

"THE FUTURE OF LONG-TERM CARE AND MEDICAID:
SMALL BUSINESS ROUNDTABLE"

July 10, 2006

1:00 - 4:00 p.m. EDT

Washington County Commissioners Meeting Room
Second Floor, Room 227
100 West Washington, Street
Hagerstown, Maryland

TAPE TRANSCRIPTION

ATTENDEES:

THE HONORABLE DONALD MANZULLO (R-16-IL)
Chairman, Small Business Committee

THE HONORABLE ROSCOE BARTLETT (R-6-MD)
Vice Chairman, Small Business Committee

PANEL ONE:

ANTHONY MCCANN
Secretary, Department of Health & Mental Hygiene
Member, Commission on Medicaid
Baltimore, Maryland

GRACE-MARIE TURNER
President, Galen Institute
Member, Commission on Medicaid
Alexandria, Virginia

DENNIS SMITH
Director, Center for Medicaid and State Operations
Centers for Medicare and Medicaid Services
Baltimore, Maryland

PANEL TWO:

STEPHEN MOSES
President, Center for Long-Term Care Reform
Seattle, Washington

DR. JAMES MITCHELL
Administrator, Moran Manor
Westernport, Maryland

GREGORY STANGEL, II
Co-owner, Stangel & Stangel Financial Services
Cresaptown, Maryland

1 PROCEEDINGS

2 MR. MANZULLO: The increasing cost of
3 long-term care is one of the most significant
4 challenges we're faced with. In 2000, there were an
5 estimated 9.5 billion people with long-term care needs
6 in the U.S., including 6 million elderly and 3.5
7 million non-elderly.

8 These numbers are projected to grow
9 significantly in the coming years, especially after
10 2030, when the Baby Boom Generation begins to reach 85.
11 The senior population, 12 percent in 2000, by the year
12 2030 will grow to 20 percent.

13 As a matter, in the twenty-first century, the
14 provisions and financing of long-term care is a
15 daunting challenge for seniors, soon to be seniors, and
16 their children. The cost of long-term care is high and
17 increasing, averaging over \$70,000 annually for a
18 private room, \$25 an hour for a visit by home health
19 aide, and an average annual base rate of over \$32,000
20 for the services of an assisted-living center.

21 Since 1990, the price of nursing-home care has
22 increased at an average annual rate of 5.8 percent,

1 almost double the overall inflation rate. Medicaid,
2 paid for by federal and state taxpayers, has become a
3 primary way of financing long-term care for elderly
4 people in nursing homes. The 40 percent or more of
5 those who need long-term care during their lives, about
6 two-thirds of all recipients of long-term care must
7 depend on Medicaid.

8 The current mix of financing for long-term
9 care, in which a significant share of financing comes
10 from government programs, that a depression that the
11 federal government will experience with the aging of
12 the Baby Boom Generation. Entitlement, or mandatory
13 spending, is the largest proportion of the federal
14 budget, and has been increasing at faster rates than
15 the GDP and discretionary federal spending.

16 Medicaid is a huge entitlement, and has become
17 the entitlement program with the fastest rate of
18 increase. Expenditures top \$300 billion annually, and
19 rise at eight percent annually. In total, Medicaid's
20 expenditures for long-term care for elderly people
21 since 1992 have grown at an average annual rate of
22 about five percent.

1 The Congressional Budget Office estimates that
2 in 2004 Medicaid's payments for institutional care for
3 seniors, including both state and federal expenditures,
4 totaled about \$36 billion for about 77 percent of all
5 Medicaid long-term care spending. Medicaid's payments
6 cover the care of more than half of all elderly,
7 nursing-home residents.

8 The Deficit Reduction Act, which became law on
9 February 8, 2006, makes several changes to the
10 long-term care and Medicaid dynamic, and that's what
11 we're here today to discuss. I'm looking forward to
12 the discussion that will follow. And, again, I want to
13 thank Congressman Bartlett for inviting me here to
14 discuss this important issue.

15 I only have, I think, one written statement.
16 Did you -- could you collect the written statements, so
17 that I can follow them?

18 Before I turn it over to -- thank you -- to
19 Roscoe, we try to keep the testimony at about five
20 minutes. And at about 4 minutes, there may be a gentle
21 tap; at five minutes I take it and I throw the gavel at
22 you, to give you an idea. That will give us plenty of

1 time for discussion.

2 Congressman Bartlett?

3 MR. BARTLETT: Thank you very much. I'd just
4 like to comment on the "five minutes." There are some
5 of our hearings on the Hill that last several hours,
6 and the testimony is about 10 seconds long. So we're
7 happy to be here, and we're ready for your questions.
8 This is particularly true of the Marine Corps. So be
9 assured that there's going to be more than ample time
10 to expand on anything that you want to expand on during
11 the question-and-answer period.

12 As a student sitting in class I noticed that
13 an hour is a very long time; and then later I was a
14 teacher, and the hour was far too short, and I couldn't
15 get everything I wanted to get in. So time has a very
16 different aspect depending on whether you are listening
17 or talking.

18 So thank you very much for being here. I want
19 to thank my Chairman and my friend -- we came in
20 together, as Don mentioned, in '92 -- for coming out
21 today. This is a subject that concerns a lot of
22 people.

1 America is graying, of course, and more and
2 more of us are living longer and longer. Just a few
3 weeks ago, I passed my eightieth birthday, and I was
4 just wondering to my wife when I would enter mid-life,
5 because I haven't yet. And this is true of America,
6 we're getting -- we're graying, getting older and
7 older, and more of us will be ending up needing
8 long-term care.

9 The Deficit Reduction Act made some changes,
10 and the general intent of these changes was to prevent
11 people from impoverishing themselves, so that they
12 could then get their healthcare really from their
13 friends and neighbors. The average person looks at it,
14 and frequently they're encouraged by their attorney to
15 look at it this way: Don't worry about it; it's
16 government money. But, of course, basically government
17 has no money.

18 There is no such thing as a "federal dollar".
19 Every dollar the federal government has, they took
20 from the paycheck of some hard-working American.
21 Notice that I didn't include businesses because really,
22 fundamentally you cannot tax a business, because a tax

1 on the business simply becomes a part of the cost of
2 doing business, and they pass it on to the consumer.
3 So ultimately all of our taxes are paid by consumers,
4 are they not?

5 And there's an interesting phenomenon, and
6 this relates to that. When I came to Congress, Tax
7 Freedom Day was about the ninth day of May, and
8 Government Freedom Day was about the fourth of July,
9 which gave a special significance to Independence Day
10 because it was not until Independence Day that you
11 could work to get any money for yourself, because up
12 until Independence Day, you were working to pay your
13 taxes and the additional costs of government.

14 What was that roughly two-month period between
15 when you'd finished paying all your federal, state, and
16 local taxes and you finished paying for the cost of
17 government? That represented the time that you were
18 working to pay for unfunded federal mandates.

19 Now, we've done a little better on taxes. We
20 tried really hard to reduce taxes. We've done a little
21 better. We moved that day from the ninth of May back
22 to sometime near the end of April, maybe almost two

1 weeks back. But Government Freedom Day, Don, has gone
2 from about the fourth of July to about the ninth of
3 July. So although we've reduced taxes, the unfunded
4 federal mandates have grown until now you're working
5 even a longer time to pay for the total cost of
6 government than you were working to pay for government
7 in '92, when we came to the Congress.

8 Of course, Medicaid is a part of that because
9 the cost of Medicaid to the states is mandated by a
10 formula, and I understand that no states have opted
11 out. You can't opt out of Medicaid. Nobody has opted
12 out of Medicaid. And so when people artificially
13 impoverish themselves so that they qualify for
14 Medicaid, what they're doing -- not just asking their
15 friends and neighbors to pay for their healthcare.

16 But increasingly today, Don, we're asking our
17 kids and our grandkids to pay for it because we're
18 amassing an incredibly large -- this is the largest
19 inter-generational-debt transfer in the history of the
20 world, and we're bequeathing this to our kids and our
21 grandkids.

22 And what this legislation did was intend to

1 require those who could pay for their healthcare to pay
2 for their healthcare so that their friends and
3 neighbors weren't paying for it. And, even worse, so
4 that their kids and their grandkids weren't paying for
5 it.

6 You know, I know of no seniors, when they
7 understand, who really want their kids and their
8 grandkids to pay for their healthcare. And so I think
9 that when you get the information out there, that
10 seniors are going to be the strongest supporters of
11 these changes that we've made in eligibility for
12 Medicaid.

13 So I wanted to thank you for chairing this
14 hearing, this roundtable. And I want to thank our
15 witnesses and those in the audience for coming. Thank
16 you very much.

17 MR. MANZULLO: The first witness is Tony
18 McCann, the secretary of the Maryland Department of
19 Health and Mental Hygiene. Mr. McCann.

20 MR. MCCANN: Chairman. Chairman Bartlett,
21 thank you for inviting me to speak today. I'm here
22 today to talk about Medicaid and the recent DRA

1 changes. And, as indicated, for the record, my name is
2 Tony McCann and I am the secretary for the Department
3 of Health and Mental Hygiene for the state of Maryland.

4 Medicaid was conceived as an acute-care
5 program, serving recipients of NAFDC and their
6 children. While long-term care services were covered
7 at the time of passage, the rapid growth in this
8 segment has been a relatively late development.

9 Today, long-term care expenses for the elderly
10 and individuals with disability represent a substantial
11 portion of our expenditures. They are the largest per
12 case costs that we have, and they are growing more
13 rapidly than any other part of the program. Maryland,
14 like other states, has been forced to implement
15 cost-containment initiatives to try and constrain the
16 growth of this and other components of Medicaid. Our
17 approach, however has been to try to cut -- to minimize
18 cuts and services and the impact on individuals.

19 We also believe that better use of data and
20 the improvement in various kinds of quality improvement
21 initiatives can go a long way to improving the
22 efficiency of the program. And I would commend those

1 approaches to you as things to be considered as you
2 look forward to making further changes in the program.

3 We also have a proposal in for managed care to CMS,
4 which I'll talk about briefly at the conclusion of my
5 remarks.

6 The Deficit Reduction Act of 2000, the DRA, is
7 an important step forward. It provides options for
8 more individuals to receive services through community
9 supports, and provides individuals greater control over
10 their own care. It also guarantees greater protections
11 in Medicaid services, to assure that our services are
12 focused on the more vulnerable of our population.

13 Most importantly, we must continue to ensure
14 that Medicaid does, in fact, focus on the most needy.
15 DRA helps us in this regard in several ways. Dennis is
16 going to speak in detail about the nature of the
17 program, so I'll not go through it in detail but simply
18 to add that.

19 First of all, the increase in the look-back
20 period from three to five years makes the exchange in
21 assets, inappropriate exchange in assets, more
22 difficult. The way in which penalties are now

1 calculated also makes it more difficult to shield
2 assets that should be used to support long-term care
3 from that process and the changes in home equity and
4 the way home equity is considered are all important
5 tools for us.

6 Most importantly, from my point of view, the
7 law also gives us the capacity to grant various kinds
8 of hardship waivers, so that when we, in fact, do come
9 across a circumstance in which an individual has in an
10 appropriate fashion tried to take care of their various
11 affairs, their children's affairs and so on, we're able
12 to deal with those issues in an appropriate fashion.

13 It is also true that in the state of Maryland,
14 as we enforce the law, we're going to be looking for
15 those cases in which there are large changes in assets,
16 large allocations, and so on. We're not in the
17 business of trying to figure out somebody giving \$10 or
18 \$15 to a various charity as they approach time to come
19 to a possible nursing home, nursing-home needs.

20 Additional reforms that we believe are
21 necessary: I think the most important thing to
22 consider as you think about additional long-term care

1 needs is to not consider the long-term care population
2 as a single, homogenous whole. The disabled, those
3 with developmental disabilities and physical and mental
4 disabilities as a result of injuries and disease are
5 different from those recovering from injuries and
6 diseases; and they, in turn, are different from those
7 whose health status is declining as a result of age.

