THE CURRENT SYSTEM FOR PROVIDING

LONG-TERM SERVICES AND SUPPORTS

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THURSDAY, JUNE 27, 2013

Commission on Long-Term Care

Washington, D.C.

The Commission met, pursuant to notice, at 1:59 p.m., in Room 2322, Rayburn House Office Building, Bruce Chernof, Chairman of the Commission, presiding.

Present: Chairman Bruce Chernof, Vice Chairman Mark Warshawsky and Commissioners Javaid Anwar, Judith Brachman, Henry Claypool, Judith Feder, Stephen Guillard, Chris Jacobs, Neil Pruitt, Carol Raphael, Grace-Marie Turner and George Vradenburg.

Also present: Larry Atkins, Staff Director

OPENING STATEMENT OF CHAIRMAN CHERNOF

Chairman Chernof. Well, good afternoon, everyone. Thank you for being here with us today.

I am Dr. Bruce Chernof. I am the Chair of the Long-Term Care Commission. And, on behalf of all of the commissioners here, I want to take a moment and welcome you today.

This is our initial meeting. We have gotten off to a good start.

It gives both Mark and I great pleasure to introduce

our Staff Director, Larry Atkins, who is sitting to my right, who has just joined us. He is three days old, and we are very lucky to have him.

We appreciate your patience as we have gotten off the ground in a very short period of time. We will have more information up shortly. We will be developing a web site and ways for all of you to be more directly engaged. But be a little patient with us as we are all of about three days old at this point.

I must admit I am really honored to have this opportunity to chair this Commission. It is a very difficult topic and one that all of us on the dais, and clearly all of you in the room, care a lot about.

And I am really honored to serve in this role with Mark Warshawsky, who is my Vice Chair

To all of the colleagues who are on the Commission, who care very deeply about this issue and this notion that we have got to think about how to restructure our Nation's long-term care system, the time is now for us to have that discussion.

You all know that numerous attempts have been made to do this over the past 40 years, and it goes all the way back to the founding of Medicare and Medicaid, and we have had multiple efforts over the decades to try to do this. Maybe every five years or so, we have had some form of a

discussion along these lines, and we have not kind of gotten all the way home. And we have a real need to think about how to do that.

Now we know that as the Boomers hit their retirement age, as that demography moves through their health and functional needs over the next couple of decades, we are going to need to think differently about care.

And, frankly, we are all going to--the great thing about medicine--as a physician, I can share with you. You know, we can do a lot more than we used to be able to do in, say, 1965 when Medicare and Medicaid were created. But that also means that people will live with potentially more opportunities for risk of functional limitation.

How do we manage that in a way that is both clinically effective, efficient, cost-effective and person-centered?

So that is the challenge in front of us.

We know that about 70 percent of people over the age of 65 will need some form of long-term services and supports. Now I am not talking exclusively about nursing homes. It could just be a little bit of support to be at home. It could be support that is provided by family, friends, community, formal caregivers or structural arrangements to provide the care. There is the whole continuum.

And I know in many ways we are preaching to the choir because all of you know that, but our obligation as a

Commission is to think about how we advance that discussion.

I think for us we recognize the fact that Congress and the Administration tasked us to work in a bipartisan way. And one of the things that Mark and I have tried to commit to in our work--our early work as a team today--is to think about how we do that.

How do we try to change the discussion to understand the places where we can advance the discussion and the places where more work needs to be done so that we have kind of a better sense of how to move forward?

We are committed to that, but we need all of you in the room to be part of that discussion. And today is the beginning of that discussion.

I need to acknowledge to all of you that we have a very short time line. That is an important thing to put in front of us. There are a lot of things that we as a Commission would like to do--love to do--if we actually had a full six-month window in which to do our work because we will be done by the end of September.

Many of us feel that there is an opportunity for there to be a longer discussion, but that is not the charge that we have at the moment. So we are very committed to being responsive to the time frame that is available to us.

Again, I think today is the beginning of the discussion. And we will welcome all of your input in ways

as we unfold our organization, to collect information, and we look forward to seeing you at future meetings.

I want to take a moment and give Mark a chance to give us a few words, and then we will turn to our panel.

OPENING STATEMENT OF VICE CHAIRMAN WARSHAWSKY

Mr. Warshawsky. Thank you, and I also want to say my appreciation to my fellow Commission members and to Bruce for putting the Commission together in a very quick fashion and then in that regard, particularly, thank the panel members who we will hear from. They got very little notice, and we are very appreciative that they were able to pull together what looks to be very impressive material for setting the baseline in terms of our understanding of the current system works--just the basics.

And that is really what the focus of today's hearing is so that we can hopefully move beyond that. But I think it is very important both for the education of the Commission members, but also, more broadly, hopefully, this information will get out so that everyone can be informed of just what the baseline is.

So, again, thank you, everyone, for being here.

Chairman Chernof. Great. With that, let's hop right in.

Let me just talk a little bit about how we are going to handle this session. We would like each of you to speak for

15 to 20 minutes.

We are then going to ask commissioners to offer questions to each of you as panelists. We have asked commissioners to pose their question to a specific panelist. We would like to get every commissioner to have an opportunity to ask you a question.

So, if somebody feels a burning need to--if a panelist feels a burning need to add a comment, that is fine, but what we would like to do is sort of move through all of you so we can hear from you multiple times.

We are going to start at the far end, at my left, your right. So, Judy, you will lead us off in questions when we are done with the presentations.

And we will move right through to our end point at 4:00.

And so with that, I would like to begin by asking Anne Tumlinson to lead us off with a look at demographics, please.

STATEMENT OF ANNE TUMLINSON, SENIOR VICE PRESIDENT, AVALERE HEALTH

Ms. Tumlinson. Thank you, Bruce. Thanks, everyone. So who is advancing?

[Off microphone response.]

Ms. Tumlinson. Okay. Great. So you all have a copy--a hard copy--of the slides that I am going to walk through this afternoon.

Thank you so much for inviting me to come. Even though it was short notice, I am very honored to be here.

And my job, as I understand it, this morning is to give you what I am calling a tour of the long-term care population and helping you to understand how we think about defining this population and understanding their need, so if we can go to the next slide, actually.

If there are two things that you just come away from my brief remarks understanding it is that, number one, this population is actually really quite diverse. We are not--there is not one characteristic that we can point to that is common to the folks who are in the long-term care population. Having said that, if there is one, it is in fact that they have a need for substantial assistance with ongoing activities of daily living.

And so I prepared a report for a previous commission some time ago, and I think that what I wanted to emphasize

here is that the need for long-term care can occur at any age.

And, as I said in this report, it can be a child born with developmental disabilities. It can be an adult who has multiple sclerosis. It can be an old person with Alzheimer's Disease or cognitive impairment or just experiencing the aging cells and the frailty that come with old age.

Okay, so we can go to the next slide. All right.

So this population contains huge points of divergence. In particular, we have very different age groups. We have very different precipitating events or conditions underlying the need for long-term care. And we have very different places where they live.

And there are other differences as well, and I am going to talk about those.

But the point of unification of this population is the need for ongoing assistance, as I said earlier, with highly personal activities that are essential to everyday life and, frankly, essential to their survival. And these activities can include things like bathing, eating and dressing.

So I just want to pause for a moment because as you all engage in the work that you have in front of you it is very important to understand how we measure this need for long-term care, which we often call functional impairment, and

this is the measurement of the need for assistance with activities of daily living. It is this need that characterizes someone as being part of this population. It is not the underlying condition, and it is not their service use.

And this is probably the thing I think is most difficult for folks to understand, particularly if you are used to dealing with health care or medical care issues. We do not look at this population as a population that is using services as much as a population that has a need for services and is likely to use them.

So, if we can go to the next slide, I think this drives home the point that I am trying to make, which is that long-term care need is not defined by chronic illness. Chronic illness is often what precipitates a long-term care need, but as this graph shows--and I think you all have a hard copy, so you can see it a little bit more clearly.

If you look at the far right-hand bar, all this shows is that when we look at just the Medicare elderly population, so the over age 65 population, we have lots of people in that population who have 5 or more chronic conditions but no functional impairment, no need for long-term care.

There is, in fact, a subgroup, about 25 percent of those who have 5 or more chronic conditions, who have a need

for long-term care.

So I just want to train you all to think about this in terms of functioning and not in terms of disease.

And go to the next slide.

I am going to spend a little bit more time on this slide because this is truly the tour of the long-term care population.

So I am going to start you in the far left-hand corner. You will see that there is a total of about 11 million people that have derived from the survey that the authors of this study used in order to calculate the size of the long-term care population.

But I just want to say 11 million is just--it is just an estimate. Depending on how you define these sort of gradations of need around activities of daily living, you could get anywhere from 9 million to 12 million in that number.

So we are really talking about a range when thinking about the whole population of the United States--a range of about 9 to 12 million people.

But at some point you have to make a decision when you are studying the data. In this case, we took a fairly--the authors took a fairly broad view of the population, and the number is 11 million.

So, if you go to the far right-hand side, this is

really critically important. Of that 11 million, 44 percent are under the age of 65. So this is an issue where we often think about this being an issue that is mainly related to the elderly population or important to think about in terms of seniors, but 44 percent of that 11 million are actually under the age of 65.

So these two populations break down, and the over age 65 and the under age 65 are really quite different. And one of the things that is different about them is if you go up to where we have the estimate of nursing home residents within this long-term care population, within the elderly population, the over age 65, in fact a much higher proportion of the over age 65 population with long-term care need is actually living in a nursing home compared to the under age 65 population.

And I want to say just a couple other things about this. In the over age 65 population, the group that is living in the community, which is that dark blue bar, the dark blue piece of the pie right there--those folks can live in a number of different settings.

So, when we are talking about a nursing home, we are talking about a true nursing home, a certified nursing home.

But in that dark blue part of the pie those folks could be living in private homes. They could be living in assisted living facilities. They could be living in

independent living. And so there is really a wide range of ways that this population is being served--either in private homes or in facilities like assisted living facilities.

And then, if you look at the under age 65 population that is living in the community, the same is really true. So those folks could be living in private homes. They could be living in group homes. They could be served in a number of different ways.

And when they are served in private homes, whether it is under or over age 65, we definitely see a lot of caregiving that is going on by informal caregivers as well as paid caregivers.

So, if we can move to the next slide.

So what we have done here is we have actually broken out the data, starting first with the over age 65 demographics.

So I just want to draw your attention to a couple of statistics. This population really breaks down a lot by gender, marital status and income.

So what I mean by that is that--well, what I really mean by that is that you tend to see a lot of very old--within the over age 65 population, those who need long-term care tend to be very old, they tend to be female, they tend to be unmarried, and they tend to have relatively lower income compared to the folks who do no have long-term care

need.

So then, if you go to the next slide--and I am not going to dwell on these statistics very much. You can look at them later.

But what is interesting is if you go to the next slide, which is the under age 65 population, this group is really not defined as much by gender, and if it is, quite frankly, it is more likely to be male. They are still very much unlikely to be married compared to the people without long-term need--to be unmarried--and they are definitely more likely to be low income or under the 200 percent of the Federal Poverty Level compared to those without long-term care need.

So we see some differences in these two age bands--large age bands, over age 65 and the under age 65.

Okay, so if we could go to the next slide.

I want to just focus for a moment on a particular subgroup within the over age 65 population.

So we have been talking a lot about the inability to perform daily activities.

So, in the elderly, loss of functioning can come from a variety of illnesses medical events, such as a stroke or from the normal course of aging as I mentioned before, and it can present itself mostly through physical manifestations.

But the inability to function can also occur as a result of dementia or cognitive impairment or Alzheimer's Disease. This is a subset of mostly the elderly population, but the decline in mental ability can be quite severe, particularly in the case of Alzheimer's.

And this is important as you think about public policy related to long-term care because the caregiving needs--the caregiving burden for folks who are taking care of the Alzheimer's population can in fact be very, very challenging.

