nursing homes, because he is afraid that that is going to make Medicaid too attractive a program.

**KONDRACKE:** No, he's—you just don't want Medicaid to pay for it.

**MOSES:** I am diametrically opposed to that statement of my position. My position is that if we can get the people off Medicaid who don't need to be there and get them insured, or paying privately for their care through home equity—

**KONDRACKE:** Which you—this is the majority of people in your opinion.

**MOSES:** Yes. By far the majority of people, if the incentives were there to plan ahead, would for long-term care. Instead, we ignore this until it's too late. They go one Medicaid and Medicaid can't afford that.

**KONDRACKE:** So if there was one change in law that you would want to do, it would be to

count the home, the equity in the home, as an asset and limit the availability of Medicaid to people who prevent—until they'd paid down their equity.

**MOSES:** Until they have consumed the liquid equity in the home, so that Medicaid is no longer paying a windfall to heirs for ignoring this problem and not helping their parents prepare for long-term care.

So that we would pump private financing into this revenue-starved long-term care system, so that we would enhance home- and community-based services because that's what people would buy with their own money. And so we can relieve the burden on Medicaid, so that covering a much smaller clientele of people it will be able to pay a market rate for top quality home- and community-based care—

**KONDRACKE:** Respond to that.

**KONDRACKE:** So what's wrong with that?

**WIENER:** Well, you know, I would just, as Steve was saying that I was just thinking, we started this program by saying that a new social insurance program for long-term care is, you know, perhaps not politically viable.

But I would not want to be a Congressman or Senator who was suggesting that we were going to do away with the exemption of the home from Medicaid eligibility.

**KONDRACKE:** He's got a point. He's got a point, politically.

**MOSES:** The third rail of politics is no longer as strong an argument as it used to be, and in another decade or two it will be politically infeasible not to tackle this issue.

**WIENER:** When George Bush was governor of Texas, the bill came up, you know, that's when they were talking about doing this kind of estate recovery. Somehow the state of Texas didn't pass it. Why didn't they pass it? Because people in Texas didn't want that kind of take-over of their home equity.

I mean, one has to really—we really haven't talked about the—

**KONDRACKE:** You really do get into a situation where, say, I'm the spouse of somebody who is disabled and needs long-term care insurance. Long-term care, sorry. Long-term care.

**WIENER:** —never be able to get long-term care insurance.

**KONDRACKE:** I am living in our family home and what you are asking me to do is to basically pay down the equity in the house to take care of my loved one, right?

**MOSES:** Yes. But you'll be able to live in the house for as long as you—

**KONDRACKE:** Until the money runs out.

**MOSES:** —are—no. No. The way the reverse annuity mortgages work nowadays is that they are in essence medically underwritten in such a way so that people are actuarially protected for the use of the home, and the lender takes the risk based on how much they are willing to pay you based on the equity that you have that you won't outlive that actuarial expectancy.

So you are assured the use of the home for the rest of your life.

Now, if you don't want this to happen, then start in your thirties, forties, and fifties, buy the insurance, and avoid the risk.

**WIENER:** I think you alluded to one of the problems we didn't really talk about with the private insurance, which is that there is a substantial population under the age of sixty-five who are disabled, who have problems, and because of medical underwriting with private insurance, they will never be able to buy private insurance.

**MOSES:** Those are precisely the people who we are trying to save the Medicaid program for because they are the ones that Medicaid needs to be there to serve.

But Medicaid has been stretched too far. It's serving too many people. And it has desensitized—

**KONDRACKE:** Now, what I understand is that what you would do is substitute an entitlement—

**WIENER:** Or even just—I mean, I am really on the opposite side of Steve on this, because if you look at what states are trying to do with—and both Republicans and Democrats, in terms of home- and community-based services, they are trying to expand it. They are trying to go up the income eligibility level, because they recognize that this is the kind of service that people want, and you know, the Medicaid eligibility level is only two-thirds of the federal poverty line.

So you can be talking about, you know, people higher up who are still hardly wealthy by any stretch of the imagination.

**KONDRACKE:** Well, let's talk about what the states have done, because I know that the head of the National Governors Association, Dirk Kempthorne, has been focusing on this problem because Medicaid is broke and going broke.

So what is the adequacy level, would you say, of what the governors are doing, what the states are doing on this?

**MOSES:** Well, they are doing what they can. But there's nothing left in the pot, you know.

Medicaid is driving these fiscal crises—

**KONDRACKE:** But they are promoting healthier lifestyles. They are promoting, to some extent, tax deductions, or tax credits.

**MOSES:** And they are promoting home- and community-based care.

**KONDRACKE:** Right.

**MOSES:** With which I have absolutely no objection except that you've got to get the eligibility hemorrhage under control before you start paying for services that are—

**KONDRACKE:** Now, we are just about out of time. I will give you thirty seconds to sum up, and you, too. If you can do it in less that will be better!

**WIENER:** Yeah. It seems to me that we have a major problem here and part of the problem is that we don't have an insurance program for people—that protects people against the catastrophic costs of long-term care.

Private insurance is a important way of trying to finance that, but even with Steve's use of home equity, we are going to have a large portion, a large majority of the portion of the population that will not be able to afford private long-term care insurance.

So if we are serious about doing something for the overall population—and so far in America we have not been—then we need to be looking, I think, to government programs, expanding Medicaid and moving to other kinds of government programs.

**KONDRACKE:** You have less than thirty seconds.

**MOSES:** We do not spend too much, too little government money on long-term care. We spend too much in the wrong ways with every good intention. We've had the unforeseen consequence of desensitizing the public to the risk.

If we stop doing what we've always done, we'll stop getting the same results and people will, in the right system of incentives, plan for their own long-term care, relieve the burden on Medicaid and give it back to the poor, whom it is supposed to serve.

**KONDRACKE:** Thank you so much for joining us in this spirited debate, and thank you both for providing it. I enjoyed myself immensely and learned a lot. Thank you.

END