8 Each of them needs to be considered
9 differently. Each of them has different expectations
10 from the long-term care program. Each of them has
11 different needs in terms of institutional and
12 non-institutional care. And each of them, I think,
13 needs to be focused on as a different subset of the
14 population.

15 Finally, more needs to be done to integrate
16 Medicare and Medicaid services. This includes
17 financing, delivery, administration of primary, acute,
18 and long-term care, social and behavioral services.
19 These are the so-called "dual-eligible" individuals.
20 Many elderly persons and individuals with disabilities
21 are served under both programs, and too many existing
22 barriers prevent us from providing total, integrated

1 care plans for these populations. To address this
2 issue, Maryland has submitted an 11-15 waiver, which I
3 mentioned earlier, to the federal government, which
4 seeks approval to operate a managed, long-term care
5 program.

6 Under the waiver, individuals would enroll
7 with a Community Choice Care organization. While we
8 cannot require individuals who enroll in a CCO -- to
9 enroll in a CCO for Medicare services, we would require
10 the CCOs to be licensed, Medicare Advantage plans, so
11 that if they individual chose to have a completely
12 integrated service-delivery pattern, they could do so.

13 Although barriers will still exist regarding
14 enrollment, marketing, quality assurance, data-sharing,
15 and other kinds of services, we need to try -- continue
16 to try to integrate all of the services into one single
17 program for those individuals who are Medicare and
18 Medicaid eligible.

19 With that, Mr. Chairman, I'll conclude my
20 remarks and try and respond to any questions you may
21 have, I assume, after my colleagues have completed
22 their testimony.

1 MR. MANZULLO: Thank you. Our next witness is
2 Dennis Smith, director, Center for Medicaid and State
3 Operations at the Center for Medicare and Medicaid
4 Services, CMS. Look forward to your testimony.

5 MR. SMITH: Thank you, Mr. Chairman, for
6 inviting me today. And I do have a written statement
7 for the record, and we also provided, for the
8 committee, a separate document that we call the Roadmap
9 for Medicaid Reform.

10 We did two roadmaps, one for acute care, and
11 the one I brought today is, New Options to Support
12 Individuals with Disabilities and Long-Term Care Needs.

13 MR. MANZULLO: The written testimonies of all
14 the witnesses will be accepted into the record without
15 objection.

16 MR. SMITH: Thank you, Mr. Chairman.

17 And the Roadmap is intended to really help
18 states to understand all of the different things that
19 the DRA did and how to use the new tools that we're
20 providing. The DRA really was a remarkable piece of
21 legislation that really has not gotten the credit that
22 it is due to bring Medicaid into the twenty-first

1 century.

2 And I often talk about Medicaid needs to keep
3 pace with the people that it serves. And just as an
4 example, just walking over here from the parking lot to
5 the building here, I saw three people in power
6 wheelchairs, here on the streets of Hagerstown.

7 We have a service -- we have a program,
8 though, that this built on institutional care in
9 long-term care. Seventy percent of the Medicaid
10 dollars for long-term care still go to institutions.
11 There are many, many people that Medicaid is supporting
12 who are in institutions who can go back into their
13 homes and communities. And the DRA has a number of
14 provisions that helps encourage states to be able to do
15 that.

16 The DRA really was bipartisan. At the state
17 level, it was very bipartisan. It had the overwhelming
18 support of the bipartisan National Governors
19 Association, state legislators, et cetera. There were
20 many reforms in here that had been supported by the
21 states for a number of years.

22 And the program itself is in need, still, of

1 substantial reform. As Mr. Bartlett noted, it is still
2 growing at eight percent a year, which is generally
3 outpacing state revenues, in order to support their
4 share of the program. Medicaid is 57 percent federal
5 dollars, 43 percent state dollars, state and local
6 dollars, on average. And it's built -- each state has
7 a different match rate according to their relative
8 wealth compared to other states as a whole. So you do
9 have states with different match rates.

10 One of the -- I think going through the
11 long-term care provisions in the DRA itself is, as I
12 said, spelled out in our roadmap, but first, to be able
13 to increase access to community supports. Again, today
14 an individual is entitled to a nursing-home care. But
15 if you have needs and your family wants to care for you
16 at home, state has to come to Washington and get a
17 waiver, a Home and Community-Based Service Waiver, and
18 says, "May I serve this individual at home? Will the
19 federal government match these services, helping the
20 individuals in the community?"

21 We've had Home Community-Based Waivers now for
22 more than 20 years. We think it is time that it be

1 incorporated as a state-plan option, and the Deficit
2 Reduction Act did that in itself.

3 Secondly, "promoting personal responsibility,
4 independence and choice." Again, the DRA offers the
5 states a new way to offer individuals to self-direct
6 their own personal-care services without coming to
7 Washington for a waiver. Self-direction is about the
8 individual having control over a budget, making the
9 decisions about what services they want and from whom
10 do they want those services. Oftentimes, it is an
11 agency or a federal government agency making those
12 decisions on the individual's behalf.

13 And, as I said, I would be very hesitant to
14 think that very many of us would tolerate a different
15 stranger coming into our home every week to give us a
16 bath or to help us with most intimate, personal needs
17 that we have. So self-direction is about giving that
18 control over to the individual. It's been widely
19 successful in a number of states that have been tested
20 out, and now states will be able to do that without a
21 waiver.

22 Opting to participate in the State Long-Term

1 Care Partnership Program, this is an incentive for the
2 states, for the -- an incentive that the states can
3 participate in to build private insurance coverage and
4 to make those products available. The way Long-Term
5 Care Partnerships works is basically, if an individual
6 does buy that coverage, then a certain amount of income
7 is disregarded from Medicaid -- in case the individual,
8 in fact, does still eventually come to Medicaid. But
9 the experience has been, very few people -- there are
10 four states currently that offered Long-term Care
11 Partnership programs.

12 Congress put a moratorium on the partnerships
13 a number of years ago. The DRA lifts that moratorium,
14 in effect. But the partnerships -- very few people who
15 purchased the partnerships ever did come to rely on the
16 Medicaid program. So those states that have
17 partnerships do believe they're widely successful, and
18 now other states have those options, as well.

19 We also -- and Secretary McCann mentioned how
20 we have changed the eligibility rules for Medicaid.
21 And as Mr. Bartlett pointed out, Medicaid fundamentally
22 is for people who are poor and people who lack the

1 income and the resources to provide for their own
2 healthcare. But we have seen, over the years, growing
3 trends in which people artificially impoverish
4 themselves by protecting assets or transferring assets
5 to other individuals. But when they do that, they are
6 basically saying, "I am transferring my assets to this
7 individual," my child, typically, "and therefore, now
8 my neighbor is going to pay for my healthcare."

9 So the asset-transfer provisions in Medicaid,
10 again, I think are important to change people's
11 attitudes back towards Medicaid that to be on Medicaid,
12 you truly don't have the resources to provide for
13 yourself. The DRA provided a number of other
14 provisions. It expanded eligibility in different ways.

15 So families who have a child with a disability that
16 family income is of modest amounts, to be able to have
17 Medicaid, to have the child with disabilities enroll
18 into the Medicaid program so that they have the
19 healthcare that they need.

20 MR. MANZULLO: How you doing on time, Dennis?

21 MR. SMITH: I can sum up whenever you care to
22 have me to, Mr. Chairman. Thank you very much for

1 inviting me. I look forward to your questions.

2 MR. MANZULLO: It doesn't take too long to get
3 that word across, does it?

4 You know there's a sand thing up here. I'm
5 trying to figure out if this is for a three-minute egg
6 or a five-minute speech, but I haven't been able to
7 time the sand yet. It's sort of a primitive, Roscoe, I
8 don't know if I'd want to -- it's been around for a few
9 years, I could wear it on my watch like that.

10 Our next witness is Grace-Marie Turner,
11 president of the Galen Institute and a member of the
12 Commission on Medicaid. We look forward to your
13 testimony.

14 MS. TURNER: Thank you, Mr. Chairman, Chairman
15 Bartlett. I appreciate the opportunity to be here. I
16 am the president, also, of the Galen Institute. We're
17 a nonprofit research organization that focuses on
18 free-market ideas for health reform, and I was honored
19 to have been asked to serve on the Medicaid Commission,
20 to look at long-term reform recommendations.

21 Secretary Leavitt created the Commission a
22 year ago, and our first charge was to come up with

1 recommendations for a short-term reform of the program.

2 And many of those recommendations were, in fact,
3 incorporated in the Deficit Reduction Act. So, unlike
4 most commissions that just have one report, we've
5 actually already had one report and our next report is
6 due the end of this year.

7 Secretary Leavitt has charged us with coming
8 up with recommendations to modernize the Medicaid
9 program, so it can continue to provide high-quality
10 care in a financially sustainable way. We have 15
11 voting and 15 non-voting members of the Commission.
12 They come from a range of different organizations:
13 patient groups, businesses, government
14 research-provider groups; and we have two current and
15 two former governors on the Commission. It's chaired
16 by former Tennessee governor, Don Sundquist, and the
17 Vice Chair is our former governor, Angus King of Maine.

18 And Florida governor, Jeb Bush and West Virginia
19 governor, Joe Manchin serve on the Commission also to
20 provide us real-world experience with the challenges
21 that they've been dealing with.

22 I need to say here that I'm speaking for

1 myself today only and not for the Commission.

2 We -- I'm going to skip over this part about Medicaid
3 because you did such a good job of describing the
4 overall challenges of the Medicaid program.

5 Governor after governor -- and I think that's
6 what Dennis is talking about when he talks about the
7 bipartisan recommendations in the Deficit Reduction
8 Act -- governors are looking at not only their current
9 budget struggles, but their out-year budget struggles
10 and wondering how on earth they're going to continue to
11 provide for public safety, education, roads, if they
12 don't get control of the Medicaid budget. So all of
13 these efforts really are aimed at trying to continue to
14 allow this program to take care of our most vulnerable
15 and truly needy citizens, while making sure that we
16 give the states the flexibility to spend these dollars
17 wisely and to be able to get control over their
18 budgets.

19 One of my colleagues, Bob Helms from the
20 American Enterprise Institute, and I, just last week,
21 submitted recommendations to the Commission for some of
22 our recommendations for long-term care reform. And

1 I'll read just a couple of those.

2 We had seen a couple of -- we've really
3 received wonderful testimony before this Commission of
4 what different states are doing to really optimize
5 their Medicaid program. Vermont gave us some wonderful
6 examples of what they're doing to really tailor
7 long-term care resources to the needs of individual
8 patients. You know, they -- 500,000 people live in
9 Vermont; they can practically know the names of each
10 one of these patients. They can really get down to
11 very specific.

12 And it seemed clear to us that getting down to
13 the level of really taking care of patients' specific
14 needs and not trying to fit them into the program is
15 how we need to begin to think about Medicaid reform.
16 We also saw a wonderful video, put together by the
17 American Association of Homes and Services for the
18 Aging, that gave us a vision of what Medicare -- what
19 long-term care could look like in the future.

20 Instead of being institutional
21 care -- institutionalized, people can stay in their
22 homes and, through really remarkable but relatively

1 inexpensive technologies, continue to be monitored,
2 have their medications dispensed on time, make sure
3 that they are getting the care that they need, but
4 using electronics and using twenty-first century
5 technologies to do it. It seems like it would be
6 expensive, but it's certainly not going to be the
7 average \$32,000 a year of the average care for somebody
8 needing long-term care services today.

9 So we've sort of seen the future in talking
10 about what some of the recommendations are to help get
11 us there. It's essential that we begin now to
12 encourage people who are working to get long-term care
13 insurance. And the new Long-term Care Partnership that
14 Dennis mentioned is absolutely crucial to that. We
15 believe also that federal and state tax incentives to
16 encourage people to purchase long-term care insurance
17 are crucially important, the greater use of reverse
18 mortgages, so that people can continue to stay in their
19 homes, and go on the resources that they have
20 accumulated, rather than having their neighbors and
21 their children pay for these services, makes an awful
22 lot of sense to us.