And, when we look at the data, we see that as the nursing home population has changed over time with the advent of assisted living, the people who are living--the long-term care population living in nursing homes over the age of 65 is more and more tending to be people who have cognitive impairment and Alzheimer's Disease.

Okay, so we could go to the next slide.

I just wanted to take a minute and also walk you through another subpopulation for the under age 65 group.

So I focused on Alzheimer's Disease and cognitive impairment as an important subpopulation for you to understand within the over age 65.

So I am going to talk a little bit about a subpopulation that is important for you to understand within the under age 65, and this is people with developmental

disabilities.

Just in general, developmental disabilities--the CDC definition of this is a group of conditions due to an impairment in physical, learning, language or behavioral areas, and--this is important--these conditions begin during the developmental period.

So, just to pause for a moment, the onset of the inability to function independently is occurring at a completely different time and phase of life than it is for somebody, for example, who gets Alzheimer's Disease or has a stroke at the age of 70. This developmental disability can impact day-to-day functioning for a person's entire life. And often--and this is another really critical point--the caregiver in this instance will end up being the parent, and the parent will be the caregiver even through the adult years of this person's life in many cases.

So it poses a whole different set of challenges than what you might see for somebody who has Alzheimer's Disease and is being cared for by an adult daughter.

So just a couple of examples of this include autism, intellectual disability, cerebral palsy and muscular dystrophy.

As I mentioned before, this is a subgroup of the under age 65 population that has disabilities. Disabilities in under age 65 can occur also as a result of accidents. They

can occur as a result of degenerative diseases such as multiple sclerosis or Parkinson's Disease.

So what I am trying to do right now is just paint a picture for you of what this population looks like and the diversity that it contains.

All right, so we can go to the next slide.

Here is another characteristic of the long-term care population that I feel particularly moved to mention, and that is that people with long-term care need also have high medical care use. And this, in my opinion, is a result of the lack of appropriate supports and services that often occur particularly for the vast majority of people who live in the community.

As you can see, again, when we look--and this is just the elderly population in this particular data run. But, when we look at the Medicare population with chronic conditions, and we examine those who have chronic conditions but do not have any long-term care need or functional impairment, what we find is that the medical care spending for that population has, in fact, significantly lower than it is for people with functional impairment.

So, with functional impairment, the need for long-term supports and services in the elderly population, in particular, can have a pretty dramatic effect on how they use medical care. And that have important implications for

Medicare spending.

If we could go to the next slide.

And, Larry, I do not have a sense at all of how I am doing with respect to time.

[Off microphone response.]

Ms. Tumlinson. Fine. Okay, I am going to come in low, which is good.

So--I guess I was talking really fast. Okay.

So we have done a lot of work projecting the size of the population over the long term as a part of our work for both the SCAN Foundation and the Department of Health and Human Services, and we have a model that produces premiums for different types of public long-term care insurance programs.

And so, as part of that modeling effort, we were able to build estimates of long-term care need out into the future. In fact, that was necessary in order to build the model.

And this model has been reviewed externally, and extensively, I might add.

So the estimates we have in this model show the size of the long-term care population increasing by about 70 percent.

Just to orient you to this, what we are saying essentially here is the entire long-term care population.

So this is not just the elderly. This is everybody. And it is going to increase from about--and again, remember before, when I said 9 to 12.

In this particular model, we are defining disability in such a way--or long-term care need, I should say in such a way--that we come up with an estimate in 2010 of about 9.8 million people increasing to about 16.5 in 2050.

And we can talk a little bit about what we expect in terms of rates of impairment in the future among the elderly, but again, this represents the entire population.

I guess maybe just since I have time I will just mention one more thing about this. What we assume in this model is, in fact, that age-specific prevalence rates decline slightly over the short term but that they even out starting in about 2025. It is very challenging to try to predict what is going to happen with impairment rates in the future.

Okay, we can go to the final slide.

Okay. So this is--the reason why you saw the prevalence rates in the previous slide increasing so much over time is because--so I said before this is about the whole population--the under age 65 and the over age 65.

At the same time that I am saying this I am telling you that it is, in fact, the growth in the over age 65 population needing long-term care--especially the growth, as

you see in that last bar, of the 85 years and over proportion of the over age 65--that is really driving the increase in the prevalence rates into the future in our long-term care model.

So, that 16.5 million people is a result of the increase--is largely, I should say, a result of the increase in the over age 85 population.

Even if we do not assume any--even assuming a slight decline in the prevalence of disability or functional impairment within the over age 85 population, we still see a tremendous increase just in the sheer numbers of people.

So I am going to stop right there.

[The prepared statement of Ms. Tumlinson follows:]

Chairman Chernof. Thank you very much, and if we could move on to our second speak of the day, Kirsten Colello--my apologies--who is going to talk with us a little bit about eligibility and current financing.

STATEMENT OF KIRSTEN COLELLO, SPECIALIST IN HEALTH AND AGING POLICY, CONGRESSIONAL RESEARCH SERVICE

Ms. Colello. Great. Thank you.

Good afternoon. Thank you for the opportunity to appear in front of the Commission today.

I will provide an overview of financing for LTSS and eligibility for public programs. First, I am going to provide information on who pays for LTSS, including how much is spent by public and private payers as well as how much is spent by payers across settings. Then I will focus my comments on those public programs that provide financing, eligibility for these programs and the types of services covered, with a focus on Medicaid.

You have an expanded discussion of these topics that I provided in some written comments to you.

It is important to note that there is a wide variation of LTSS settings and services. This creates challenges for researchers and policymakers in establishing a common definition of LTSS for the purpose of evaluating spending and determining policy.

For example, some argue that Medicare skilled nursing facility and home health are post-acute services, of limited duration and scope, and should not be categorized as LTSS. Others argue that Medicare is an important payer in the continuum of LTSS since many nursing facility residents

start with Medicare paying for the cost of care, but after the coverage period ends, Medicaid may pay for these expenditures.

My testimony includes Medicare skilled nursing facility and home health expenditures as part of LTSS.

The data I present are from the National Health Expenditure Accounts and are published annually, with the most recent data from 2011. They represent aggregate health and LTSS spending in the United States.

I want to point out that formal LTSS spending underestimates total LTSS spending as the data do not include informal or uncompensated care provided by family caregivers. Also, the data do not include indirect benefits through Federal and state tax deductions for LTSS expenditures.

Next slide, please.

In 2011, an estimated $317 billion was spent on LTSS. This represents about 14 percent of the $2.3 trillion spent on personal health expenditures. If Medicare spending is excluded, total LTSS spending in 2011 was $242 billion or 11 percent of personal health expenditures.

Figure 1 shows LTSS spending by payer for 2011. Public sources accounted for the majority of LTSS spending, about 73 percent, and include Medicaid, Medicare and other public programs. The remaining 27 percent was paid by private

sources, including private health and long-term care insurance policies, out-of-pocket expenditures and other private sources.

For 2011, the combined Federal and state spending on Medicaid was the single largest payer at $133 billion or 42 percent of LTSS spending.

Medicare represented the next largest share of spending at 24 percent.

Other public sources of funding include the Veterans Health Administration and the State Children's Health Insurance Program as well as other state and local financing for LTSS, which represented 7 percent of the total.

Note that there are public funding sources not included in the National Health Expenditure Accounts, specifically, Federal discretionary funding for LTSS provided under the Older Americans Act and Title XX of the Social Security Act, the Social Services Block Grant Program. These are not included in the above expenditures.

Next slide, please.

So Table 1 shows LTSS spending in 2011 by payer across three settings--nursing care facilities, home care and other residential facilities--for persons with intellectual and developmental disabilities, mental health conditions and substance abuse issues. In the aggregate, about half of LTSS spending was for care provided in nursing facilities

while more than one-third was for LTSS in the home.

Across all three settings, public payers were the predominant source of LTSS spending. Public spending accounted for a substantial share of home care, 90 percent, but less so among residential and nursing facilities.

Across these three settings, Medicaid was the predominant public source of payment while private payments represented a smaller share.

Next, I am going to focus on public sources of financing for LTSS and program eligibility, specifically within the Medicare and Medicaid programs as they are the largest public payers.

However, much of my testimony is focused on the Medicaid program and eligibility as Medicaid is a primary funding source for LTSS. In addition, the rules for determining Medicaid eligibility are complex.

Across all public programs, it is important to note that program eligibility requirements and benefits vary widely. Moreover, among the various public sources of LTSS financing, none is designed to cover the full range of services and supports that may be desired by individuals with long-term care needs.

Also, my discussion of Medicare and Medicaid programs does not specifically address dually eligible individuals or dual eligible beneficiaries. These are individuals eligible

to receive benefits from both programs.

First, I will discuss Medicare eligibility and coverage.

Medicare is a Federal program that pays for covered health care services of qualified beneficiaries. Generally, individuals are eligible if they or their spouse worked for at least 40 quarters in Medicare-covered employment, are 65 years of age and are a citizen or permanent resident of the United States. Individuals may also qualify if they are a younger person with a permanent disability or have a certain health condition.

In fiscal year 2013, the program will cover an estimated 52 million persons of which 43 million are age 65 and over and 9 million are disabled individuals.

While Medicare covers primarily acute care benefits, it also provides some coverage for two types of LTSS-skilled nursing facility, or SNF, services and home health services. These benefits provide limited access to personal care services, both in the home care setting and in skilled nursing facilities, for certain beneficiaries on a short-term basis.

Next slide, please.

In 2011, Medicare spent $75 billion on SNF and home health services combined, which was over 1/5th of all LTSS spending. These expenditures include Medicare Parts A and B

and estimated Part C, or Medicare Advantage, payments attributable to SNF and home health care.

Of total Medicare LTSS spending in 2011, more than half was paid to SNFs.

Figure 2 shows the share of home health and SNF expenditures as a proportion of all Medicare LTSS spending for selected years. The change in Medicare home health expenditures between 1995 and 2000 can be attributed to the Balanced Budget Act of 1997, which implemented an interim payment system and limited the number of home health visits that could be reimbursed by Medicare, subsequently reducing Medicare expenditures on home health.

There is significant debate among policymakers and stakeholders over the classification of these Medicare benefits into post-acute or LTSS benefit categories. This is likely due to the fact that Medicare and Medicaid both cover stays in nursing homes as well as visits by home health agencies, yet the type of service and coverage are generally different.

Medicare, unlike Medicaid, is not intended to be a primary funding source for LTSS.

Medicaid nursing facility and home health benefits are available to eligible beneficiaries for as long as they qualify while Medicare, SNF and home health benefits in general are limited in their duration.

In addition, Medicare, SNF and home health include coverage of rehabilitation services that will, presumably, improve the beneficiary's physical condition or functional status.

Next, I am going to provide an overview of Medicaid eligibility and coverage of LTSS.

Medicaid is a means-tested entitlement program which finances the delivery of health care and LTSS to certain eligible low-income individuals. The Medicaid program is state-operated and is funded by both state and Federal revenues. Each state designs and administers its own program within broad Federal guidelines.

Historically, to qualify for Medicaid, individuals must meet certain categorical and financial requirements. To qualify for Medicaid LTSS, individuals must also meet state-based functional eligibility criteria.

Federal Medicaid law requires states to cover certain population groups, which are referred to as mandatory eligibility groups, and gives states the flexibility to cover other population groups, or optional eligibility groups.

Under Federal Medicaid law, states are required to provide coverage to aged, blind and disabled persons receiving cash assistance through the Supplemental Security Income, or SSI, program. As a result, the Medicaid program

relies on SSI program rules for determining eligibility for aged and disabled individuals who may need LTSS. However, Federal law gives states the option to use eligibility criteria that are more restrictive than SSI.

For 2011, the SSI rules specify that recipients must have monthly income at or below $710 for an individual and $1,066 for a couple, about 75 percent of the Federal Poverty Level. SSI rules also limit the countable resources individuals may have up to $2,000 for an individual and $3,000 for a couple.