1 And also, it's really important to continue to
2 enforce the provisions of the DRA, so that Medicaid is
3 paying for long-term care for people who really need it
4 and not for people who have other options and could
5 draw on their own resources. So those are some of the
6 things that will allow this to continue to be flexible
7 and allow people to be part of this program.

8 Two other things: It's essential that
9 Medicaid begin to look at the services it provides as
10 encouraging wellness and prevention and not just taking
11 care of people after they get sick. Integrating
12 wellness and prevention, much better disease management
13 and care coordination as part of the infrastructure of
14 the program. Some of the things that we've seen with
15 allowing patients to have more control over the
16 resources being spent through the Cash and Counseling
17 Program, for example, allows them to decide who they
18 want to come and give them a bath, allows them to say,
19 "You know, I need a wheelchair ramp for my house" or "I
20 need a microwave." "I don't need this long list of
21 services, but here are the things I need to allow
22 people to be more engaged partners."

1 And then, finally, we have recommended that
2 Medicaid, a new Medicaid Advantage Program, building
3 upon the Medicare reform provisions for Medicare
4 Advantage to allow people to do what Tony is talking
5 about in allowing Medicare and Medicaid to be
6 integrated at the patient level, so that you have a
7 seamless continuum of care.

8 We have heard so many people saying, "We don't
9 want to keep falling off cliffs and figuring out how to
10 fit into all these boxes." We need a continuum of
11 care. And in order to do that, the money needs to
12 follow the patient, so we're recommending a Medicaid
13 Advantage program to build on some of the reforms we've
14 seen already being so successful in the Medicare
15 program.

16 Thank you so much.

17 MR. MANZULLO: Thank you. Roscoe, why don't
18 you go ahead?

19 MR. BARTLETT: Thank you very much. The
20 current cost of Medicaid is \$300 billion, one of you
21 said, and growing at eight percent a year. That \$300
22 billion is about the same as interest on our debt. And

1 of course, the eight percent growth per year is, what,
2 roughly three times the average rate of inflation?

3 Clearly the program cannot keep growing.

4 When Albert Einstein was asked what the next
5 great force was going to be after he was partly
6 responsible for discovering atomic energy, he said that
7 clearly, the most powerful force in the universe was
8 the power of compound interest. And what we have here
9 is an exponential growth. And if it grows at eight
10 percent a year -- that eight percent growth curve, by
11 the way, is just astounding. It almost stands on end;
12 it is like a hockey stick if you plot that.

13 Two percent growth is very, very flat compared
14 to eight percent growth, and clearly this will just
15 consume us if this continues. It will -- it not only
16 is increasing a debt which we're passing on to our kids
17 and our grandkids, but it will consume us if it
18 continues, so we clearly have to bring this under
19 control.

20 Just like to ask a -- make a couple of
21 comments and ask if I am correct.

22 Medicaid -- pronounce it Medicaid, but if I look at the

1 word it's really Medic-aid, isn't it? And I gathered
2 from that that the intent was that it was kind of a
3 welfare thing that was intended originally for people
4 who couldn't help themselves. Sometimes looking at the
5 root of words helps us understand the meaning and where
6 they came from.

7 So this was originally intended to be
8 available to those who couldn't, who didn't have the
9 assets to provide for their own care. Is it also
10 correct that the laws and the regulations that evolved
11 from those laws are all intended to keep the program
12 focused on its original intent, and that is, to help
13 those who can't help themselves?

14 MR MCCANN: No, I don't necessarily think
15 that's true. I think that the combination of groups
16 trying to expand services and some fairly innovative
17 folks figuring out how to finance things have led us to
18 expanding beyond the -- I think the original group of
19 people who are involved because, as you indicated, the
20 primary group of people who were originally involved in
21 Medicaid, who were the old AFTC-eligible individuals
22 and groups, and other assorted groups of categorically

1 eligible people. But I don't think it's -- I don't
2 think everything we've done between then and now
3 focuses exclusively on maintaining that focus.

4 MR. BARTLETT: Why would we want to make these
5 services available to people who can pay for
6 themselves?

7 MR. MCCANN: That's a broader question than I
8 think I can answer, Mr. Chairman.

9 MS. TURNER: But I do think it really gets to
10 the point that, in some states, Medicaid eligibility
11 goes up to 300 percent of poverty, and that's clearly
12 not one of the original intents of the Medicaid
13 program. One of our concerns is that that then makes
14 it more difficult for people who have no other options
15 to get the care that they need.

16 And one of the reasons that we're recommending
17 that people start to look ahead and realize Medicaid is
18 not going to be there for affluent seniors who want to
19 pass on their resources to their children rather than
20 having -- paying for their own long-term care needs.
21 So I think getting back to basic principles is really
22 an important consideration.

1 MR. BARTLETT: The Deficit Reduction Act, is
2 it your impression that that was Congress's intent, to
3 try to move us back to the original intent of Medicaid?

4 MR. SMITH: Certainly on long-term care. The
5 original intent was to be for individuals who could not
6 provide for themselves, but as I said, it also created
7 an incentive for individuals to go out and get private
8 insurance on their own, so it did both of those things.

9 MR. BARTLETT: You mentioned private
10 insurance. I'm not a big fan of government and
11 government regulation, and I think that the private
12 sector does a better job.

13 And I would -- you may notice that you never
14 see a person drinking beer on television. Have you
15 ever noticed that? When it's advertised they're never
16 drinking it; the industry just decided that wasn't in
17 their best interests.

18 SPEAKER: Worldwide Wrestling Channel.

19 MR. BARTLETT: I'm sorry.

20 SPEAKER: If you ever watch MTV or Worldwide
21 Wrestling Channel.

22 MR. BARTLETT: Well, you may see somebody the

1 camera is focused on. But the advertisements, you'll
2 never see them drinking beer because they decided it
3 was not in their best interest for people to be seen,
4 actually be seen drinking beer. And as you may have
5 noticed, hard liquor is not advertised on television.
6 And these were decisions that the industry made in
7 their own self-interest.

8 You mentioned long-term care. What I would
9 like the industry to do, that any healthcare policy
10 would include long-term care. Now no 18-year-old ever
11 believes he's going to need long-term care, but if that
12 was an invariable part of a healthcare plan, it would
13 cost literally pennies.

14 You've seen the advertisement on television,
15 "How much is going to cost for half a million dollars
16 of term life insurance for the guy who's 40 years old?"

17 And it's less than, what is it, less than \$25 a month.

18 That's because very few people die when they're 40
19 years old. There's a reason for that.

20 So it would cost literally pennies, and I
21 really hope that the industry would help us solve this
22 problem by insisting that you cannot buy a health

1 insurance policy that does not have long-term care in
2 it. If that was true, then we wouldn't be faced with
3 this problem, because most people worked.

4 We need to do two other things, by the way, to
5 make this workable. The policy needs to belong to the
6 person and not the employer, so that it has
7 ultimate -- I see you put your thumb up, thank
8 you -- so it has ultimate transferability.

9 This will do a lot of good things. It makes
10 the person a careful shopper. They will now look for a
11 policy that serves their interests. They're paying the
12 fee for the policy, not their employer, and so they're
13 going to want to limit the abuses of that policy,
14 because if they don't the fee is going to go up.

15 But if we could do those things: move the
16 policy to private ownership so that it would have
17 transportability, that you'd buy a policy when you
18 enter the workforce, that's the policy you have until
19 you go to your grave, and that policy will include
20 long-term care. What's wrong with that, and why
21 wouldn't that be helpful?

22 MS. TURNER: Exactly the right solution, and

1 that's really a twenty-first century solution. We see
2 employment-based health insurance declining and people,
3 they just can't afford it. New figures out last week
4 that said the average price of a family policy, of
5 somebody with job-based coverage, is now \$13,300. And
6 it's becoming prohibitively expensive, people can't
7 afford it. And yet in the private and individual
8 market, you see policies as little as \$100 a month.

9 When people are shopping for themselves and
10 they're making their own decisions about what that
11 policy is going to cover, then they make smarter
12 shopping decisions and are able to find better deals.
13 And if you were to have privately owned health
14 insurance, I think people would see the value of adding
15 that \$2 or \$3 extra a month to include long-term care
16 insurance. And that's portable, so they don't lose
17 that insurance when they lose their job. So I
18 absolutely agree with you, Chairman.

19 MR. BARTLETT: What's wrong with the insurance
20 industry deciding that they're not going to offer any
21 policies that don't have long-term care? Isn't that
22 the compassionate thing to do?

1 Why do we want to see seniors coming to -- and
2 I talk to a lot of seniors who just want to die because
3 they are now spending the estate that they wanted to
4 turn over to their kids and their grandkids, and
5 they're in a nursing home, and they just want to die so
6 that their estate -- I don't want to see our seniors in
7 their golden years faced with this kind of a problem.

8 Why shouldn't the industry help us solve this
9 problem by just not issuing any policy that does not
10 include long-term care? Wouldn't this problem, a
11 couple generations from now, essentially go away if
12 that's what the industry did? And why shouldn't they
13 do it? It's going to cost just pennies when you're 18
14 years old to include that in your policy.

15 MR. MCCANN: I'd only suggest you keep in mind
16 that, in the state of Maryland at least, with respect
17 to the Medicaid program, the elderly, while a large
18 portion of our long-term care expenditures, are by no
19 means the majority. The larger share are increasingly
20 the developmentally disabled, those individuals who
21 become disabled as a result of disease or accident, and
22 the mentally ill.

1 In some cases, those are insurable events, but
2 increasingly, for example, 20, 25 years ago, we made a
3 social decision that we would no longer, for lots of
4 very, very good reasons, we would no longer try and
5 maintain individuals with developmental disabilities in
6 state institutions. And so we have been
7 effectively -- no one has answered.

8 For all intents and purposes, the state
9 institutions in the state of Maryland over the last
10 five or ten years, one or two here, but they've been
11 declining in size. And those individuals are in the
12 community, and they are, by and large, still being
13 cared for by parents. And as our healthcare system,
14 for example, has improved, you have parents that are in
15 their 70s and 80s caring for children that are in their
16 40s, and 50s, and 60s.

17 Those individuals are going to come into our
18 system. They've probably, given the costs that
19 they -- that the parents bore, would never be able to
20 insure against that kind of an event. So again, I
21 would go back to my suggestion that if you think about
22 long-term care as a single program, you're going to

1 miss a lot of people.

2 You've got to -- and whether my way of
3 dividing the world is the right way or not, I don't
4 know. But you definitely have to separate the issues
5 and the concerns of an elderly individual who has to
6 plan for their declining health years from a perfectly
7 normal family that all of a sudden has a child with a
8 developmental disability; to a family, adult or a
9 child, who has an accident or disease; to chronic
10 mental illness, each of which has a different set of
11 requirements, some of which are insurable, some of
12 which are not; some of which are insurable at prices
13 people can pay, some of which are not.

14 MR. BARTLETT: Shouldn't it be our long-term
15 goal that Medicaid would be there for those -- as a
16 safety net for those --

17 PANELIST: Absolutely.

18 MR. BARTLETT: See, my suggestion that
19 long-term care ought to be an invariable component of
20 every healthcare policy. Now there would be a tiny
21 percentage of those that are now on Medicaid would be
22 on Medicaid a generation from now if we had that

1 policy.

2 And I would like the industry to do this. I'm
3 not a fan of big government. I just -- you know,
4 government needs to step in only when the private
5 sector doesn't. And I think we step in too early, and
6 the private sector spends most of their energy trying
7 to survive in spite of our regulations, and I'd like to
8 slowly move away from that.

9 Let me come to some of the perceptions about
10 this Deficit Reduction Act and what that has done.
11 It's my understanding that if you had had a practice of
12 tithing your money, giving it to your church, and
13 giving additional monies to missions, and if you had a
14 practice of giving the maximum, which is now, what?
15 \$12,000 a year for each parent to their children, if
16 that has been your practice and you continue that
17 practice, that this will not be considered a willful
18 act to impoverish yourself, and that the look-back
19 would not try to go get that money if that's been your
20 policy for the last 30 years, and you're just
21 continuing it.