States may also extend Medicaid coverage to other optional eligibility groups. For elderly and disabled individuals, states may use more liberal standards for determining financial eligibility than under SSI.

States also have flexibility to modify SSI rules with respect to counting assets. Most states use these provisions to ignore or disregard certain types of income or resources, thereby, extending Medicaid to aged and disabled individuals with assets too high to otherwise qualify.

For example, states may extend coverage to those residing in nursing facilities who have income of up to 3 times the basic SSI payment level, referred to as the 300 Percent Rule.

In general, an individual with LTSS needs can meet financial requirements for Medicaid eligibility in one of

three ways:

First, individuals may have assets equal to or below the state-specified limits for their eligibility pathway and thus qualify for Medicaid by meeting the financial requirements at the time of application.

Second, individuals who have assets above specified limits, but who would otherwise qualify for Medicaid absent these financial requirements, may over time deplete these assets to specified limits by paying out of pocket for the cost of their care--a process known as spending down.

And, third, those individuals who have assets above specified limits may divest their resources for purposes other than spending out of pocket for the cost of their care.

This third group of individuals are of particular interest to policymakers because they may divest resources in an effort to protect them, thereby, meeting financial requirements for Medicaid and any applicable LTSS.

Congress has enacted several laws over the years aimed at limiting the ability of individuals to divest financial resources in order to become eligible for Medicaid LTSS. The Deficit Reduction Act of 2005 was the most recent action taken by Congress to further limit the ability of individuals to divest their assets for the purpose of qualifying.

Next, I am going to briefly describe some of the financial rules for Medicaid LTSS.

Generally, states follow SSI program rules concerning the treatment of most types of assets, including income and resources that individuals possess at the time of application to Medicaid. While Federal Medicaid law does not contain provisions specifying how all assets should be treated, it does include special rules about how states must treat certain types of assets, such as annuities, loans, mortgages and trusts.

In addition, while a primary residence, regardless of value, is not a countable resource for the purposes of Medicaid eligibility under SSI rules, the equity value of a home may affect whether or not an individual receives Medicaid LTSS. Eligibility may be restricted if the applicant's equity interest in the home exceeds a statutorily determined amount, which is currently $536,000. At state option, this threshold could be higher, up to $802,000.

Such limits do not apply to individuals who have a spouse, a child under the age of 21, or a child who is blind or permanently disabled of any age, residing in the home.

Also, states can choose not to apply this rule if doing so would cause undue harm.

Adding to the complexity of determining Medicaid

financial eligibility is the treatment of the assets of a couple when one spouse needs institutional care and the other remains in the community. Medicaid specifies rules for equitably allocating how much income and resources, as well as which resources, are to be credited to each spouse. Commonly referred to as Spousal Impoverishment Rules, these rules are intended to prevent the impoverishment of the spouse remaining in the community.

In general, states must establish minimum income and resource allowances within Federal limits for a community spouse which are not applied toward the institutional spouse's eligibility determination or LTSS costs.

Medicaid also requires states to apply rules regarding the transfer of assets prior to qualifying for LTSS. These rules attempt to ensure that applicants apply their assets toward the cost of their care and do not divest them to gain eligibility sooner than otherwise.

Eligibility may be delayed for applicants who have disposed of certain assets for less than fair market value on or after a look-back period. This look-back period is five years prior to application for Medicaid.

In other words, transfers for less than fair market value may be, but are not always, prohibited during the five-year period prior to application.

Medicaid has another set of rules for the treatment of

income after a person has become eligible for coverage and is either living in an institution or is receiving certain HCBS. These rules are commonly referred to as the Post-Eligibility Treatment of Income Rules. In general, beneficiaries qualifying through certain eligibility groups are required to apply their income exceeding specified amounts toward the cost of their care.

Within Federal guidelines a beneficiary may retain a certain amount of income for personal use based on the services one receives. The amount a beneficiary may retain varies by care setting.

Other provisions in Medicaid seek to recover LTSS costs through state recovery programs. Federal Medicaid law requires states to recover any amounts paid for certain LTSS and other related services upon a beneficiary's death. Specifically, states must pursue the estates of those who were receiving services in a nursing facility or intermediate care facility for the developmentally disabled, regardless of age, and also the estates of individuals aged 55 and older who received nursing facility, HCBS and related hospital and prescription drug services.

Once enrolled, beneficiaries in general are entitled to those services that are required or otherwise made available under the state plan.

In addition, individuals in need of LTSS may be

required to meet level-of-care criteria that may include, but are not limited to, the need for the level of care provided in an institution.

With respect to LTSS, Medicaid covers services for beneficiaries in both institutional and home and community-based settings though the portfolio of services offered differs substantially by state.

Federal law requires state Medicaid programs to cover nursing facility services for certain beneficiaries while states have the option to cover these services for other beneficiaries and in other institutional settings.

Medicaid law also offers states two broad authorities under which to offer HCBS, either as a benefit under the state plan or through a waiver program.

Next slide.

An important debate for Medicaid spending involves perceived institutional bias; that is, states are required to cover nursing facility services for eligible beneficiaries, but coverage of most HCBS is optional.

Figure 3 shows the share of institutional care and HCBS spending as a proportion of Medicaid LTSS spending for selected years. In 1995, more than 3/4ths of all Medicaid LTSS spending was for institutional care. Since then, expanded Federal legislative authorities and additional administrative activities have allowed states to expand

HCBS.

These Federal activities were, in part, prompted by the Supreme Court's Olmstead Decision which held that the institutionalization of people who could be cared for in a community setting was a violation of Title II of the Americans With Disabilities Act. As a result, the share of Medicaid LTSS spending for HCBS as increased steadily from about 21 percent of Medicaid LTSS spending in 1995 to just over half of total Medicaid LTSS spending in 2011.

As shown in Figure 3, Medicaid LTSS spending in 2010 marked a significant shift. In 2010 and 2011, HCBS spending was a greater proportion of Medicaid LTSS spending than institutional care.

Finally, I would like to discuss Medicaid home and community-based care, the majority of which are optional services for states to cover. The exception is home health services, which is a Federally required benefit under a state's Medicaid plan and must be offered to individuals entitled to nursing facility coverage.

States, at their option, may offer other HCBS services through their state plan, such as personal care, respiratory care for persons who are ventilator-dependent, case management and targeted case management.

States often use waivers to extend HCBS to individuals with disabilities of all ages. Such waivers are referred to

by their Social Security Act reference, such as Section 1915© Home and Community-Based Waivers and Section 1115 Research and Demonstration Waivers.

These waiver authorities allow states to provide HCBS to certain targeted populations and limit the number of individuals served. Waivers, by definition, permit states to waive certain Medicaid requirements so that states can provide HCBS to a limited geographic area or provide services that are not necessarily comparable in amount, duration or scope.

Examples of covered waiver services identified in statute are personal care, homemaker/home health aide, adult day health and respite care. States also have the flexibility to offer additional wavier services approved by the Secretary.

States may also use state plan authority to provide HCBS. For example, states may use the HCBS state plan option under Section 1915(I) of the Social Security Act to provide HCBS to certain Medicaid beneficiaries who meet financial and functional needs-based criteria without a Secretary-approved waiver.

Another option for states is a Section 1915(j) authority, also referred to as the Community First Choice Option, which covers home and community-based attendant services to certain beneficiaries under the state plan.

Established under the Affordable Care Act, this option provides a 6 percent increase in Federal matching payments to states for expenditures related to this option.

This concludes my testimony on LTSS financing and public program eligibility. I would be happy to respond to questions from the Commission.

[The prepared statement of Ms. Colello follows:]

Chairman Chernof. Great. Thank you so much.

And we are now going to turn to Bill Hoagland, who is going to take us through the Federal budget implications of where we are today.

STATEMENT OF G. WILLIAM HOAGLAND, SENIOR VICE PRESIDENT, BIPARTISAN POLICY CENTER

Mr. Hoagland. Thank you. Mr. Chairman, Mr. Vice Chairman, members of the Commission, good afternoon.

First, let me thank you for your public service and willingness to serve on this Commission. I need not tell you, as the Chairman has already, how difficult the challenges are that lie ahead of you in meeting your task.

Second, when I was asked by Dr. Atkins earlier this week to testify before you, I questioned him as to whether I was the right person to appear here with these other real experts on long-term care. I will be the first one to admit up front that I am not an expert on this subject. I fall more into the category they would call green eyeshade, or a budgeteer.

But, in retrospect, your Commission is the result of a Federal budget dispute concerning the long-term actuarial solvency of the CLASS Act. So maybe it is appropriate as you begin your Commission's work that you be briefed on the current Federal budget environment in which you will be operating over these next few months.

As a budgeteer, it is hard to make these presentations, of course, without the crutch of graphs and charts. In fair warning, what I present to you I do not think will make your task any easier. It may, however, give you some insights on

the challenges that lie ahead and help focus maybe some of your policy recommendations.

With the benefit of these slides, let me address four broad issues--the current fiscal outlook, number one; two, the major components of Federal spending and that outlook; the near-term spending constraints that could impact policies affecting long-term care; and my, admittedly rough, estimates of national expenditures on long-term care and issues surrounding those estimates.

Up slide one, please.

The graph and numbers I present are all based on the latest projections from the Congressional Budget Office and the Joint Committee on Taxation.

As an alumnus of the CBO, I am well aware of the difficulties in making such projections and the assumptions that are required to produce them, but there is one variable that I have some certainty to, and that is that everyone in this room will be 10 years older 10 years from today. And that demographic reality is, of course, the challenge of the Federal budget and the Commission's work.

While the Federal deficit has improved significantly from the recent past and is expected to decline over the next four years, beginning in 2016 it is expected to return to its upward path--or, in the case of this chart, downward path. This reversal is almost concomitant with the

expiration of the Budget Control Act of 2011 that set spending caps on discretionary spending and the increasing aging of the early wave of the Baby Boomers who have already entered, such as I have, their retirement years.

Up slide two, please.

Putting this chart into numbers, slide two presents the aggregate Federal spending revenues, deficits and debt for the current fiscal year and the next five years.

I highlight the fact that while the annual deficit is projected to decline through 2015 and begin that slow upward path in 2016, more important to me than the annual deficit is the accumulation of debt held by the public throughout this period. As you will see, it averages close to 70 percent of GDP--well above historical averages of approximately 40 percent over the last 40 years.

A few things to keep in mind with these current projections:

Number one, they assume that the level of spending in the discretionary accounts--what we call defense and non-defense--remains constant--remains constrained by the Budget Control Act of 2011 that set caps and automatic spending reductions through 2021.

I will highlight later the assumption--that it is already being questioned, of course, in a Senate-passed budget resolution and guidance that that has given to the

Senate Appropriations Committee in setting their funding for 2014. I will come back to that in a minute.

Second, keep in mind these projections assume that the physician fees will be reduced 25 percent beginning next January--the so-called SGR--and that would total nearly $170 billion to add back if you were just to freeze.

And this would be in addition to what is already assumed in these numbers, that there will be a 2 percent reduction in Medicare reimbursement rates prior to payments beginning in October associated with the so-called sequester--the second sequester.

Third, directly relevant to this Commission's work, these projections follow the Congressional budget score-keeping convention that despite the exhaustion of the Social Security Disability Trust Fund in 2017 those benefits continue to be paid at current policy. It assumes that.

But the reality, of course, as you all know, is that you are going to have to pass some law to make that not happen, or else you fall back to a pay-as-you-go, and then disability payments--Social Security disability payments--would be reduced 20 percent at the beginning of 2016 or 2017 by CBO's estimates.

Further, there is a number of expiring tax provisions that are assumed to expire at the end of this year, totaling nearly $1.1 trillion over the next decade. Many will surely

be extended.

And, finally, the very big unknown--the 10-year Treasury notes are assumed throughout this to remain low, at 2.1 percent in 2013 and 2.7 percent in 2014, before they get back to about 4.5.

Yesterday alone--just the market yesterday--the 10-year T-bill rate was 2.5. So we have already exceeded that.

And I remind you a one percentage point difference in interest rates from the CBO's assumptions would increase spending and the deficit over 999--let's round it. A trillion dollars over the next ten years.

The simple point I am trying to make here is that there is a significant risk that these projections, even in the near term, could prove optimistic unless policy changes are adopted this fall.

Up slide three, please.

Even with the assumption of the recent slower spending trends in Medicare and Medicaid, along with Social Security disability and other health care spending, these programs serving both the elderly and the disabled will constitute nearly 70 percent of primary Federal spending in 2013. That excludes interest.

Up slide four, please.

And the importance of this fact is shown in this slide--the area of the Federal budget that will continue to grow.

Social Security and health care will be at the expense of discretionary spending for both defense and non-defense programs.

Many programs in the non-defense discretionary category provide social services, as Kirsten said, to those needing long-term care, such as transportation, housing, Meals On Wheels and other social services. Equally as important, this is the category of the Federal budget where research at NIH and other agencies, addressing cures and ailments that afflict those--that is the same area, and you can see that it is on a downward path to the lowest level it has been in 40 years under current assumptions.

Next slide, please.

Impact of the sequester--no need to belabor this point any further. Relative to the Budget Control Act spending caps, spending will be automatically reduced $109 billion beginning next year, half in defense and half in non-defense--the bulk of this in that area we call discretionary spending, $91 billion, and all that coming out of that.

So, up slide six.

This is a messy chart. I apologize. But the practical impact of this $91 billion difference is reflected in this slide by what we call the allocations to the Senate and House Appropriations Committees.

The Senate-passed budget resolution this year assumes

the sequester will not take place and that funding will be at the capped BCA level of $1.58 trillion.

The House here assumes the sequester level of 967, if you go down to the bottom of the comps.

The difference between the two is $91 billion.

But look even more carefully at where the committees also differ on their allocations at the subcommittee level. The House level for the Labor-HHS-Education Subcommittee, as an example, is nearly $43 billion below the Senate-assumed level for next year and nearly 20 percent below the level of funding for this year even after the March sequester is taken into consideration.

Obviously, this is a subcommittee where Federal funding is directed at programs serving the vulnerable populations this Commission will address.

I am going to skip the next slide, slide seven, and go to the next one, slide eight. And I am going to finish with two last slides here and not discussing the remaining ones in the interest of time.

It is with much trepidation that I present this slide and the related one to follow. As I said, I am not a long-term health care expert. I am pleased to hear Kirsten's numbers which tend to validate what I have done here.

Indeed, we at the Bipartisan Policy Center will be building upon a recent report that we put out on health care

cost containment authored by Senators Daschle, Frist, Domenici and Rivlin, and we will try to expand upon and address the cost drivers and policies impacting long-term care coming forward.

But, to establish some form of a benchmark for that work, I have tried to estimate what might be thought of as a proxy for what constitutes long-term health care spending. I had not seen Kirsten's presentation.

I did this also prior to a release late last evening from the Congressional Budget Office of a chart book on this very subject. When you look at that chart book, though, I would admonish the staff, I think it only looks at those over the age of 65 and does not include the broad categories. And, therefore, I feel a little bit more comfortable with my numbers.

The long-term care services cover, as we all know, as Kirsten and others have already pointed out, more than those over 65 and quite a large--what Anne said--44 percent under the age of 65.

So, no surprise, our numbers are not identical. And I have not incorporated, Mr. Chairman, the value of informal care provided by family members and friends into these figures.

But, again, I was somewhat allayed with my little concern for, Mr. Chairman, your SCAN Foundation's estimate

of nearly $450 billion in unpaid family caregiving. If I adjust for that, we come to relatively similar numbers.

I would also point out, Mr. Chairman, that CBO's estimates last night were about half of that, though--$234 billion.

So, based on the same numbers that Kirsten used in terms of national health care expenditures, historical and projected and excluding unpaid family care, the proxy here includes residential and personal care, home health, nursing care and continuing care communities. And today those expenditures are approximately $342 billion, close to Kirsten's numbers, and are expected to nearly double over this period of time.

Spending--again, it seems to me there are some differences here in the numbers I have heard this day already--seems to be primarily directed at nursing care facilities at roughly 40 percent, residential personal care at about 40 percent. And the category that I think most elderly and disabled would prefer to receive care in--home health care--appears to have stabilized, and in the projections going forward in the national health care expenditures is at around 20 percent.

Overall spending for long-term care--that represents about 5.1 percent of national health care expenditures in 1960--now will exceed well over 13 and going on up.

Again, with the limitations of the national health care expenditure data, the annual rates of growth over this period--long period--while exceeding total national health care growth rates, do appear in the long term--do appear to have slowed in recent years. But I think that simply reflects the overall reduction and slowdown in all health care expenditures.

Further, the high rates of growth, as you can see in that chart, in the 1980s and 1990s, in home health care and nursing care facilities seems to have declined.

So my final slide up--next slide, please.

My final slide took that data and parsing it by categories of funding, similar to what others have done here, reflects what I believe other researchers have discovered:

Number one, there is a significant shift in funding for long-term care away from personal expenditures, out-of-pocket, combined with extremely limited private insurance coverage that results in, or has resulted in, there being both those offset by a rapid growth of Medicaid and Medicare spending.

So, if I try to tie the broader budget presentation to these two final slides, I conclude two issues that the Commission might consider in its deliberations.

The first, and probably the most obvious--while

Medicare and Medicaid have become the major funding source of long-term care, the Federal budgetary pressures going forward would suggest that continued reliance on those public funds cannot be simply assumed to continue at current pace, and therefore, payment reforms will be necessary broadly throughout health care to maintain those programs on a sustainable path in the future.

Alternatives must be found to long-term care demands funding, whether that is through greater information and incentives to save for one's golden years or--and I am not taking any position here--whether to purchase private insurance through the market, possibly subsidized better through the tax code.

And number two, and finally, I conclude that today once access to Medicare and, particularly, Medicaid-financed long-term care becomes available, after the insurable event has occurred, Medicaid and Medicare end up paying the most expensive long-term care. At this point, private insurance is unavailable, and personal income and assets are at risk.

So, while well intentioned public policy goals to provide long-term care are commendable, I think the current design and functioning of the system today discourages long-term care planning, it overwhelms state and Federal resources and, at the same time, severely limits care to people who badly need long-term care.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Hoagland follows:]

Chairman Chernof. Thank you very much.

And we would now like to hear from Marc Cohen who will speak to the state of the private long-term care insurance market at the moment.

Thank you, Mark.

STATEMENT OF MARC COHEN, CHIEF RESEARCH AND DEVELOPMENT OFFICER, LIFEPLANS, INC.

Mr. Cohen. Thanks.

Is this on? Great.

Thanks very much.

I can see what a great thing it is to present on the state of the private long-term care insurance market after the budgeting discussion because it is clear no matter what I say it is going to sound very positive.

Dr. Chernof, Dr. Warshawsky and distinguished members of the Commission, let me begin by thanking you for your service and by saying how delighted and honored I am to have the opportunity to talk to you today about the state of the private long-term care insurance market. The words, delighted and private long-term care insurance, do not often go together, but I am very happy to be able to talk about what is happening in this market.

I am Marc Cohen. I am Chief Research and Development Officer of LifePlans, a company that has worked with and conducted research on the long-term care insurance industry for over 25 years.

It would not be an exaggeration to say that the industry today is at a critical crossroad regarding the role it will play in financing our Nation's long-term care needs. It can continue to play a niche and relatively modest role

for a fairly select population, or it can play an increasingly important and broader role in helping to solve the financing challenge before us.

Today, I am going to present an overview of the market by providing information on market size, the profile of individuals buying policies with an emphasis on how this has changed over the last 20 years, product evolution and recent information on why a number of carriers--a large number of carriers--have exited the market.

Can I have slide three? Perfect.

So, in this slide, we summarize a number of key industry parameters.

There are two ways to think about the general market. There is an individual market, where policies are sold directly by agents and brokers to individuals, and a group market where policies are sold through sponsors, primarily employers.

Today, somewhere between 7 and 8 million Americans have policies, and they are paying roughly $10 billion a year in premium.

Recent years have seen a significant decline in the number of sales. By way of example, annual sales in 2010 were 65 percent lower than in 2000 even as activity in the group market has been somewhat positive.

Could I have the next slide?

This slide basically shows the growth in the number of people with policies and reflects both new sales as well as people who no longer have policies because either they had them and have passed away or they have lapsed their policies. The key point on this slide is that the market, in terms of overall growth, has been flat over the last five or six years.

Next slide.

What slide five shows is that growth has been declining, and this is in the individual market only. Since 2009, sales in the individual market have stayed roughly between 220,000 and 250,000 policies. I believe this is lower than--yes, it is lower than levels back in 1990.

Could I have the next slide, please? Thank you.

The group market represents a growing share of sales. If you look here, you see that in 2000 75 percent of sales were attributable to the individual market and maybe 25 percent in the group market. By 2010, that had increased where 42 percent of sales were in the group market.

There is a lot of concentration in this market, or there always has been. Fewer than 10 companies account, and have accounted, for the vast majority of sales in this market.

Market penetration is currently less than 10 percent of the population aged 40 and over. But it is worth noting

that of those aged 65 and older, with at least $20,000 in income, penetration is closer to 1 in 6.

I suppose an optimist would say, well, you know, at 10 percent, this shows there is tremendous opportunity out there for the industry to play a broadened role.

And a pessimist might say, well, after 30 years of effort, a successful industry, one might have expected, would be covering more people.

I am not telling you where I fall on that spectrum.

Slide eight, next slide--Characteristics of Policies, just to make sure that people understand what these policies actually do and what they cover. They began as nursing home insurance in the 1980s, and they were called nursing home insurance, but now they reimburse the cost of care in a variety of settings, both community and institutional--home and community-based care, assisted living facilities, nursing homes and so on. And most policies are structured as giving individuals access to a pool of dollars whereby they can use those dollars in any of the settings that I mentioned.

Typically, policies are structured so that they reimburse the costs of services, and standard benefit triggers are based on many of the functional triggers that Anne talked about. If an individual has two or more limitations in activities of daily living or has severe

cognitive impairment requiring human assistance, then they qualify for benefits. Most companies provide some level of care management at claim time although there is a great deal of variability.

The average premiums differ by market. The group market, where the average age, of course, is much lower, average premiums are around $57 a month and in the individual market, around $189 per month. Again, that is heavily driven both by policy design but primarily by age at purchase.

Could I have the next slide, please?

There is a lot of information on this slide. It is basically one slide that tries to capture product evolution over the last 20 years.

Let me make a couple of key points.

Number one, if you look at the top row, you can see just how much policies have changed. In 1990, most policies only covered nursing home care. By 2010, nursing home-only policies had virtually disappeared from the market, and policies covered a much more comprehensive set of services.

The daily benefits both for nursing home care and home care had increased significantly. If you compare those benefits to the average cost of care, they are very comparable; that is, pegged to an institutional-based benefit.

Most individuals choose to have some type of inflation protection included in their policy, whether it is automatic compounding of inflation or the opportunity to make choices as they age.

You can also see, of course, that the premiums have increased significantly over the period, and I will talk about that briefly.

You know, before I leave, I always ask myself: In terms of the product evolution, does this product pass the mother test? Is this something that I would, with a straight face, actually turn and say, you know, mom, this is something you ought to buy?

And I would say the answer to that is yes. The challenge, of course, is one of affordability--how many people can afford this level of premium. But, in terms of the benefits that are provided by the policies, they are very comprehensive.

Next slide.

As policies have become more comprehensive and actuarial assumptions have trued up, premiums have increased. And what this slide shows is for each of the age groups, between 1995 and 2010, changes in the average premium.