22 Is that a correct assumption? It better be

1 because that was our intent when we passed the
2 regulation.

3 MR. SMITH: I think you're -- I think the
4 intent is exactly the thing to key on. In which, why
5 are you giving away your assets? If you are giving it
6 away in order to -- for your intent to be to get on to
7 Medicaid, that is what we're trying to prevent.

8 MR. BARTLETT: But you can't get inside my
9 head. You don't know why I'm doing it. If I have a
10 practice of doing it for the last 30 years, and I
11 simply continue that practice for the last five years
12 before I go into the nursing home, then it's my
13 understanding that you could not look at my giving
14 during that last five years, which was not different
15 than the previous twenty five years, and say that I was
16 trying to impoverish myself.

17 MR. SMITH: Again, if I may: The distinction
18 that we are looking at -- again, this is about giving
19 away assets for less than their fair market value in
20 order to get on Medicaid.

21 If you are tithing part of your income, this
22 is not about your income. So you giving your weekly

1 contribution to your church, that is not something that
2 gets looked at.

3 MR. BARTLETT: -- continue doing that, even
4 during the look-back period, and that's not a problem?

5 MR. SMITH: Because you're giving away your
6 income. The asset-transfer is about giving away
7 assets, that you have a -- some other -- stocks, things
8 of value that you are divesting yourself of that, and,
9 again, in order to get on Medicaid.

10 The DRA did a couple of different things, and
11 again, in the -- what you're trying to do is really
12 prevent people from sheltering things, and from
13 artificially becoming eligible for Medicaid. So the
14 typical individual who, again, is tithing to their
15 church part of their monthly income, that's not what
16 you'd be looking at.

17 What you'd be looking at is if you had
18 \$100,000 asset, and now you have given them -- that
19 away in order to become eligible for Medicaid. The
20 states would still go through -- at the eligibility
21 level, you would still be looking at -- the look-back
22 period has said, "What have you done in the last five

1 years? Did you actually give away something of that
2 type of value?" (Interruption to tape.) And then
3 again, "Why?"

4 And as -- Secretary McCann mentioned that even
5 on an individual level, there still could be a hardship
6 exemption. Perhaps an individual did do something that
7 was -- now put that individual in a situation that
8 would be a detriment to their health or their life; the
9 state could give a hardship exemption. But
10 in -- generally, if you found something and that you
11 did do an asset-transfer that the social worker would
12 be looking at, you found that, typically, again, then
13 you say, "Well, can you get it back? Can you -- you now
14 have a need for it on your own, and is it really still
15 available to you in order to use?"

16 MR. BARTLETT: But if it's not available and
17 if you, in fact, had cheated, if your intent was to
18 artificially impoverish yourself, and you've given
19 money away and do you now -- the state tries to go get
20 that back and they can't get it back, and you mentioned
21 the hardship, the reality is that no matter whether
22 you've been wicked or not, whether you've intended to

1 impoverish yourself, that you will not be denied
2 adequate healthcare. You can -- the exemption or the
3 waiver is obligatory is my understanding.

4 If you have impoverished yourself with intent
5 to go on Medicaid and you -- the look-back, you cannot
6 go and get that money back, you still can declare
7 hardship and get full healthcare.

8 MR. SMITH: Then you would have a hearing
9 before the state, and the state would make a
10 determination.

11 MR. BARTLETT: And that determination
12 invariably is that if your health is going to be
13 impacted by not being in the nursing home, you stay in
14 the nursing home is my understanding. Correct?

15 MR. SMITH: Generally, I think that that is
16 the way it has worked.

17 MR. BARTLETT: Okay, I just wanted to get
18 that, to get that on the record because there are
19 people who believe that if they can give money to their
20 children or give it to their church and the regulators
21 think that that was -- whether it was an intent or not
22 to impoverish themselves, if the regulators think it

1 was intent to impoverish yourself, now they're going to
2 be out on the street on a stretcher on the curb.

3 That's just not true, is it?

4 MR. SMITH: I do not think that's true. I
5 think you're correct.

6 MR. BARTLETT: Okay. Thank you.

7 MR. SMITH: But what you're trying to do,
8 again, is to change people's attitude up front to say,
9 again, the -- whereas it has been very commonplace in
10 recent years, for individuals to say "go ahead and get
11 rid of your assets so your neighbor will take care of
12 yourself," I think the intent was to -- people to think
13 again about doing that, saying I'm responsible for my
14 own healthcare, and I need to hold on to those
15 resources so I can pay my own way and not be asking my
16 neighbor.

17 MR. MANZULLO: My -- the whole purpose of the
18 Deficit Reduction Act is to make sure that the pot of
19 money for Medicaid stays around as long as possible.
20 In most states, at least in my home state, Medicaid is
21 25 percent of the state budget, and it continues to
22 grow.

1 When I practiced law before I was elected
2 Congress, we would periodically toss out, at my office,
3 people who came in who wanted to scan the system. They
4 wanted to keep my Ma and Dad's house, and usually it
5 was just -- it wasn't a problem, as long as there was
6 a -- both spouses were living, but when one spouse had
7 passed away.

8 I mean it was common for them to come in and
9 say, "Ma wants to give me the house so she can go on
10 Medicaid." And that's garbage. It's cheating because
11 if you don't have a disabled child living in that
12 house, and if your spouse is dead -- what's more
13 important is that the fund to maintain the integrity of
14 the system be there, as opposed to so-called "right to
15 inherit" anything from your parents.

16 We got a situation in our family where the
17 family restaurant was still in my mother's name. She
18 was approaching 79 year old. My brother had run the
19 restaurant ever since he got out of the Service, around
20 about 35 years. And for estate planning purposes, you
21 don't transfer an asset, because it would have gone in
22 at my mother's basis, which would have been \$13,000 for

1 the restaurant. Can you imagine that? As opposed to
2 the present value, which was a couple hundred thousand
3 dollars.

4 So my mother said, "Look it, I'm going to be
5 80 years old. I called an insurance fellow, and I can
6 get long-term healthcare for \$300 a month. And I said,
7 "Well, to preserve the family asset," I said, "We'll
8 kick in \$150 a month each. And she said, "No," she
9 said, "I got the money."

10 And it wasn't but a year after that that she
11 had a blood clot; her right leg is amputated. And
12 here's a lady who went from working 60, 70 hours a week
13 at the family restaurant to having to go and pick out a
14 long-term healthcare facility.

15 The insurance paid \$83 a day, and the cost of
16 the facility was \$85 a day. So that, plus her Social
17 Security, was really more than sufficient to do it.
18 But I just -- it just really, it really grinds at me,
19 the professional cheats out there, the law firms that
20 would go opposite of what I did to encourage people how
21 to scam the system. And in fact a big -- aren't there
22 criminal penalties imposed for people that try to do

1 this?

2 MR. SMITH: In terms of advising someone how
3 to do this, there are not.

4 MR. MANZULLO: No, I'm not talking about the
5 attorneys because the attorneys are just taking law as
6 they see it and trying to work around it. And that,
7 unfortunately, is one of the jobs of being an attorney
8 compared to my Congress, of course.

9 But in terms of somebody who intentionally
10 takes property from his parent to make him qualify for
11 Medicaid, are there any state statutes that would catch
12 any criminal liability to that?

13 SPEAKER: Not that I'm aware of. I'm not
14 counsel, either.

15 MR. MANZULLO: I understand that. The -- I
16 introduced a bill, and Roscoe, I don't know if you had
17 joined on. It was Nancy Johnson and I put in a bill
18 about six years ago, we've tried to renew it each year,
19 to give a tax deduction either to the senior who pays
20 for long-term healthcare or to the children who are
21 buying the policy on behalf of their parents, to
22 encourage them to do that.

1 I think somewhere along the line when you see
2 the statistics that say -- is it 30 or 40 percent of
3 people who are presently age 50 may spend some time in
4 a nursing facility? Is that correct figure; is that
5 high?

6 SPEAKER: It's historically correct. I think,
7 going forward, it's probably high.

8 MR. MANZULLO: Okay, but in any case, it's a
9 huge number. And now that long-term healthcare is
10 being offered sometimes as part of the cafeteria
11 plan -- but the premium is very nominal. And I
12 represented a lot of farmers who did estate planning
13 back then to preserve the assets. You'd never hear too
14 much about long-term healthcare insurance. Of course,
15 that was several years ago.

16 And yet, the biggest blow to any family asset
17 would be for Mom or Dad to go to a nursing home,
18 because you're looking at \$40,000 to -- it would depend
19 upon the extent of the care -- \$40,000 to \$70,000 a
20 year, which would -- in my brother's case, if my mother
21 had not done that, it would have been disastrous.

22 She never applied for Medicaid because she

1 didn't qualify. We certainly didn't even think about
2 that option. But here is a 79-year-old lady that had
3 the savvy -- and she called us in, and I said, "Ma, why
4 do you want this insurance? There's never been anybody
5 in our family that's ever gone to the nursing home."

6 Well, that decision that she made literally
7 saved the family restaurant, because she was in that
8 nursing home for about five years.

9 MS. TURNER: She's not only smart to get the
10 long-term care insurance, but she did a really good job
11 of shopping for good premiums, too, at age 79, to find
12 one for \$300 a month.

13 We have heard testimony from members -- from
14 people who are on Medicaid, who are being threatened
15 with being thrown off Medicaid, and sometimes these are
16 kids' parents, so the kids have -- are in wheelchairs,
17 they're parapalytics (sic), they need 24/7 care, and
18 they're being threatened with losing Medicaid services
19 because of some rule or regulation that they haven't
20 abided with.

21 And it just breaks my heart to see those
22 people, who have no other options --

1 MR. MANZULLO: Well, we have some friends back
2 home with two children that are disabled, and the town
3 threw a fundraiser to raise some money to help buy a
4 van. And guess what happened? They counted out \$8,000
5 to buy a van, and they've been ineligible for a period
6 of time.

7 They eventually got it straightened out, but
8 you're figuring, here you are trying to help
9 people -- and now the town, again, threw another
10 fundraiser because the kids are like 19 and 21, and
11 they both have Werdnig Hoffman disease: two incredibly
12 bright kids that are in a wheelchair when they're up,
13 and they sleep in an air chamber at night to help them
14 breathe.

15 And they -- one wants to become a lawyer and
16 the other one -- I mean, what these kids are doing in
17 the march of efficiency in medical care has been
18 astounding, because these kids were not expected to
19 live past the age of five years old.

20 MR. SMITH: And in that, Mr. Chairman, DRA
21 created a new eligibility group to help those children
22 with disabilities to where now -- Illinois, if they

1 adopted that provision, could make those children
2 eligible for Medicaid and didn't have to worry about
3 the asset tests.

4 MS. TURNER: And those are really -- that's
5 the population that Medicaid needs to be thinking
6 about --

7 SPEAKER: Yes.

8 MS TURNER: -- not somebody who wants to
9 protect the house for their affluent children who just
10 don't want to lose those resources. That's really
11 important, to get back to first principles and such --

12 MR. MANZULLO: Their biggest concern now, as
13 the parents age and so do the children: Who is going to
14 take care of the children?

15 And Roscoe, I know that's why you called this
16 hearing, because these are the really, really tough
17 ones with kids that -- I mean, they're in good health;
18 they're just disabled. Their minds are quick and they
19 have a lot to add to society. One works on websites,
20 and these kids are -- now they want to go away to
21 college. And their mother said, "What?"

22 Yeah, they want to go away to college.

1 They're checking things out, and the school is working
2 with them.

3 But I just -- I want to commend you, Dennis.
4 I know you're in the middle of all these changes that
5 we're trying to make. Roscoe, I want to commend you
6 for calling this hearing, because most Americans don't
7 realize, as Tony mentioned, when we talk about
8 Medicaid, it's not just the seniors that are being
9 impacted, but with the quality of healthcare
10 improving -- it's the disabled ones that really, really
11 need the help. And this program has actually been
12 carved out to -- has been changed to not only save
13 money, but to direct the resources towards those who
14 have the greatest need.