While they have increased over the period, the largest increase has been at the youngest ages. And the reason for

that is because these policies are pre-funded, meaning that the premium that is collected is designed to remain level-funded over the life of the individual and at young ages the probability of needing long-term care is very small. So much of that premium is being invested so that at the oldest ages, when the probability of needing care and having expenses is much greater, you have built up a reserve to pay for claims costs.

A big reason why the premiums have gone up so much at the younger ages is because of some of the challenges with the interest rate environment and the ability of long-term care insurers to earn a rate of return on their invested reserves. I will get back to that when I talk about why companies have left the market.

If we look at slide 11, 1 can see very clearly here that the profile of individuals buying the policy has changed over the last 20 years. Number one, people who are buying the policy are much younger. They are wealthier. They tend to be employed and college-educated. So you can discern a shift over the period of a very different type of purchaser.

And, if we turn to the next page, in order to capture some of this shift, looked at between 1995 and 2010, just took the income distribution from the Census and split it up into thirds and said for the purposes of trying to

understand whether or not the policy over this time period we see an increasing or a decreasing share of middle-income buyers. Define low-income buyers as people less than a third of the income distribution; middle-income buyers, between 33 and 66 percent; and high-income buyers, over 66 percent.

And what you can see over the period is that the proportion of buyers is coming more from the upper income spectrum of the income distribution and less from the middle income.

Next slide.

The main reason that people choose not to buy policies is because they cost too much. Given what I just showed you about the shift over time away from the middle market, changes in premiums, that is not surprise.

What is interesting, though, is that if you track over a 15-year period what the primary reason is why people have not bought, it is almost like a 50 to 60 percent rule. Or, sorry, a 55 to 60 percent rule. Always about 55 to 60 percent tell you that policies cost too much and that is why they are not purchasing them.

Next slide, please.

There used to be, I think, a notion out there that the only reason to buy long-term care insurance is if you want to protect your assets.

When you ask people why--and we have surveyed people over the 20-year period in 5-year increments--why they buy policies, two things stand out. One is that there are a lot of different reasons, and number two, that when you think about it, most of the reasons why people buy the insurance are related much more to lifestyle and consumption and not just asset protection--the desire to be able to purchase services so you can stay living at home, so you are not a burden on your children, and so on.

Next slide.

There has been public policy support for growth and development in the private market. I choose sort of three broad categories:

There is the Health Insurance Portability and Accountability Act, which gave tax qualification status to the purchase of long-term care insurance.

There are partnership programs that allow people who purchase qualified policies, if they complete their benefits--they run out of their benefits--they can access the Medicaid program without having to meet certain income and asset thresholds.

And there are state tax incentives for the purchase of long-term care insurance. In more than half of the states, there are such tax incentives.

One thing I want to point out, and that is the fact

that few individuals actually benefit from the tax benefits if you look at the income distribution of people purchasing the policies, and this is even back in 1995 and 2000. The benefits require you to itemize deductions and so on, and if you look at who goes about doing this, not many people get HIPAA benefits.

The same thing--there has been research showing the impact of state deductions as a practical financial matter does not have a big impact.

The importance of it, however, though, is to signal consumers that the government thinks citizens should give consideration to the insurance, taking personal responsibility. But at least, heretofore, there is little meaningful subsidization of the product. I want to make that point.

Slide 16.

The product has been around long enough now so that we have been able to conduct some research on claimants, and this is research that was funded by the Department of Health and Human Services, ASPE, that looked at a cohort of long-term care insurance claimants over time.

And there are a lot of data on this page. I just want to make one general point, which is while in recent years there have been a number of questions raised about the claims paying practices of certain companies, the empirical

data shows that the vast majority of policy holders who require benefits are well served by their companies. Claims denial rates are relatively low. It is not like there are a large number of people that have to quarrel with their insurance company in order to access benefits. And most of the claimants felt that in the absence of their policy they would not be able to get the level of service that they need to stay at home.

So there is a fairly--at least with respect to this particular aspect, which, at the end of the day, this is where the rubber meets the road. When you buy insurance, you want to make sure that when you actually need it, it is going to be there for you. And, at least at this point, it is fair to say that the industry is scoring fairly well on that measure.

Could we skip to slide 18?

Actually, slide 17 said Recent Trends, significant market exit among major carriers, and that is how I want to finish up in my remaining 3 or 4 minutes.

There are very few companies selling private long-term care insurance. Roughly a dozen companies are still selling a meaningful number of policies. In 2002, AHIP reported at least at some level over 100 companies selling policies, not all a large number. Now you can count the number of companies on two and a half hands.

We conducted a study, again funded by the Department of Health and Human Services, that looked at why companies were leaving the market--what was driving companies out--in particular, over the last five years. And the single most important reasons for why companies have left the market has to do with the inability to hit profit objectives and the capital requirements needed, that the companies had to set up in order to support the products.

While most companies have indicated that there are sales challenged and so on, and these were considerations and factored in their decision, it was never cited as the primary reason for leaving the market--was the challenge about sales.

Next slide, slide 20. Thank you.

It is also not true necessarily that the concern about hitting profit objectives was driven by poor claims experience. What this slide shows is the cumulative experience of the industry--how much companies expected to pay out at this point and how much they are actually paying out.

And what it shows is, at least by 2009, there was an actual-to-expected claims payment rate of 103 percent. So the industry was paying out 3 percent more than it had anticipated.

It is true that in the last couple of years experience

has deteriorated, but this is not what has been making it so difficult for companies.

We asked companies whether they would come back to the market, whether they would consider coming back to the market.

The next slide, please.

The current management of most carriers who have left the market indicate that they are not very likely to reenter the market anytime soon, and that comes out very strongly. Thirty-six percent basically said, not going to happen. This is current management.

We also asked companies--next slide--are there circumstances under which you might reconsider or things that might need to happen in order to get you to come back into the market? And this shows there are a lot of varied reasons, having to do with changes to the structure of the problem, certain regulatory changes, changes in tax policy, and so on.

I believe this is the last slide.

There remain key demand and supply issues in the market, and there is just a short list here--the lack of information, shrouded attributes about the need for long-term care in the future, misperceptions among the public, myopia, misunderstanding about public and private coverages, confusion about the product and mistrust of the industry.

There are also supply side issues that make it very difficult for the industry. For example, there are common shocks that the industry has no control over, like a complete falling out of the market of interest rates. No one would have predicted zero interest rates for the last four or five years.

To conclude, by all measures, the private market is not meeting initial expectations. I think everyone would agree with that.

There are public policy and regulatory approaches that should be explored and designed to help the industry reset to attract a middle market of buyers--things that lower the cost of policies, allow greater product funding flexibility, support new forms of combination products and so on, provide companies with more certainty around rate relief and so on, and encourage strategies that help to minimize risks that are outside of the control of certain companies so that capital requirements can be lowered.

So, with that, I will stop.

Thanks very much.

[The prepared statement of Mr. Cohen follows:]

Chairman Chernof. So, on behalf of the entire Commission, I want to thank the panel for an excellent set of presentations that really help us set the table.

I would like to start with Commissioner Brachman to my left, and I would ask you to pose a question and to the person who you would like to have respond.

Commissioner Brachman. Thank you, Dr. Chernof.

This question is to Dr. Cohen. Just looking at your conclusions, I wonder if you could go into a bit more detail as to what might make the market better.

Hearing what Mr. Hoagland had to say about the apparent lack of public resources that will be available in the future, then it would seem that--I am looking at the private market--would be a desirable alternative. So could you address that in a little more detail, please?

Mr. Cohen. Sure. I will start by saying that I am not sure it represents a full alternative. My own personal view is that there needs to be both of these markets working together in various ways.

And actually a number of the solutions that have been put forward are summarized really nicely in a SCAN Foundation paper that looked at: What can we do to try and jumpstart the private long-term care insurance market?

Let me just throw out a couple of ideas. And I will try and be brief, but I think the paper goes into a lot more

detail. I think it is a fun read.

[Laughter.]

Mr. Cohen. So, number one, I think on the demand side, simplification and a little bit more standardization of the products I think could really help. There is evidence that suggests that when consumers are faced with multiple choices it serves to paralyze their decision-making.

And we have some examples from, for example, the State of Minnesota--the Federal Long-term Care Insurance Program--where you had a smaller number of select packages of benefits that people could purchases, and they had much higher success in take-up rates.

So that is number one.

There are also elements related to the structure of the product. I mentioned level-funded premiums. That has caused a lot of problems for the industry.

There are other designs that may be particularly attractive--combination products, linking it with--and there are combination products out there in the market right now.

Term pricing of products, indexing premiums and benefits to make it more affordable to the middle market.

Linkages to other products--also, you could think of linkages to health care so that, potentially, selling costs can be reduced so that the product is more affordable.

There are issues related to risk spreading and consumer

understanding--education campaigns. You could imagine that when individuals turn 65, forcing people to make an active choice, making long-term care insurance part of the exchanges so that people become educated about it.

And there is just the general choice architecture, for example.

There is a central role for employers to play. I showed you that that market is growing significantly. Employers are often trusted sponsors of products. They offer an efficient means of distribution. And it may be the case that employers are mandated to offer--make an offer to employees--so that people become more aware of the product.

I do not want to hog all the time, but those are some of the ideas.

Quickly, on the supply side, one could think of multi-state reinsurance pools to provide some protection to the industry against what are called common insurance stocks, where the industry has no control over these but gets hammered. And there are examples of that in flood insurance and so on.

Such reinsurance pools may also require less capital to support the product, which may allow more companies--may make it more attractive for companies--to return to the market.

Commissioner Brachman. Thank you.

Commissioner Turner. Thank you all very much for your testimony. It was very informative, and I know it was produced on a very short time frame. So thank you so much for giving us so much information so efficiently.

Dr. Cohen, I would like to follow up a little bit on what you just said.

I was intrigued by the slide about circumstances under which the companies would consider reentering the market. Forty-six percent was other. Were those some of the ideas on slide 22? Were some of those ideas that you just talked about some of the changes in policy?

Are there other things as well--tax policy changes, et cetera--

Mr. Cohen. Yes.

Commissioner Turner. --looking at your slide 15 about tax policy changes that might help?

Mr. Cohen. Yes. I mean, it all ties together.

You have got people who have been approached by these policies who say they are too expensive, and so you see the shift toward the upper-income market. Anything that would reduce the cost of policies would make it more attractive.

However, that is not enough. I really believe strongly that you need a multi-pronged approach.

There is tremendous misinformation out there.

There is myopia about planning.

And so I think--so the answer to that is yes, that tax policy certainly would help. Anything that makes the policy less costly, distribution--finding ways to distribute the policy more cheaply will lower the premiums, and so on.

So the reason I said--I think to the first question--that in all cases there is going to be a public and private role is because the reason to encourage people who have the means to plan ahead and protect themselves is so that the social safety net is designed precisely for those who cannot avail themselves of private alternatives. I mean, that is the whole reason for thinking about how to get the private market to work.

And, in terms of more of the reasons, very shortly, ASPE, the Department of Health and Human Services, will publish a paper that has much more detail on the specific items, and that will be out well before your work is completed, probably within the next few weeks to a month or so.

Commissioner Anwar. Hi. Thank you all for your presentations, excellent information.

I just had a question for Kirsten Colello on your presentation. Did I miss that, or was it included anywhere, where the public at the back end of things reports because of the overhead costs?

For instance, by an example, patients who are in acute

care facilities and do not have insurance and have an acute event that snowballs into complications and are in the hospital for prolonged periods of time, and they cannot be discharged because you have to meet a safety screen, and it all adds up to overhead of the facility and has to be calculated back in, and the public ends up paying for it, obviously, in higher costs.

So is that a part of the equation where you presented the estimates as to how the costs are growing?

Ms. Colello. If you are talking about acute care expenses in a hospital setting, then those would not be part of any of the National Health Expenditure Accounts that I was reporting since those were specific to the long-term services and supports payments that Medicare or Medicaid or other public programs are making.

Commissioner Anwar. Right, because some of these patients have Medicare, and they run out of their Medicare days, and they have no other insurance. They are those that are waiting for some sort of support.

And there is the next group of patients who have--there is no support system at all, financially, to support their care, and they are just lying in these acute care facilities, but they are really long-term problems.

Ms. Colello. Right.

Commissioner Anwar. And I have seen some lying there

for more than a year, two years sometimes.

Ms. Colello. Right. So the National Health Expenditure Accounts that--the categories that we looked at were specific to skilled nursing facility and home health payments. It would not involve an acute setting even though you are talking about something that is more chronic or ongoing.

Commissioner Anwar. Right. Thank you.

Commissioner Feder. So, again, thank you all for your testimony.

Kirsten, I wanted to ask you a couple of questions.

First, I wanted to clarify your comments in making the Medicare and Medicaid distinction in terms of what kinds of benefits are covered, and you talked about Medicare as having limited access to personal care services.

I would just say that it is not necessarily--they are not statutorily limited to short-term. They have functioned that way, and there is lots of controversy about that.

And I also wanted to point out that I think that as Bill--and I appreciate your budget expertise and your noting that long-term care newness--that counting home health and skilled nursing facilities in your growth in those services, those expenses have grown so dramatically. Having, most people would say, very little to do with personal care services might heavily influence those projections.

And now to my question, when you looked--when you talked about the rules for eligibility--and I appreciated the information you gave us.

I wondered if you would, one, comment on the variation in actual practice across states and the variations in Medicaid services and coverage and availability across states. My own work suggests it is quite varied and quite limited in many, if not most, places.

And then, secondly, I wondered whether you had looked and CRS had looked at the issue of--you talked a lot about the asset divestiture.

And, again, my Georgetown colleagues did some work not so long ago and found in the research that there were far less creation of trusts than people would expect, far less protection of assets, that people most likely to need long-term care were actually likely to save more and avoid spending in order to be able to take care of themselves, and that the direct assessment showed very few actually transfers of assets, in part perhaps related to the rules, but the exploration shows it is really quite minimal and that most of those people have very limited resources.

So I wondered if you had looked at that.

Ms. Colello. Thanks. Those are really good questions.

To talk about the variation in eligibility in Medicaid, across states and within services, I think the important

thing to understand about Medicaid eligibility and service options is that there are some services that are mandatory.

Let's talk about eligibility. There is one eligibility pathway that is mandatory. The rest are optional.

So, when we look at the variation across states, it is largely those optional eligibility pathways that states are choosing to take up, and there are five or six different optional eligibility pathways which focus on particular populations, whether they are elderly or disabled, and focus on--and have different income and resource requirements that are attached to each.

So it is hard to actually tell you anything specific without saying, it exists and it is very large and different.

So it means that one person might be Medicaid-eligible in one state, but in the next state over they may not be.

In terms of variation in services, it is the same situation. You have certain services that states have to offer through their state plan. Others are optional, and most of the home and community-based services are optional services.

What that has created is ways for states to offer HCBS largely through what are called these waiver programs. And so, within the waiver programs, what you see within 1915© is the Home and Community-Based Waiver Program. Many states

are using these. There are over 300 in the Nation.

So states are not just using one or two. They are using seven or eight within their state to target particular HCBS services to a particular group.

And this helps states because they can offer services to particular vulnerable populations but control costs. They can control the number of people who are eligible for the waiver. They can limit the services and provide services on a less than statewide basis--so, target certain geographic areas.

And there has been a lot of movement in these waivers over the past few years. The trend right now is actually into managed care within Medicaid, and some states are using these waivers and combining different waivers, or consolidating waivers, to offer managed care as a delivery and financing option to Medicaid-eligible individuals, particularly who need LTSS.

Commissioner Feder. And on the transfers?

Ms. Colello. The transfers--we have not done any analysis on that, and I would like to see someone who would do analysis on that. It is a great question.

I think there has been really a lack of information and evidence since the DRA in 2005 to really understand the effect of those provisions on Medicaid eligibility.

Ms. Tumlinson. Mr. Chairman, can I just make one

remark with respect to that question?

This is a very difficult issue to analyze in the data that we have available to us, and lots of researchers have tried and come up with very different conclusions.

The only thing that I can offer here is that one of the things that we try to do in our work is to go beyond the National Health Expenditure data to understand how people actually pay for long-term supports and services beyond what is recorded as a National Health Expenditure.

So the Federal Government collects data on how much is spent on nursing facilities and home health agencies, but they do not necessarily collect data on what people spend for a lot of different types of residential care settings that are not considered health care. So they do not come up in the National Health Expenditure data, and we do not get that information about how much people are spending on them.

So what happens is that good, solid analysts like us--we try to do the best we can with the data we have, but we miss the fact that people are actually spending a tremendous amount of out-of-pocket dollars of their own personal funds on assisted living, on independent living, on all kinds of variations of that, that are not considered health care.

And my own kind of hypothetical view, or my view of this, is that it demonstrates at least a willingness on the part of a lot of people, many of whom, by the way, are--that

funding is coming from their adult children.

So some work that NCAL did and the National Investment Center did showed that, in fact, like 30 percent of people living in assisted living were receiving the funds for that from their adult children.

So we see at least a willingness on the part of quite a few people to fund long-term care out of their own private pockets and even the pockets of their adult children, I think, making this view of the spend-down issue a lot more nuanced than sometimes you get when you just look at the data sources we have available.

Commissioner Feder. I really appreciate that addition, and I think that speaks to a couple of things. One is transfers go both ways, and that is one thing. And I think it also speaks to the distribution of the out-of-pocket in the public, that not only is the health side being exaggerated in the Medicare and Medicaid piece, but the out-of-pocket spending is being underestimated--

Ms. Tumlinson. Under, exactly.

Commissioner Feder. --for the reasons you said.

Ms. Tumlinson. Yes, yes.

Commissioner Feder. So thanks very much.

Ms. Tumlinson. My just final point on that is just that it speaks to the public policy response to that is important, whether the problem is out-of-pocket or the

problem is the Medicaid. What problem is it that you are trying to solve?

Chairman Chernof. Thank you.

Commissioner Pruitt?

Commissioner Pruitt. Thank you. I, too, appreciate your testimony as very insightful.

Sticking to the Medicaid transfer issue--and I understand that we do not necessarily have the data to estimate, to your point, that amount--I am particularly interested in when you talked about the partnership programs and the lack of adaptation by the consumer to be likely to purchase that program. Do you think that asset transfers fall into one of the problems for the lack of consumer interest?

For instance, if we were to tighten the asset transfer rules, do you think we would see more penetration in that market?

Mr. Cohen. So that is very complicated issue, and there is a lot of anecdotal evidence on both sides.

There has been some very good research done--theoretical research done--showing that the Medicaid program crowds out a large section of the public that would buy private insurance.

I am among those who are more skeptical of that, but the reason is maybe a little bit different. I have been

looking over the last 20 years at people who are totally confused when they are in their 40s and 50s and early 60s about what Medicaid is, what Medicare covers and what it does not.

So the notion that at the time you would be making a purchase decision, let's say at those younger ages, that there would be such a large swath of people who would be saying, you know, if I become disabled, I am not going to buy this insurance because I know that I am going to be able under all circumstances to rely on Medicaid.

There are those people who believe that, but it is not necessarily related to the asset transfer. It is misinformation about what public programs cover, which is a separate issue from this whole asset transfer. There is a lot of controversy--a lot of controversy--about that.

Commissioner Pruitt. Thank you.

Commissioner Claypool. Again, I thank you for spending part of your afternoon with us and on such short notice. It is really appreciated.

So I would just like to ask maybe almost rhetorical questions to open with and maybe to Marc.

How many individuals that have current long-term care needs are really being offered a long-term care insurance product in the individual or group markets? Do you have any idea?

Mr. Cohen. People who--

Commissioner Claypool. People that currently need long-term care services.

Mr. Cohen. I would say that would probably be zero.

[Laughter.]

Mr. Cohen. But I may be off.

Commissioner Claypool. Okay.

Mr. Cohen. By one. But that would be zero.

Long-term care insurance is a voluntary insurance product, as you know, and so there is underwriting of that product as there is with all voluntary insurance.

Commissioner Claypool. So it is an important point to note when we are talking about an extraordinarily large population of individuals that need these services.

And I would like to follow up a little bit with Kirsten. Forgive me for my familiarity with using your first name, but--do you have any idea about who is paying out-of-pocket for what services?

Does your data tell you anything about these individuals--the needs they have, what their spending the money on, what types of services they are purchasing, their economic circumstances, are they working?

Ms. Colello. Yes. Not the National Health Expenditure data--Account data.

I am trying to think if there are other data out there

that may. Nothing as robust as what you are talking about.

Commissioner Claypool. Thank you.

I largely asked the question just to note that we are dealing in largely the dark here, and we need a great deal of rigor brought to these issues if we are ever to find a way out of the circumstance that we are trying to deal with today.

And it really does begin with digging deeper into some of the data. It is a challenge, and our colleagues at HHS and ASPE have been toiling in these fields.

But I think one population that I would urge, maybe if CRS ever has a chance, is to really look at working age individuals that are paying out of pocket for long-term services and supports and exactly what are they buying, you know, how much are they earning, something along those lines.

And then lastly, not to consume all the time, I wanted to turn to Anne and ask a little bit more about this population that is typically under age 65.

You mentioned some of the diversity in that population that relies on LTSS. Can you speak a little bit more to-- you have talked about functional impairment and developmental disabilities, but I believe there are people with behavioral health issues that also receive benefits through the program.

Ms. Tumlinson. Sure. Well, this gets to the real challenge in defining this population because what we do is we rely on survey data.

And the survey data ask this question, which is, what degree to which do you need assistance with an activity of daily living?

And if somebody responds that they do in one or more, we typically tend to consider that person to be having a need for long-term services and supports. But there are also--there are populations that are often missed in that data.

So, for example, we worry about folks with cognitive impairment not always showing up in that data because they may appear to their family members to be functioning in many of these activities even though they, in fact, might not be.

So another population that you mentioned that we have actually studied quite a bit is the population that has severe mental illness under the age of 65. In fact, this is a population that uses a tremendous amount of services and supports and particularly when there is co-occurring substance abuse. So their medical care actually tends to be quite high, and they also tend to be dually eligible for Medicare and Medicaid and on disability--various disability programs.

So that is definitely one of the--a population that

does not show up in the survey data but that does have some need for services and supports that is not going to necessarily be captured in that group.

And there are others too, but I think that--so, for example, when we did our--we built our model. We looked at the survey data, and then after classifying everybody we realized that we were actually missing quite a few people in the developmental disability category because really there are just so many different kinds of conditions that can actually--that are a result of development, that do not necessarily show up in that data. And those folks have actually tremendous need and tremendous service use.

Ms. Colello. Can I just add a point about some of the data issues that I have come to experience?

I think the challenges in studying and surveying a long-term care population are a couple. One is setting. It is hard to come up with a national survey that looks both at the community population as well as institutional or even a residential care facility population, and then across age span.

So you tend to have a survey that just focuses on 60, 65 and older, and we are missing the younger adults and children with disabilities.

So to come up with a large sample frame and a large survey that can look at and get data nationally, to actually

drill down and have population estimates that look at these different populations, is really expensive and time-consuming.

Commissioner Claypool. And, finally, gosh, Bill, it is really not much of a question, but when looking at Medicaid and the growth of costs there, it appeared in some of the data that Medicaid spending is lower than health care spending in general.

And I am wondering if you have any views on future payers of long-term care. Is perhaps the Medicaid program a rather efficient purchaser of these services and might we be looking to them in the future as a model to pay for these services for people that need them?