15 MR. BARTLETT: I want to thank you all very
16 much for coming. I just wanted to reiterate that the
17 intent of this legislation, the intent of the
18 regulations that were promulgated as a result of that
19 legislation, was to make sure that Medicaid would be
20 here for those in the future who need it. Unless we
21 make appropriate changes, it won't be here, because it
22 cannot continue to grow at eight percent a year.

1 Now \$300 billion increasing at eight percent a
2 year, some real simple arithmetic will show you that
3 that is going to consume our total federal budget in
4 not very many years. Eight percent growth rate is an
5 incredibly high growth rate when you compound that, and
6 this is compounded. When you compound, it's an
7 incredibly high growth rate.

8 We have got to do something to control this.
9 I would hope that the industry would act responsibly.
10 I just think the responsible thing to do is to make
11 long-term care an obligatory part of every healthcare
12 policy. When you're 18 and enter the workforce, you're
13 now paying -- it would literally be pennies. That is
14 correct; is it not?

15 It would be pennies a week to provide for your
16 long-term care. You may not need it, but your brother
17 or your sister may need it. And we would be sitting
18 here now, 50 years from now, talking about a real
19 catastrophe, which is what we're going to have unless
20 we fix this problem.

21 And wouldn't that largely fix the problem?
22 We're going to have to make do until then, but if we

1 now had obligatory long-term care in every policy,
2 would we -- we could pretty much stop worrying about
3 Medicaid in the future, couldn't we, if we did that?
4 And why don't we do that?

5 And I don't want to have to mandate that from
6 the government. I just -- I'm not a big fan of
7 government. I would hope that the private sector would
8 do that. And I would hope that they would see that
9 it's in their best interests to do that.

10 (Chorus of thanks to the Chairman.)

11 MR. MANZULLO: Who was it that raised their
12 hand back there? Ma'am, with the glasses, did you have
13 a -- why don't you stand up and -- let's get the second
14 panel posed, up here.

15 QUESTION: I'm sorry. You want me to come
16 back?

17 MR. MANZULLO: No, no, no. Just stand right
18 there.

19 QUESTION: Okay. Well, when Mr. Bartlett was
20 proposing -- an idea that we're going increase the
21 number of uninsured significantly. Right now we have
22 15 percent of the population uninsured and growing, and

1 the reason for that is --

2 MR. MANZULLO: I don't think that's the case,
3 ma'am. He was speculating --

4 QUESTION: -- in the intervening five years --

5 MR. MANZULLO: He was speculating on whether
6 or not somebody would at least start the study as to
7 what the cost of long-term healthcare would be if it
8 were tacked on to a regular health-and-accident policy.

9 QUESTION: Well, let me say what I want to
10 say, please.

11 MR. MANZULLO: Well, go ahead. And hurry up,
12 because we want to get to the next panel.

13 QUESTION: -- for the high number of uninsured
14 is enhance -- the cost of healthcare in the United
15 States is twice -- and higher --

16 MR. MANZULLO: Ma'am, ma'am, ma'am? Ma'am,
17 please. We have these three witnesses here. I just
18 thought that you had a question or a short comment.

19 QUESTION: I have a question that you -- both
20 of you are on the House Small Business Committee, so
21 you ought to be aware that the U.S. healthcare costs
22 could drop the U.S. small business to extinction. So

1 how can you be at the same time advocating that
2 healthcare is not a responsibility of the federal
3 government?

4 MR. MANZULLO: Well, I don't think that's the
5 issue here. My brother just closed his restaurant
6 after 41 years, because his healthcare insurance for
7 him and his wife was \$13,000 a year. And he had to
8 sell \$70,000 worth of spaghetti each year, just to
9 cover his healthcare for him and his wife. He could
10 never afford to offer it to his employees.

11 No one knows those burdens more. The problems
12 with the mandates that come from the state -- the state
13 of Illinois has mandated in-vitro fertilization, for
14 example, treatments that are mandated by state policy.

15 Any time you get those mandates in there that spikes
16 the cost of health and accident insurance.

17 We've held several hearings. Mr. Bartlett has
18 been involved in these for years, the small business.
19 What we're trying to do in the Small Business Committee
20 is somehow to allow small business people to right to
21 form their own groups, such as labor unions do, into
22 these national associations that would have the

1 purchasing power that would give them the same
2 purchasing power as large corporations and unions
3 and -- bring down the cost of health and accident
4 insurance.

5 Okay. Our next panel is -- let's see. We'll
6 start with Anthony McCann -- oh, I'm sorry. We'll
7 start with Stephen Moses. Stephen is the president of
8 Center for Long-Term Care Reform. And you came all the
9 way from Seattle, Washington.

10 MR. MOSES: I did.

11 MR. MANZULLO: Thank you very much, Mr. Moses.
12 We appreciate that.

13 MR. MOSES: It's an honor to be here. Mr.
14 Chairman Manzullo and Vice Chairman Bartlett, thank you
15 for the opportunity to testify before you today about
16 Medicaid, long-term care financing, and the impact of
17 the Deficit Reduction Act of 2005 on those two critical
18 issues. I've submitted detailed written testimony,
19 which explains and defends the Deficit Reduction Act's
20 important changes in Medicaid eligibility rules and
21 long-term care financing policies.

22 It took courage for members of Congress to

1 pass those critically needed but politically sensitive
2 changes. But instead of receiving the kudos they
3 deserve, they have often been criticized. Why?

4 Medicaid is a means-tested public assistance
5 program, in a word, "welfare". It is supposed to be
6 the public assistance safety net that guarantees access
7 to quality long-term care for people who are
8 financially unable to provide for themselves. Over the
9 years however, Medicaid has expanded to become the
10 primary third-party payer of long-term care for most
11 Americans, not just the needy.

12 Contrary to popular opinion, Medicaid
13 long-term care eligibility places no certain limits on
14 program recipients' income or assets. Income may be
15 unlimited if medical expenses, including the cost of
16 nursing-home care, are high enough. Assets can be
17 unlimited, as long as they are held in exempt form,
18 such as a business, home, automobile, term life
19 insurance, prepaid burials, et cetera, et cetera.

20 Medicaid's income and asset eligibility rules
21 are easily stretched even beyond these already highly
22 generous limits. Medicaid and estate-planning

1 attorneys are in the business of doing just that. By
2 means of creating legal strategies, they artificially
3 impoverish middle-class and even affluent people to
4 qualify them for Medicaid's long-term care benefits.

5 This practice has had devastating consequences
6 for the program. Today, Medicaid financed long-term
7 care has a reputation for severe problems of access,
8 quality, reimbursement, discrimination, institutional
9 bias. Yet the program continues to explode in cost.

10 Because Medicaid financing of long-term care
11 has been so readily available for 40 years, the
12 American people have become anaesthetized to the risk
13 of long-term care. They rarely plan to save, invest,
14 or insure for that risk. Therefore, most people end up
15 on Medicaid when they do need long-term care.

16 Now crisis is approaching. As the age wave
17 crests and crashes over the next 30 years, America
18 cannot sustain the \$84 trillion dollar unfunded
19 liability in the Social Security and Medicare program
20 and still provide Welfare-financed long-term care to
21 non-needy Americans.

22 That's why the Deficit Reduction Act was such

1 an important measure. It removed some of the perverse
2 incentives in public policy that have discouraged
3 responsible long-term care planning. By extending the
4 look-back period from three to five years, the DRA
5 discouraged the common practice of giving away wealth
6 to qualify for public welfare.

7 By the way, the look-back period under
8 Germany's socialized long-term care system is ten
9 years: double ours. By changing the date when a
10 transfer-of-assets eligibility penalty takes effect,
11 the DRA eliminated the single most common
12 Medicaid-planning strategy called, "half a loaf."
13 Thus, removing the main reason people gave away assets
14 to qualify for Medicaid.

15 By lowering Medicaid's home equity exemption
16 from "unlimited" to "at most \$750,000," the DRA
17 discouraged the routine Medicaid-planning practice of
18 "hiding money in the home." By the way, the home
19 equity exemption is only \$36,000 in the United
20 Kingdom's socialized long-term care system. So we're
21 much more generous here in good old, free market
22 America than in the European socialized systems.

1 By restricting the use of annuity,
2 self-canceling installment notes, life estates, and
3 other egregious Medicaid planning gimmicks of
4 self-impooverishment, the DRA sent yet another message
5 to Medicaid estate planners that their practices are
6 unwanted and counter to clients' and citizens' best
7 interests.

8 Now in 1996, Congress passed and the President
9 Clinton signed a law that criminalized the practice of
10 advising clients for a fee to transfer assets to
11 qualify for Medicaid. Actually, that was '97.
12 Although unenforceable, that law clearly established
13 congressional and presidential intent to preserve
14 Medicaid as a long-term care safety net for the poor.
15 So Congress should be praised for trying in the DRA to
16 save Medicaid.

17 Instead, they've been accused of denying
18 access to needed long-term care. Critics have said
19 that the DRA will penalize people for routine gifts to
20 charities or grandchildren. They said, "It will deny
21 people critically needed care after all their assets
22 have been extended."

1 Such attacks are totally unfounded. Nothing
2 in the DRA changes the clear statement in the Social
3 Security Act itself that to be penalizeable, asset
4 transfers must be done for the purpose of qualifying
5 for Medicaid. Routine gifts to family members,
6 religious tithing, and other asset transfers are exempt
7 if they are not done for the purpose of qualifying for
8 welfare benefits.

9 What about the claim that people will be
10 denied care when they need it most? That, frankly, is
11 nonsense, too. The DRA eliminates the main reason
12 people give away assets for purposes of planning for
13 Medicaid. That's the so-called "half a loaf" strategy.
14 That is, give away half your money, and qualify for
15 Medicaid in half the time.

16 Thus, Medicaid planners can no longer
17 recommend that strategy. There is no longer any reason
18 for people to give away assets. And therefore no one
19 should become vulnerable to that penalty.

20 But what if it does happen? The DRA
21 strengthened the rules governing undue hardship waivers
22 to protect people who unwittingly incur a

1 transfer-of-assets penalty.

2 Now let me close by explaining the real reason
3 for the attacks on courageous members of Congress who
4 voted for the Deficit Reduction Act. Medicaid estate
5 planning has been a lucrative subpractice of the law
6 for 25 years or more. Medicaid planners routinely make
7 6-figure incomes and 7-figure firm revenues by
8 diverting Medicaid's scarce revenues from people truly
9 in need to their own, often affluent clients. The DRA
10 makes this harder to do, and that's why Medicaid
11 planners oppose it and attack the people who voted for
12 it.

13 Responsible public policy requires that we
14 target public assistance to people truly in need, and
15 encourage everyone else to plan early, save invest, and
16 insure for long-term care. In the long run, that is
17 the only way we can ensure access to quality long-term
18 care for all Americans: rich, poor, and in between.
19 Thank you.

20 MR. MANZULLO: Thank you, Mr. -- are those
21 books that are on your tie, there?

22 MR. MOSES: Yes, sir.

1 MR. MANZULLO: Okay. That's a Smithsonian
2 tie, isn't it?

3 MR. MOSES: I believe it might be.

4 MR. MANZULLO: I had one like that with
5 railroads, with trains on it, one time.

6 MR. MOSES: I have one with fountain pens as
7 well, there's a literary --

8 MR. MANZULLO: Is that right? Well, Jim, your
9 tie is nice, but it's not extraordinary like Steve's.

10 Our next witness is Dr. Jim Mitchell,
11 administrator of -- is it Moran?

12 DR. MITCHELL: Moran Manor Healthcare Center.

13 MR. MANZULLO: Moran Manor in Westernport,
14 Maryland. We look forward to your testimony, Dr.
15 Mitchell.

16 DR. MITCHELL: Pardon?

17 MR. MANZULLO: We look forward to your
18 testimony.

19 DR. MITCHELL: Thank you very much. I'd like
20 to thank you, Mr. Chairman and Congressman Bartlett,
21 for the opportunity to be speaking with you today. As
22 mentioned, my name is Dr. James Mitchell, and I am the

1 administrator, and proud to be, at Moran Manor
2 Healthcare Center.