Mr. Hoagland. Looking to the Medicaid payers to pay for long-term?

Commissioner Claypool. Right. The per capita costs grow at a slower rate than health care costs in general.

Mr. Hoagland. I will try to very bipartisan about this since that is the organization I represent and as you know my concern about the rate of growth in total public spending and debt.

I would think that--I still would think that the direction one would want to focus is to try to encourage private, not public, expenditure in the future, and that would probably be the direction I would prefer to see you

go.

Ms. Tumlinson. Can I just respond very quickly to that?

Commissioner Claypool. Sure.

Ms. Tumlinson. I would just point out that Medicaid spending on long-term care, in fact, has really steadily remained a third of Medicaid budgets for as long as I have been working on this issue. It has not grown as a proportion of Medicaid. In fact, it probably will decline as a proportion of total Medicaid spending in the advent of the implementation of the ACA, at least for the near term.

Again, I think it is important to understand what problem it is that you are trying to solve. The problem with Medicaid is not so much at the moment, how much we are spending as a government on it. The problem with Medicaid is the fact that it is not an insurance program.

It is a safety net program, and it does not actually pay very well for supports and services. Anybody who operates a nursing facility will tell you that, and anybody who operates a home and community-based program will tell you that. People living in the community, getting supports and services from home and community-based service programs are not getting largely as much as they probably need to be safe and remain in their homes.

So, you know, the growth--I do not see the growth of

this program to be the issue. I think the issue is that it does not, in fact, meet the needs of people who are eligible for it and it does not reimburse providers adequately for those services.

Commissioner Claypool. So just basically to close--

Chairman Chernof. Yes, then we can move on.

Commissioner Claypool. --given the constraints that we have been hearing about with the budget, I look forward a solution to that problem. If our only payer for people that currently need it really is not doing it efficiently, we have work to do, don't we?

Chairman Chernof. With that, I am going to move us on to the next commissioner.

Vice Chairman Warshawsky. Again, I will echo my fellow commissioners in thanking you all, every member of the panel, for a truly, truly excellent presentation, wonderful.

I would note--and this is just a note--that the interesting questions that the commissioners were asking around this issue of spend-down, eligibility, who gets what and whether there is gaming going on--I think it is worthy of a deeper dive, and I hope we can--the Commission can--do that.

My question is to Anne Tumlinson.

So it is actually specifically on chart 11. There are two questions.

One is I am a little confused by the axis. The projected number of Medicare beneficiaries--and this is what you call the size of a long-term care population. I am little just confused by that.

Ms. Tumlinson. Yeah. Well, you know, I think that is because your chart is mislabeled.

Vice Chairman Warshawsky. Oh, okay.

Ms. Tumlinson. Yeah. So I am really sorry for that.

We had about 12 iterations of this yesterday, going on among my staff and me. And the one that I have says we project the size of the long-term care population. So this not the Medicare population.

Vice Chairman Warshawsky. Thank you very much.

Ms. Tumlinson. So I can see why you would be confused.

Vice Chairman Warshawsky. Okay.

Ms. Tumlinson. Yes.

Vice Chairman Warshawsky. That was a great clarification.

Ms. Tumlinson. No, it is an important question.

Chairman Chernof. I will give you another question.

Vice Chairman Warshawsky. Yes, I will take another question.

I have a substantive question now on this, and that is to the nature of your projection, which clearly is related both to the demographics--the age groups and so on--as the

rate, but it is also the rate of impairment.

Ms. Tumlinson. Mm-hmm.

Vice Chairman Warshawsky. So you indicate a little bit about your assumption, which is you indicated that--very briefly, I think you said you had further decline in rates of impairment, but then you have it flat.

Now, if you could tell us a little bit more about, you know, I guess the basis of your assumption simply because my read of the literature is that in the elderly population there have been actually very nice improvements in terms of less rates of disability, and this has been going on for some time.

I am much murkier in my read of the literature--I just do not find the data--in terms of the under age 65 population. Perhaps you could just tell us a little more about that.

Ms. Tumlinson. Sure. Yeah. No, that is great. I would be happy to do that.

So it is true that the literature at least is showing thus far--and let me just say something about projections, right?

So projections are--really, all they are is your best understanding of history, right?

So a projection has to always be tempered with, yes, this is what happened historically or this is what is

happening today, and based on that we can make some assumptions about what might happen in the future.

So what we see in the literature, or at least in the data I should say--a lot of work that has been done on the National Long-Term Care Survey--is that we are seeing that the rate of--I am going to use the term, disability.

Earlier today, I was defining this population as being that term I am now using interchangeably with functional impairment--so, folks who have a need for long-term care.

In the elderly population, this group, this subgroup, has actually been declining as a percentage of the elderly in recent years.

So, when actuaries--and this is actually a really important issue with respect to private insurance as well.

So the challenge really is to understand what is going to happen to the rates of disability in the elderly population or in whatever population you are studying in the future.

And so what we have done is take what I would consider to be kind of a middle-of-the-road or conservative approach to this, which is simply, what is it that we do not want to make the mistake of doing when we do not want to underestimate the rate of disability in the future?

In other words, we do not want to underestimate the cost of a program.

So, if the purpose of the model is to try to peg what would be the cost of long-term care insurance benefits that would then have to be paid for by premiums, what we want to do is essentially say: All right, we understand this trend in the literature. We are going to assume that it continues at a very moderate rate over some period of time.

And so these are age-specific prevalence rates, and then we are just going to assume that those rates at those age bands stay the same from that point on, 2025 forward.

And this is also in part because we are looking at the whole population. We see somewhat good research in the over age 65 population but very, very bad information on the under age 65 population, like wildly speculative. You know, one way versus the other.

Oh, obesity rates are going up. You know.

When we look at nursing home use, we actually are seeing an increase in use--long-term use--of nursing homes. There is sort of this like little pocket of people who are, in fact, using nursing homes for things like post-acute care for obesity.

And so we ask ourselves, well, what will those trends be?

We really do not know. So this is a hedge to some degree.

Vice Chairman Warshawsky. Thank you.

Ms. Tumlinson. So it was a longer answer.

Chairman Chernof. My question is for Mr. Hoagland.

You ended with two kind of key take-home points you wanted the Commission to give some thought to. Could you, for me, restate the second point?

Mr. Hoagland. The second point--and it relates directly to what the Vice Chair just said about the spend-down. I think there is an issue, and I am just looking at the data.

And I will preface this by saying, I still look at the fact that, in 1970, 40 percent was out of pocket and 25 percent was Medicare and Medicaid, but today 12 percent is out of pocket. I think there is an issue here as to what is going on.

So what I simply said was--and I will restate it--that once you achieve access to Medicaid, however you get there--and I am looking at that middle-income group that Marc said was a reduction in private insurance.

If you gain access, however you gain that access--by spending down or releasing your assets--once you gain that access, then it is after the insurable event. So there is no way you are going to sell insurance to that individual because they will have qualified for Medicaid, and that is probably one of the more, as I said, long-term, most expensive group.

And all I said was at that point private insurance is unavailable, and personal income and assets have been put at risk.

And so all I was suggesting--it is just a thought. It is very well intentioned, good public policy. We should be taking care of this population. But the design of Medicaid may have precipitated the growth in the Medicare costs at the expense of individuals' out-of-pocket private responsibility.

That is all I am saying. That is the interaction.

Chairman Chernof. Thanks. That answers my question.

Mr. Cohen. Can I just add one point?

Chairman Chernof. Sure.

Mr. Cohen. I just want to make sure that you know the reason that we talk about this in an insurance context, and I think it is most people are not going to have major catastrophic long-term care expenses. Most people require the care for less than two years. There is only a small probability that somebody is going to experience catastrophic expenses, which is why, regardless of who sponsors the insurance, it is an insurable--an insurance product.

As we talk about the different population groups and so on, we have not focused, I think, enough on how long people actually require services. And I just want to make sure

that everyone understands there is a group--and we do not know where we are on that distribution--for whom long-term care is a catastrophic event, and there is also a very large group for whom it is a relatively short-term event that is not going to lead to a catastrophic financial event.

Chairman Chernof. Thank you for that clarification.

Commissioner Raphael. So I have a question for Marc and one for Anne in line with what you just said.

I have heard recommendations to address the affordability issue of trying to change the duration or characteristic of the benefit from making it a one-year benefit that kicks in after a catastrophic event to having a two-year duration and only having home care as the available service. So I was wondering if you thought that kind of redesign would have any significant impact on affordability.

Mr. Cohen. I absolutely do, but here is the challenge. For example, for me, the perfect policy would be where I have to pay my own expenses for a year or two years, and then after that--

Commissioner Raphael. Right.

Mr. Cohen. --insurance takes care of it so that I have taken care of the catastrophic part of it. That type of insurance is not allowed right now on the market.

A short-term policy that you are talking about, if it is less than two years, it cannot be defined as long-term

care insurance on the market today.

The only issue I have with that--first of all, so you have to be very clear about what it is you are buying. You want to make sure the consumer really understands that. There is a tradeoff between lots of different kinds of policy designs and the simplification that I was talking about earlier.

Commissioner Raphael. Right, and the standardization--

Mr. Cohen. Exactly.

Commissioner Raphael. --à la Medigap policies--

Mr. Cohen. Exactly.

Commissioner Raphael. --that you want to achieve, right.

Mr. Cohen. However, if you have a one-year policy, I believe a one-year policy is going to cover probably 70 percent of the need out there. I think--I believe that 20 percent of the people will need care for longer than 2 years.

Maybe my colleagues can help me out, if that is the right statistic. I do not want to put the wrong statistic out there.

Commissioner Feder. My recollection from--

Mr. Cohen. Sorry?

Commissioner Feder. My recollection from the Comisar-Kemper study is it is 40 percent need more than 2 years of

some kind. You know, it is not an expense. It is the likelihood of need.

Mr. Cohen. Yeah.

Commissioner Raphael. So then my question for you, Anne, is a question about the so-called what might be the Ham Sandwich Generation will probably become the Avocado-Tofu Generation of the future.

But from your demographic analysis, we are relying primarily today on informal caregivers--families and friends. As you look at demographic trends, to what extent do you think we will be able to continue to rely on the caregivers in the future?

Ms. Tumlinson. That is a good question.

I worked on a paper for the last commission where we looked at this at some depth, I guess, and the conclusion is essentially that we are--first of all, most caregivers are women. It is, by far, a job that is performed by women, by adult daughters and, to some extent, spouses.

And so, while there will continue to be women to perform these tasks, the demands that are being placed on them from both a workforce perspective and also from--you know, there are fewer children being born, so there are fewer daughters. You only need one, but--

[Off microphone response,]

Ms. Tumlinson. Yeah, a good one. Right.

But I think there is a view that, increasingly, the demands will outstrip the supply, so to speak, of that.

And, really, they are providing the vast majority of long-term services and supports that are being provided in this country.

Yeah, I could go on.

Mr. Cohen. Can I add just one point on that--because I looked quickly at some background information I have.

So a recent study shows that for a couple turning 65 the expected out-of-pocket spending on long-term services and supports over the remaining years is around $63,000. There is a 5 percent chance that you will spend over a quarter of a million dollars.

Commissioner Raphael. Thank you.

Commissioner Guillard. Again, thank you very much for your testimony.

I have two quick questions--one for Anne and one for Dr. Cohen.

Anne, on this slide on page five, that is a snapshot, correct?

Ms. Tumlinson. Oh, yes. Thank you.

That is right. That is a point in time.

Commissioner Guillard. Right, because--

Ms. Tumlinson. Yes.

Commissioner Guillard. --we have far more people that

move through nursing homes, for example, than 1.3 million, and it is predominantly because of the increase in short-stay activity.

Ms. Tumlinson. Yes. Yeah, actually, just to comment on that--thank you for raising that. That is a very important point.