3 I believe that President Bush, in his signing
4 remarks on February 8, stated that structural change is
5 required in the Medicare and Medicaid system. And I do
6 agree with those, and I believe that the DRA makes a
7 good step in that direction.

8 Congressman Bartlett alluded to the eight
9 percent increase in costs per year, and had mentioned
10 that Albert Einstein said that that was one of the most
11 powerful forces. I believe it was John D. Rockefeller,
12 the original John D. Rockefeller, that was asked if he
13 was a gambling man. And he said, "No, I believe in
14 compound interest." So I understand --

15 SPEAKER: As opposed to Einstein? Was it
16 both?

17 DR. MITCHELL: No, Rockefeller one time was
18 asked if he was a gambling man, and his comment was,
19 "No, I believe in compound interest."

20 SPEAKER: Oh, I see. Okay.

21 DR. MITCHELL: In any event, much of the
22 conversation today has revolved around statistics and

1 projections, numbers and dollars, and I would just like
2 to take a minute or two to talk about the real face of
3 long-term care and what it means, not only to the
4 facility, but the to the community itself.

5 In November of last year, Moran Manor was
6 awarded the DelMarva Foundation award for excellence,
7 and the press release accompanying that indicated that
8 this was an award that is only given to the top-five
9 percent of nursing homes nationwide.

10 Another aspect of the facility is a literacy
11 program that we started with third graders and the
12 Westernport Elementary School. And we have been
13 fortunate for the past two years to be able to have
14 third graders come to Moran Manor and learn an
15 appreciation for reading and also communicate and
16 interact with some people that are, perhaps, ten times
17 as old as they are.

18 They were asked to write some comments, and
19 one of the students wrote that Moran manner is fun to
20 go to. "We read at Moran Manner and the people there
21 are very nice. This place is very fun to me." If we
22 can have an eight year old say that a nursing home is

1 fun, then we've probably done our job because we want
2 to perceive nursing homes not only as healthcare
3 facilities, but as community resources.

4 And I think that our plea to Congressman
5 Bartlett, Congressman Manzullo would be to continue to
6 provide the resources necessary to have the
7 compassionate and dedicated care that we provide day in
8 and day out to the most frail and vulnerable population
9 in the country. And that will conclude my brief
10 comments. Thank you.

11 MR. MANZULLO: Thank you. Our final witness
12 is Greg Stangel, co-owner of Stangel & Stangel
13 Financial Services. And we look forward to your
14 testimony.

15 MR. STANGEL: Thank you very much. Thank you,
16 Chairman. Thank you, Congressman.

17 MR. MANZULLO: Dr. Mitchell, could you hand
18 the mic over there? Thank you.

19 MR. STANGEL: I feel like I should be stating,
20 "I have not now or ever been a member of the Communist
21 Party."

22 MR. MANZULLO: You've been watching too much

1 television. Those things don't happen. I'm sorry
2 about that.

3 MR. STANGEL: Those -- my generation. I'm
4 sorry about that.

5 I have the opportunity to address you as both
6 a small-business owner and a long-term care insurance
7 salesperson. And I wouldn't dare to try to speak as
8 intelligently as the other panel members concerning the
9 scope and details of the DRA, however I would like to
10 make a brief statement concerning a forgotten
11 generation of blue collar, middle-class retirees.

12 For this generation, Medicaid was understood
13 to be an option. Artificial impoverishment, in many
14 cases today, is a purely defensive move in a game where
15 the rules have changed. The more mature members of our
16 citizenry, especially those of blue collar,
17 middle-class background, are textbook in-betweeners.

18 Long-Term care, if not thought of as a
19 government funded program, was a concept rarely
20 discussed 10 to 20 years ago. In fact, Mr. Moses
21 mentioned the anaesthetizing of long-term care
22 planning. It simply was not discussed.

1 Now these seniors are stuck in between
2 generations. They are too young to have benefitted
3 from prior Medicaid rules, and they are too old to
4 provide for their own long-term care in the form of
5 private insurance. Premiums for such insurance have
6 outpaced the ability of a fixed income to provide for.

7 The nest egg these blue-collar seniors have
8 accumulated throughout a lifetime of hard work and
9 taxpaying has become forfeit, due to impoverishment
10 laws designed to combat abuse by the financially
11 fortunate. The reforms brought about by the DRA have
12 achieved their desired results for the lower- and
13 upper- class. It is the middle class, as it tends to
14 be the case in all aspects of society that bears the
15 unfortunate brunt of these reforms.

16 Congressman Bartlett mentioned that many
17 seniors desire death over impoverishment. It should be
18 the goal of future long-term care reform to remember a
19 game plan for this forgotten class. Thank you.

20 MR. BARTLETT: Thank you all very much for
21 your testimony.

22 Both my parents and my wife's parents lived

1 and died in our home or very shortly after leaving our
2 home, so we're very familiar with the plight of
3 seniors. I can identify with seniors. I said I had my
4 eightieth birthday about a month ago.

5 And my heart really goes out to those seniors
6 who have the means to provide for their healthcare and
7 everyday they're in a nursing home, they see their
8 estate, that they wanted to give to their kids and
9 their grandkids, evaporating. And they just want to
10 die.

11 You know, we don't need to be there, and our
12 seniors don't need to be there. And this is a new
13 world. You're right, you know. When I started -- I'm
14 a child of the Depression, and when I started -- nobody
15 was thinking about long-term health insurance.

16 By the way, most of these blue-collar workers
17 work for big organizations, not all of them, but most
18 of them worked for big organizations that had
19 healthcare. And if long-term care was a part of that
20 policy, we wouldn't have these problems today, would
21 we?

22 Now, we're going to take care of our seniors.

1 If they need to be in a nursing home, they're going to
2 be in a nursing home. There's two ways of providing
3 for that. One is for government to do it. And every
4 working person pays for government -- I don't think
5 government does it better than the private sector, far
6 from it. The private sector does it a lot better. Or
7 you can plan ahead and pay for it with insurance.

8 The same people are paying for it either way,
9 except that I think that the burden is disproportionate
10 when you want government to do it. If the worker is
11 doing it through his insurance, that's literally going
12 to be pennies a day. And I just hope that 50 years
13 from now -- I probably won't be in Congress --

14 SPEAKER: You'll be 130.

15 MR. BARTLETT: Fifty years from now I'll be
16 130. That's correct.

17 They'll be a panel who is talking about this
18 50 years from now, and I hope that we aren't talking
19 about a program that is threatening -- at that time, it
20 may have bankrupt us.

21 Someone mentioned that the unfunded
22 liabilities were \$84 trillion, was that Mr. Moses who

1 mentioned that? Eighty-four trillion dollars.

2 We keep Enron-kind of books in our Congress. We
3 really do, and we will tell you that the deficit is
4 something like, what, about \$7 trillion. Now, if we
5 were a business, and had to list unfunded
6 obligations -- unfunded obligations, obligation you
7 have that you will pay for, but you don't have any
8 funds to pay for it. Isn't that what it means,
9 unfunded obligations, right?

10 SPEAKER: Unless you choose to renege on it,
11 which the Congress always has the option to do.

12 MR. BARTLETT: Well, that's -- you know, they
13 wouldn't with my vote. They wouldn't with my vote.
14 But the \$84 trillion, I haven't computed that. But the
15 average person, if you divide what, 120 million
16 workers -- that's roughly how many workers we have; is
17 that correct? About 120 million workers? If we divide
18 that into \$84 trillion, just the debt, that's about
19 \$25,000 per man, woman, and child; that's a
20 crack-cocaine baby and a senior in a nursing home,
21 average \$24,000, \$25,000.

22 And that's if the debt is just \$6 or \$7

1 trillion. If it really is the \$84 trillion, now it goes
2 up 12 times that. What, \$300,000, is the obligation of
3 every man, woman, and child in this country. Just the
4 interest on that is how much? You can't pay it. You
5 can't pay it.

6 And this is where we are in America. And this
7 is why this legislation is so important, why this
8 discussion today is so important. And what I hope is,
9 discussions like this across the country will result in
10 our society doing something rational, without
11 government imposing the thing. I just think at the end
12 of the day, when government needs to step in and impose
13 it that everybody loses.

14 So what are your suggestions for the future?
15 Clearly, we got to preserve this program for those who
16 do really need it. But to avoid the kind of
17 controversy we're having today, and the kind of scare
18 tactics that one sees out there, what can we do now, so
19 that this won't be a problem down the road?

20 SPEAKER: Well, I'd quote Albert Einstein
21 again. He said, "The definition of insanity is to keep
22 doing what you've always done and expect a different

1 result." Obviously, we have to do something different
2 than we've always done.

3 What we've always done, at least since 1965,
4 is send the message to the American public that you
5 don't need to worry about long-term care. When the
6 time comes, we'll take care of you. That's -- the
7 majority of all, professional long-term care services
8 in this country are paid for by Medicaid, Medicare,
9 Veterans Administration, you name it.

10 There is very little out-of-pocket
11 responsibility. Very few people in nursing homes pay
12 privately. We have to send the message to the public
13 that long-term care is a personal responsibility. You
14 need to start in your 40s, at least, to consider the
15 possibility of insuring for that risk, and you should
16 be insured by the time you're age 50.

17 We can't send that message effectively simply
18 by educating people that their life savings are at risk
19 if they don't plan ahead, at least, as long as that
20 isn't true. And it never has been; it's always been
21 easy to get the government to pay for your long-term
22 care, until that changes. And we made some important

1 steps in the right direction with the Deficit Reduction
2 Act, but we haven't gone far enough.

3 For example, a five-year look-back on transfer
4 of assets, the average period of time from onset to
5 death in Alzheimer's disease is eight years. You need
6 to get out at least eight years. Germany, as I said,
7 has a ten-year look back on transfer of assets.

8 Are we going to allow people to shelter
9 three-quarters of a million dollars in order to get the
10 government to pay for their long-term care? That's
11 where we are now.

12 Idaho, I was the Medicaid state rep in the
13 1980s for Idaho. This is not a rich state and yet they
14 just moved their limit to the maximum allowed by
15 Congress of \$750,000 in home equity.

16 Do you know that a business, including the
17 capital and cash flow of unlimited value remains
18 totally exempt for purposes of determining Medicaid
19 eligibility? Did you know you can have prepaid burial
20 funds of unlimited value not only for the Medicaid
21 recipient, but for everyone in the Medicaid recipient's
22 direct family? Did you know you can have unlimited

1 term life insurance, as long as it doesn't have a
2 cash-surrender value?

3 You can put \$1,000,000 into a life insurance
4 y, evade the Medicaid rules entirely, and that asset
5 now passes outside of the estate, invulnerably to
6 Medicaid estate recovery. And voila, you get not only
7 your long-term care paid for by Medicaid, but all of
8 the auxiliary services that Medicaid pays for that
9 Medicare doesn't. We have barely scratched the surface
10 in sending the message to the American public that they
11 need to plan for long-term care.

12 Now I walked the walked as well as talked the
13 talk. I paid the premiums for my father's long-term
14 care insurance policy for 19 years on the grounds that
15 I didn't think he should have to pay out of his limited
16 funds to protect my inheritance. But that's because I
17 was savvy to the system. If there's anybody who could
18 have got him on Medicaid, it was me.

19 We my dad died July 4. He never had to go to
20 a nursing home, thank goodness, but we got every
21 penny's worth of value out of that policy because we
22 were protected all of those years if it had happened.

1 And if you will just change the perverse
2 incentives in the public policy to send the message to
3 the American public, I think the Baby Boomer generation
4 will do the right thing, and if they're able, purchase
5 the insurance for their parents. But at least get it
6 for themselves, because that's the generation, as
7 you've suggested, that will kill us.

8 MR. MANZULLO: Let me -- Gregory, maybe you
9 and Dr. Mitchell at the same time. How many people in
10 your nursing home, Dr. Mitchell?

11 DR. MITCHELL: Right now, at capacity, we have
12 128 residents today.

13 MR. MANZULLO: Do you have -- can you share
14 with us the number of those that are on Medicaid?
15 Would that be possible or is that --

16 DR. MITCHELL: Generally, the percentage, not
17 only in my facility, but in general, is probably
18 anywhere around 80 percent, 75, 80 percent, somewhere
19 in there.

20 MR. MANZULLO: About 80 percent? And then,
21 Greg, you have a financial services company. Is that
22 correct?

1 MR. STANGEL: That is correct.

2 MR. MANZULLO: That's a full line of
3 insurance?

4 MR. STANGEL: Absolutely.

5 MR. MANZULLO: And that also includes
6 long-term healthcare insurance?

7 MR. STANGEL: Long-term care, financial
8 planning, estate planning, the whole gambit.

9 MR. MANZULLO: You had mentioned that the
10 premiums for the blue-collar worker are not affordable
11 for long-term care?

12 MR. STANGEL: Predominantly, if you're looking
13 at an age bracket today, 2006, from age 70 and above to
14 whenever, you're basically looking at a premium that's
15 going to outpace anything that they could afford on a
16 monthly, quarterly, or annual basis, because by that
17 point, at least one of the -- if there's a married
18 couple, one of the spouses will have suffered from some
19 kind of health problem. It could be as little as blood
20 pressure. High blood pressure could boost their
21 premium substantially.

22 MR. MANZULLO: So that's phenomenal that my

1 mother was able to get that type of policy at --

2 MR. STANGEL: I was wondering if you knew the
3 name of the company. I was going to write them down.

4 MR. MANZULLO: I don't remember what it is.

5 SPEAKER: That's not an unreasonable premium
6 for a 79 year old. It wasn't a very generous policy.
7 It only paid \$83 dollars a day, as I recall.

8 SPEAKER: But that's about \$40,000 a year,
9 yeah.

10 SPEAKER: Yes, it's \$36,000 a year. That's
11 about what a person would expect to pay for a policy of
12 that size.

13 SPEAKER: At that age?

14 SPEAKER: At that age.

15 MR. MANZULLO: Greg, do you agree with that?
16 Is that --

17 MR. STANGEL: Like I said, there's a lot of
18 extenuating circumstances into those things, especially
19 since you also mentioned that your family history never
20 dictated that anybody end up in a long-term care
21 facility.

22 MR. MANZULLO: Right. Right.

1 MR. STANGEL: So I'm sure the insurance looked
2 at that whenever they were generating a premium. You
3 know, the actuaries and what not. And also, once you
4 said that it only paid for \$80-some a day, that seemed
5 a little more reasonable, the \$300.

6 So what I'm saying is the higher percentage,
7 or the good money, goes with the fact that somebody is
8 going to have experienced a health problem by the time
9 they were 70. And that's going to affect them in one
10 way or the other. It may not be their health problem.

11 It may be a family illness, maybe something that could
12 potentially have killed one of their relatives in their
13 70s. Anything like that could dictate a policy
14 hike -- or a premium hike, I should say.

15 MR. MANZULLO: The -- when you sit down with a
16 family and counsel them on their insurance needs, I
17 presume you bring up long-term healthcare?

18 MR. STANGEL: Absolutely.

19 MR. MANZULLO: Then what type of response do
20 you get, especially from the 45 year old?

21 MR. STANGEL: Most of our clients are
22 50-year-old, blue-collar, union workers. And when you

1 mention to a pipe fitter, that they need to start
2 putting down monthly money for a long-term care
3 facility, it's genuinely frowned upon, most of the
4 time.

5 You know, whenever you even throw the
6 statistic out, over the past couple years there's been
7 a premium rate for 50-year-olds of five percent
8 annually. So a policy you buy ten years from now, a
9 50-year-old, ten years ago, you're going to look at
10 quite a difference in what you would have paid to get
11 into it at an earlier date. So it's --

12 MR. MANZULLO: So the premium fluctuates as --

13 MR. STANGEL: For each cost-group age. If
14 you're a 50-year-old today, a 50-year-old ten years
15 from now is going to be, obviously, paying much more.

16 MR. MANZULLO: What kind of money are you
17 looking at in terms of a premium for a 50-year-old?

18 MR. STANGEL: It depends on --

19 MR. MANZULLO: -- in good health.

20 MR. STANGEL: If you're looking at
21 preferred-plus, non-smoker, and all that, it depends on
22 how much you want that coverage to cover during any

1 given day at a long-term care facility, or the
2 equivalent money value if they're going to be cared for
3 at home by either a trained professional or a member of
4 the family.

5 MR. MANZULLO: An indemnity plan.

6 MR. STANGEL: Right. Right, so it could
7 fluctuate.

8 MR. MANZULLO: So let's say you pay the \$100,
9 \$100 a day.

10 MR. STANGEL: If you're looking at something
11 like that, \$100 a day, over the course of a
12 365 -- basically --

13 MR. MANZULLO: \$36,500.

14 MR. STANGEL: \$36,500 a year, you're going to
15 be looking at, depending on if it's a quarterly payment
16 or whatnot, a couple hundred dollars, \$200, \$300. You
17 know, depending upon if you want that \$100 coverage, or
18 if you wanted to also adjust for inflation. If you
19 want the \$100 that you could get in long-term care
20 today, you want that same \$100 to be the \$100 in 2015,
21 the policies nowadays offer you those certain riders
22 and whatnot.

1 But the biggest sell today for long-term care
2 is surprisingly not one that you see in other insurance
3 areas. People never ask, "Well, if I never use my auto
4 insurance, can I get my premium back?" But they ask
5 that for long-term care insurance. "Well, if I never
6 go into a nursing home, can I get my money back?" They
7 don't say that about, you know, life insurance, because
8 ultimately that's going to come to pass.

9 But, you know, that's the hardest sell for
10 long-term care. They think it's going to be -- even
11 though the likelihood of getting into a major car
12 accident is much less than the likelihood of spending
13 some time in a long-term care facility.

14 SPEAKER: Do you work with employers that
15 offer group plans?

16 MR. STANGEL: Currently, in western Maryland,
17 I do not know of -- well, I mean, of course there are
18 health plans that offer long-term care as a rider to
19 the employee, that they can pick up.

20 SPEAKER: Right.

21 MR. STANGEL: I'm not sure of anyone that
22 offers it as a base plan, so to speak, right now.

1 SPEAKER: Are the premiums cheaper if it's
2 offered as a group plan?

3 MR. STANGEL: Absolutely. Because then, just
4 like health insurance, you're able to compound the
5 average age of -- as Congressman Bartlett said,
6 pennies, for an 18-year-old employee that could very
7 well help to fund an older employee that's near
8 retirement that suffers from a fall or whatnot.

9 SPEAKER: So you, when you counsel with
10 employers -- you represent a lot of small business
11 people that have group plans?

12 MR. STANGEL: A few, actually.

13 SPEAKER: Okay. When you work with them, do
14 you try to encourage them to offer long-term
15 healthcare?

16 MR. STANGEL: They are all very aware of
17 long-term care, but at this point unwilling to spend
18 the money for it. And usually it's -- you know --

19 SPEAKER: Because regular health and accident
20 insurance premiums are increasing so dramatically that
21 that's where the money is going?

22 MR. STANGEL: I mean, we have small

1 businesses, we also have doctors and lawyers and that
2 are unable to contribute to their profit-sharing plans
3 because of increased health insurance for their
4 employees. So compounding that by an additional burden
5 of long-term care insurance, it's a difficult
6 proposition to make to someone at this time.

7 MR. BARTLETT: Both Mr. Stangel and Mr. Moses
8 mentioned the psychology of insurance. I don't know of
9 anybody who laments at the end of the year that their
10 house didn't burn because they bought fire insurance.
11 People seem to understand that.

12 There's also a very interesting psychology
13 about so-called "government money." And the average
14 person believes that there is such a thing as
15 government money. And I try to help people understand
16 that there's no such thing as government money. Every
17 dollar that your government spends at any level came
18 from the paycheck of some hardworking American.

19 I intentionally did not include businesses in
20 there, because it's simply a part of the cost of doing
21 business, and you pass that on to the consumer. So
22 ultimately all taxes are paid by consumers: and that's

1 your kids, that's your neighbors, that's your fellow
2 church members.

3 And when you are cheating, so that you qualify
4 for Medicaid, what you're doing is asking your friends
5 and neighbors, or your kids and grandkids, because now
6 we're financing these things through our future
7 generations, to pay for that. Do you think if the
8 average person really understood that, that he would
9 need the present incentive to go get "government
10 money"?

11 SPEAKER: Well there is a psychology going on
12 here, too, and I hear it often, when I testify and
13 speak around the country. And that is that, "Hey, I
14 paid my taxes. I'm entitled to this. The Medicaid
15 planning bar makes the argument that this is no
16 different than restructuring your income and assets to
17 reduce your taxes, just as Learned had, and said we
18 don't have to pay any more in taxes than we're legally
19 required, as long as we avoid taxes and don't evade
20 them."

21 So you can't help but kind of understand that
22 people who have lived by the rules and paid their own

1 way feel cheated when they can't get something out of
2 the system, whereas the next guy who did the same but
3 chooses to get the help to get rid of the assets takes
4 advantage of it. There's a lot of confusion between
5 our social insurance programs, Social Security and
6 Medicare, which we pay premiums for, and our Welfare
7 programs, Medicaid and Supplemental Security Income, to
8 which there is no entitlement, except as you qualify,
9 based on income and assets.

10 So I mean it really reflects back on public
11 policymakers, frankly, who have created in these
12 systems incentives to ignore the risk of long-term
13 care, avoid the premiums for private insurance, wait
14 until you get sick. If you die with your boots on,
15 you're home free. But if you do need long-term care,
16 the vast majority of people get on the slippery slope
17 and say, "Hey, I paid my taxes, why should the other
18 guy get it for free and not me." How do you answer
19 that?

20 SPEAKER: Well, the answer is that the whole
21 house of cards is going to collapse on us in the next
22 20 or 30 years. Hence the reference to the \$84

1 trillion of unfunded liability, which doesn't even
2 include Medicaid, by the way, which is just general
3 funds being spent. So we have to change those
4 incentives, so that people do begin to take personal
5 responsibility.

6 If we don't do it, what's going to happen is
7 that the whole system of Welfare-financed long-term
8 care will collapse. The people who get hurt the most
9 will be the poor. The Baby Boom generation will have
10 no place to go for long-term care other than their home
11 equity. The reverse mortgage industry will explode.
12 Once that happens and the public sees that assets
13 really are a risk, and the single biggest asset that
14 seniors have is their home, they will start to buy the
15 long-term care insurance.

16 So in 20 years, this will have all worked its
17 way through the system, and the market will have
18 resolved these problems. The tragedy is that we aren't
19 doing it quicker, through responsible public policy.
20 And, again, I applaud you for what you did in the DRA,
21 just take it the rest of the way.

22 SPEAKER: You know, I believe it was in

1 Maryland, Roscoe, your home state, where I saw a senior
2 had signed up for a reverse mortgage, and the
3 mortgage-holder in the documents actually had an equity
4 stake in the property. It was -- I believe it was last
5 year, and I think the Maryland legislature stopped it,
6 to get a stream of money at x percent. And then the
7 senior died and went into probate court and the reverse
8 mortgage-holder said, "Well, by the way," you know, "I
9 share in the equity of this house, and you know the way
10 homes have been appreciated in value."

11 Have you heard about abuses like that in the
12 reverse mortgage industry, Steve?

13 MR. MOSES: Yeah, years ago, there were a lot
14 of abuses, well publicized. But that industry now,
15 frankly, is regulated six ways to Sunday. It's
16 incredible. And I'm not -- certainly not an expert on
17 reverse mortgages, but it is an area I would strongly
18 encourage you to look into because 84 percent of
19 seniors own their homes; 73 percent of those own them
20 free and clear.

21 There's over \$2 trillion out there in the
22 American economy that could pay for quality long-term

1 care for seniors, and it's completely exempted by
2 Medicaid. The average home equity of seniors in this
3 country today is only \$85,000 and we've got up to a
4 \$750,000 exemption.

5 SPEAKER: We've spent on Medicaid like a black
6 hole.

7 MR. MANZULLO: In this area around here -- I
8 come from Illinois. It's a mostly rural area. The
9 bankruptcy exemption is only \$15,000 for your
10 homestead. It's never really been raised, and the
11 state never opted to go to the generous federal
12 exemption, which was \$30,000.

13 But it is not uncommon in areas around here,
14 where -- it's called -- Roscoe, what's the ranch home
15 that has the attached garage? There's a special word
16 for it on the East Coast that we don't have back in the
17 Midwest. But --

18 MR. MOSES: I'm from Seattle, I don't know.

19 MR. MANZULLO: Okay, but back in Illinois,
20 where a house would sell for maybe \$100,000; \$125,000.

21 Here it's \$500,000, and \$600,000, and \$700,000 for
22 these homes. I think the average priced, single-family

1 home in northern Virginia, I think it's over a
2 \$500,000.

3 And I can see -- there's a reason why states
4 should be willing to go to the \$750,000 exemption,
5 because we see very, very modest homes in this area
6 selling five, six, and seven times the amount that they
7 would sell for in the area that I come from, in
8 Illinois. And it just depends on where you are. But
9 the states have to have that flexibility to have that
10 type of exemption.

11 MR. MOSES: That's true, but it begs the
12 question of what is the proper role of Medicaid. Is it
13 to provide a safety net for people genuinely in need to
14 insure they can get long-term care or is it inheritance
15 insurance for the Baby Boomers generation?

16 MR. MANZULLO: You're right. That's correct.
17 That's correct.

18 MR. MOSES: If we allow people to ignore the
19 risk of long-term care and protect their assets -- now
20 the home is, by the way, vulnerable to estate recovery.
21 But it's interesting to note that while 83 percent of
22 seniors own their homes at age 65, by the time they're

1 on Medicaid, it's down to about 14 percent, according
2 to a GAO study.

3 So that wealth is going somewhere, and it's
4 not going to pay for their long-term care --

5 MR. MANZULLO: But in Illinois, if -- when I
6 counseled folks that came in that, you know were -- 97
7 percent of people, obviously, want to do the right
8 thing. The senior would go into the home, into a
9 retirement home. This obviously, this isn't the case
10 of somebody whose spouse is deceased, and then the
11 state of Illinois would place a Public Aid Lien on the
12 home. That's sort of like a reverse mortgage.

13 That never really bothered the individual or
14 the kids either. They realized that the home would go,
15 but at least there was an asset there that could be
16 used. And since the help paid for their parent's stay
17 in the nursing home, what you're saying is that today
18 people look upon government programs as a way to
19 benefit those who were not originally intended to be
20 the beneficiaries. And this is the children that want
21 to take the estate as opposed to that money being used
22 for long-term, nursing-home care.

1 But you have, you have tough situations, such
2 as -- the family business, the family farm, where the
3 kid is working on the farm and there's a lot of equity
4 there, and it takes a tremendous amount of
5 assets -- Roscoe, you know that. You're -- you still
6 farm, and I have beef cattle, a very small
7 operation -- where you've got -- the children are
8 helping their parents with the farm, and one of the
9 parents has to go into a nursing home: really difficult
10 situation because you can't force the sale of the farm,
11 I mean, the kid has worked there his entire life.

12 If there are assets that are available and you
13 just don't know what to do, I would presume that's
14 where the waivers come in. Is that correct, Steve?
15 The Medicaid Waivers?

16 MR. MOSES: No, the waivers don't pay for
17 the --

18 MR. MANZULLO: Not the state waivers, the
19 individual waivers.

20 MR. MOSES: Well, I'm not aware of any waiver
21 that would help people in that circumstance. The way
22 it works is that business, including the capital and

1 cash flow of unlimited value, is exempt for purposes of
2 determining Medicaid eligibility. So, it doesn't --

3 MR. MANZULLO: Including the assets and the
4 real estate?

5 MR. MOSES: Yes, yes. The home and all
6 contiguous property -- it was regardless of value until
7 February 8, with the enactment of the DRA, but to this
8 day, a business, including the capital and cash flow of
9 unlimited value remains exempt in determining Medicaid
10 eligibility.

11 Now it can become an asset for estate recovery
12 if it passes through a probated estate. But generally
13 what --

14 MR. MANZULLO: Via a lien?

15 MR. MOSES: Most states don't use TEFRA liens,
16 but they do have -- they are mandated under federal
17 law, since the Omnibus Budget Reconciliation Act of
18 1993, to have an estate recovery program. They don't
19 have to lien it. So very often home equity and
20 businesses kind of float away, out of the ownership of
21 the responsible senior.

22 I was going to give you an example of a study

1 I did in Nebraska where the family farm is a big,
2 important thing. You don't see a lot of egregious
3 Medicaid planning, like in Massachusetts, and New York,
4 and California, in Nebraska. You do see a lot of
5 pioneer spirit and good, old-fashioned values. But
6 what you do see is that it is a standard of estate
7 planning that when the older generation gets into their
8 late 60s, early 70s, they transfer everything into the
9 name of the younger generation, not with any
10 contemplation of Medicaid or long-term --

11 SPEAKER: That's to avoid the Death Tax.

12 MR. MOSES: Exactly, exactly. But a decade
13 goes by, they've never imagined ever using Welfare.
14 All of a sudden, Grandpa has Alzheimer's disease or
15 Grandma has a stroke; long-term care is necessary. It
16 is very, very expensive.

17 But guess what? Grandpa and Grandma don't own
18 anything anymore, so, voila, they're eligible for
19 Medicaid. Because of symptoms like that, in the
20 economy and in the incentives of our tax system and the
21 way all these programs work, we've basically
22 anaesthetized the public to this risk. So they don't

1 take it seriously.

2 Now I happen to have been involved in this
3 since working with the Healthcare Financing
4 Administration. I was a clear, U.S.-government
5 employee.

6 SPEAKER: That's the old HCFA, right.

7 MR. MOSES: Yeah. Out in region 10, and in
8 Oregon, which has a very aggressive estate recovery
9 program. I looked at that, and I said, "My goodness.
10 How in the world do they collect five percent of the
11 cost of their Medicaid nursing home program out of the
12 estates of deceased recipients who had to be poor to
13 get on Medicaid in the first place?"

14 And that's where I began doing this research,
15 and published reports for the Healthcare Financing
16 Administration, later for the Office of Inspector
17 General, and concluded, "We'll never get anybody to
18 take personal responsibility, as long as they can
19 ignore the risk, avoid the premiums, wait until you get
20 sick, and get the government to pay. That's
21 fundamentally what we have to change, or this whole
22 system is going down.

1 MR. BARTLETT: There were two purposes for our
2 session today. I just wanted to make sure that both
3 have been accomplished. One was to generally educate
4 relative to the intent of Medicaid and the regulations
5 and laws affecting Medicaid, and particularly the
6 Deficit Reduction Act, and what it's intent was. And I
7 think that we have done that pretty well.

8 The second was to reassure seniors that there
9 was no evil intent on the part of Congressmen to make
10 their life difficult by penalizing them if they gave to
11 their charities or they gave to their children, but if
12 they had had a -- I mean, you'd have to get inside
13 their head to decide whether or not they did it to
14 impoverish themselves or whether they simply did it
15 because they loved their children and wanted to support
16 the charity of the church. But if there is a practice
17 of giving to your church, and if you continue that
18 practice during the look-back period, it's my
19 understanding that it would be frightfully difficult
20 for the government to prove, to make the case that you
21 had done that to impoverish yourself if that was your
22 practice in the past.

1 Am I correct in that?

2 MR. MOSES: I think so, and I think there
3 would be a common sense standard. I ran across in a
4 study in Illinois, as a matter of fact, a case where a
5 woman had gone into the nursing home. Just before
6 going into the nursing home, gave over \$100,000 to a
7 grandchild for the purpose of college education. It
8 didn't interfere with eligibility because it was done
9 for a purpose other than to qualify for Medicaid.

10 Now under the Deficit Reduction Act and under
11 just common sense, I would say, if that was done before
12 the stroke it would be one thing. If there was a
13 stroke followed by the give-away of the money and
14 Medicaid institutionalization the next day, it would be
15 a very suspicious situation. So I would assume that
16 common sense will prevail in these matters.

17 MR. BARTLETT: Yeah, it was our intent to help
18 seniors and give them a better feeling of security for
19 the future, not to frighten them. And I want to thank
20 you all very much for coming to help us get this
21 message out.

22 MR. MANZULLO: Roscoe, I want to thank you.

1 It's forms like this that take these very difficult
2 bills that we have to face all the time in Congress
3 that obviously impact people. The big concern is to
4 make sure that enough Medicaid money is there.

5 Illinois spends a lot more money on Medicaid than it
6 does on education.

7 I'm not saying that's right or it's wrong;
8 it's just a fact, and the governors struggle with that
9 part of the budget each time. And as our first panel
10 demonstrated, it's an aging class of people with
11 disabilities are taking more and more of the share of
12 Medicaid than in the past. So we're looking at
13 something that's entirely different now. That is
14 families that have disabled children.

15 In one of the passing remarks -- Greg, I want
16 to address this to you. It's more of a comment than
17 anything. I was taking a look at a group
18 insurance -- group health and accident insurance
19 policy, and in -- with most private plans, when your
20 kid is 23 he has to get his own health and accident
21 insurance policy, provided he's still a full-time
22 student. In many cases it's 25.

1 With the Blue Cross/Blue Shield insurance that
2 I have and you have, I got the notice that my 22 year
3 old was being cut off, and I said, "Wait a second. The
4 private sector offers a lot better insurance than we,
5 as members of Congress, have."

6 MR. BARTLETT: I'd just like to note that in
7 Congress we have no special healthcare insurance.

8 MR. MANZULLO: Right, well it's --

9 MR. BARTLETT: We have exactly the same thing
10 that you have. When I went -- I kept that --

11 MR. MANZULLO: Well, it's not. It's worse.
12 Roscoe, it's worse, because in most plans, my child
13 would have been insured until he graduated from
14 college. But the reason I -- I look deeper into who
15 would be qualified to remain insured.

16 If you have a child who's disabled, that child
17 is always insurable, regardless of age, as long as you
18 have a policy with that company. And oftentimes, we
19 don't look at those special provisions, which -- this
20 is obviously necessary. These are some of the things
21 that cause health insurance premiums to really go up.

22 There's no other way to do it. You have a

1 child that's disabled. You're in a group plan or even
2 a single plan, as long as you pay the premiums, that
3 child could be, you know, 40 years old and still
4 entitled to health and accident insurance benefits.

5 But the reason I mention that, Roscoe, is the
6 fact that over a period of time, these special
7 circumstances have been ready to be built into
8 policies. And obviously, it was insurers who had
9 children who were disabled, when they reached the age
10 of 23, they said they did not know what to do because
11 what do you do in a case like that?

12 But that also relieves the tremendous burden
13 on Medicaid. And sometimes we fail to realize it, and
14 most group plans had that provision that keeps those
15 kids insured. It's when the parents retire that they
16 no longer have that policy. This is where it really
17 impacts the kids.

18 Roscoe, I want to thank you for having this
19 hearing. It's been extremely beneficial. We have to
20 make tough decisions in Congress. This bill that we
21 passed has as its intent to preserve the integrity of
22 the Medicaid system, to make sure that the seniors who

1 are presently receiving it will continue to receive it,
2 and that the changes that were made from three to five
3 years are for a very small number of people that want
4 to try to defraud the system. And by defrauding the
5 system, they therefore make available less money to
6 keep the program viable from the vast majority of the
7 seniors.

8 Thank you very much. This hearing is
9 adjourned.

10 (End of hearing.)

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