So this is--in fact, especially since we have been having a lot of discussion here about the skilled nursing facility benefit under Medicare and long-term care, in my mind, those are two very different things.

And I have certainly been guilty in the past of counting SNF spending in Medicare as part of long-term care, and I really would not do it anymore.

Home health is a little bit of a different story, but the skilled nursing facility benefit is, in fact, not part of this.

So all we are counting in this estimate are people--at any point in time, the number of people--who are, in fact, living in nursing homes as their primary residence, not people who are at any point in time receiving care from a nursing facility because, in fact, that number--and I do not know right off the top of my head what that is, but it is, in fact, quite large.

Skilled nursing facilities are, in fact, the primary point of discharge for formal post-acute care, coming out of

hospitals, and actually the vast majority of them are actually discharged home.

So, in fact, while the spending is very high for these people who live in nursing homes, that population is really quite small relative to those who use nursing homes in general.

Commissioner Guillard. And my second question is to Dr. Cohen.

First, I have studied and been interested in this issue of private long-term care insurance for several decades, and I have to tell you this is the best presentation and synthesis of data and information I have ever seen. So, my compliments.

Now, secondly--

Mr. Cohen. Now you have to ask me a question?

Commissioner Guillard. Yes.

[Laughter.]

Mr. Cohen. We cannot end there?

Commissioner Guillard. No.

Mr. Cohen. No, that is how it goes.

Commissioner Guillard. And here is my point. In the early days, I always questioned kind of the marketing approach to this, and you have affirmed that--that it was focused on kind of telling people, well, your probabilities are 1 in 4 you are going to go to a nursing home, and to

stay in a nursing home a year it is $100,000.

And that is kind of how those policies were marketed when, in fact, in my last 20 years of a 40-year career in long-term care, okay, every year we used to look at what the percentage of revenues were from private long-term care insurance, and it was ½ of 1 percent. It did not matter how rapid the growth in policies, or how slow the growth. It always was constant, and I was always perplexed by that.

And the answer I came to was that it really is not a benefit for nursing homes. It is a benefit for long-term care.

And the reason is that over time what we have seen in the skilled nursing industry is that admissions volume is increasing dramatically and length of stay is very low.

The last company I was associated with--we admitted 160,000 patients a year and discharged almost the entire amount, 90-some percent of those patients. Seventy percent stayed less than forty days. The vast majority, more than 50 percent, stayed less than 30 days. And they were transitory patients coming out of hospitals, recuperating and going home, which is the way the system in my opinion should operate.

So Medicare covered their stay, typically, and long-term care insurance never had an opportunity to kick in, if you will.

And, for the patients that tended to be chronic care and extended over a longer period of time, they really never had the ability financially to buy that policy.

So that is why, in my assessment, it just was de minimus.

Now, leading to my question--and that is it ties to what Mr. Hoagland said, which is we need to get to a point where we shift some of the burden to the private sector versus the public sector.

And, if we do that, it seems to me that the high cost--you have two options.

Number one, induce it via tax incentives, which then I worry about if you take it from tax, aren't you just shifting burden?

Aren't we moving sand, Mr. Hoagland?

We will come back to that in a moment.

And, number two, which I was intrigued by, Dr. Cohen, what you said is that moving the industry to form combination type policies where you merge long-term care needs with annuities or other components.

Why hasn't the industry moved more rapidly in that direction--because it just seems to me like that was a very logical, rational kind of comment.

Mr. Cohen. Okay. So I do not want to--I did not mean to paint a picture that that is not happening.

So there are combination products out there.

But just stop for a second and ask yourself: Long-term care insurance, not so easy to explain, relatively complicated product to explain. Annuities--that is a pretty complicated product to explain. Let's put them together.

[Laughter.]

Commissioner Guillard. A valid point.

Mr. Cohen. Okay. So I think there is a challenge there, but I agree with you that I think there are tremendous opportunities with new models of health care, the exchanges, and thinking about how to link in long-term care insurance.

So there have been a lot of life and long-term care insurance combinations. But, again, people buy life insurance for a particular reason; they want to leave something to their heirs and so on.

So, if you have a long-term care rider, you are buying it for a different reason.

On your first point, I just want to say that one of the things we have observed among claimants of long-term care insurance that goes exactly with what you are saying is when people have a policy they do not go to the nursing home. Many--we saw a big shift when we did studies that ASPE supported in the 90s and in 2000, where most people using their benefits do not do it in a nursing home. They go to

assisted living facilities, and they are in the community.

Commissioner Guillard. I have always believed--and Anne has heard me give this commentary--that you would stretch the public dollar, Mr. Hoagland, if you found a way to put a limit because you only need insurance for skilled nursing for a very limited amount of time.

Put that in front of Medicare versus behind Medicare. Then it would work, and then you would save money on the Federal budget.

Mr. Hoagland. Thank you.

Commissioner Guillard. And that is unsolicited advice.

[Laughter.]

Chairman Chernof. Commissioner Vradenburg, please.

Commissioner Vradenburg. I have got a couple questions for Ms. Tumlinson and one for Mr. Hoagland.

Ms. Tumlinson, I keep on going back to this chart 11, which we now have clear is the estimated increase in the total population that has functional impairments. It struck me that this is exactly the line that I see for growth in the number of Alzheimer's victims.

So what I am curious about is the relative growth in the over 65 population and the under 65 population.

Ms. Tumlinson. Mm-hmm.

Commissioner Vradenburg. Is most of this growth attributable to the over 65 and not to the under 65, or are

they growing at the same rate?

And, if that is the case, why is the under 65 population growing at the same rate as the over 65?

Ms. Tumlinson. So the--I am thinking. Hang on one second.

[Pause.]

Ms. Tumlinson. So what we did is we--yes, that is correct.

We are applying the essentially the same growth assumptions. So we are taking the prevalence rate at each age as it is currently constructed, and then we are growing it or not growing it at essentially the same rate simply because we do not necessarily have great data that suggest otherwise.

Commissioner Vradenburg. But the incidents--you are using incidents at an age, right?

So--

Ms. Tumlinson. Prevalence.

Commissioner Vradenburg. Prevalence at an age, okay.

But we know that the population is aging, that older cohorts are growing faster than the middle income--or middle age and lower cohorts. So why would you assume that they are growing at--that the rate of disability is growing at the same rate in all of those demographic components?

Ms. Tumlinson. Right. So this is a rate applied to a

number of people.

So, in other words, it is a rate--the rate of growth--in fact, this number is much higher as a result of the growth in the number of people over age 85 or over age 65, and it is taking into account the rate of--so it is a rate and a rate.

So there is a rate of prevalence within each--at each age, and then there is a number of people by whom that rate is then multiplied, if that makes sense.

Commissioner Vradenburg. So is there a reason for a rate of growth in disability in the working age population?

Is it that we have been able to extend life in Down's patients or other--

Ms. Tumlinson. We do not really have very much information at all about that population and how it is changing over time.

And, in fact, when we had to calculate, we faced this very big challenge with actually having to estimate continuance and incidence of the under age 65 disability, and we had to actually rely on estimates of change and even how disability acts over time in that population, using actually employment disability statistics because we lacked anything in the survey data that would give us any information about it.

Commissioner Vradenburg. Okay. What struck me so far

is that our public benefit program--Medicaid--is, as you characterized it, inefficient, and our long-term care insurance world, the private alternative, is sort of like weak to nonexistent.

You look at all these trends, and you say, my goodness, the public benefit side is not working, and the private benefit side is not working. So you do not know where to put your bets.

One of the things that has struck me is if you go back in history and look at what the projection was for polio health care costs, or you look in the 80s and 90s and look at the projections for HIV/AIDS health care costs, they will have this kind of line.

And one of the things that transformed it was innovation in the biomedical system that caused, at least with respect to those particular conditions, a dramatic change.

So I have not seen any discussion here about whether a prevention strategy to prevent disabilities, whether it is a research strategy or another kind of policy intervention strategy, that actually prevents the growth in the rate of the disabled population.

I do not know who to ask that to.

Mr. Cohen. I do not know if it is a question, but I will remind everyone that there has been a commitment made

at the Federal level to invest significant resources so that by 2025 we are able to eradicate Alzheimer's Disease.

Ms. Tumlinson. Mm-hmm.

Mr. Cohen. In all of the statistics, private or public, if there is significant on Alzheimer's Disease, that will have a major impact on all of the trends that Anne is talking about.

Commissioner Vradenburg. One last question.

Mr. Hoagland. I do not know if this answers your question.

Mr. Claypool and I were in a discussion with the Institute of Medicine a couple weeks ago, and the one thing--again, being somewhat naïve about all this, the one thing I will say is that I have on my iPhone an app that gives me my blood pressure and my weight in the morning.

There are lots of things I think in the area of productivity and technology that might be a way of improving the degree of prevention going forward that we have not really investigated in terms of this discussion.

Commissioner Vradenburg. Well, that is my other hat--advisory council member to HHS on Alzheimer's, but--one last question.

We talked about the private and public in the sense of the benefit programs and insurance programs. We have not talked about sort of private savings. So how might we

increase the capacity of the American people, or the incentives to the American people, to use more out-of-pocket money; that is, private savings plans?

We use college savings plans right now, right, to encourage people to save for college education through tax-incented savings plans. Are there other mechanisms by which we can build the capacity of the American people to sustain greater out-of-pocket costs as a percentage of this?

I think it is Mr. Hoagland.

Mr. Hoagland. The key question, and Mr. Warshawsky, the Vice Chair here, has done a lot of work in this area.

All I can simply say is the first issue is economic growth. You cannot save if you do not have income. And so the bottom line here is economic growth.

I also simply would suggest that there are things that we have experimented with over the years, in terms of savings programs, and have not been successful.

But I think that I would begin with the opt-out, that you are automatically enrolled in a 401(k) or a pension savings programs, that you have to opt out of that. I think that has been proven at least to be initial. And then to withdraw from that, I would make penalties harder than they are now, to maintain that.

But, again, it goes back to it does not do any good unless you have the income to save to begin with, and that

goes back to the basic fundamental problem of economic growth.

Chairman Chernof. Last, but not least, I want to give Commissioner Jacobs the prize for patience today. The floor is yours.

Commissioner Jacobs. Thank you, Mr. Chairman. That is the first time anyone has given me a prize for patience.

[Laughter.]

Commissioner Jacobs. Just continuing up on some of this conversation, I am interested in a little bit more information in the rate of spending growth in the long-term care population health expenditures versus health care expenditures as a whole.

And, specifically, the difference I think from some of the charts, Mr. Hoagland, you had provided, it seems to be slightly greater, particularly in prior decades.

But then also getting into a little bit of what the drivers of that are, is it more labor-intensive on the long-term care side of things versus health care versus technology, and what are the various factors to go into that?

I do not know if that is something that is beyond your bailiwick. I think that would be something that would be helpful in the future.

If we could get perhaps Dr. Elmendorf to come in and

brief on the chart pack that CBO put out yesterday, I think that would be helpful.

I do not know if you have any comments to that or not.

Mr. Hoagland. No, I would be misleading you if I thought I could explain to you the changes in these rates of growth.

I do think there is some benefit to be achieved as these programs have become--or as technologies improve, there certainly should be improvement in efficiency and productivity that would slow the rate of growth even. But we have also seen that, of course, recently in the overall rate of growth in total health care expenditures, and I think that is probably the major driving factor here in the slowdown in the long-term care actor also.

Commissioner Jacobs. And then I have two questions for Dr. Cohen, if he could briefly talk about--and I am interested in state differences in individual insurance policies.

In the health care insurance market, in the individual market, we see wide variations in rating, wide variations in premium, various benefit mandates.

What does a long-term care insurance market look like? Are there wide variations in the kind of rating, regulations, mandates, et cetera?

Are there variations in premiums from state to state?

Are there variations in take-up rates from state to state?

Are there some states that are better than others that we could look to as a model or that other states could emulate?

And I think that would be helpful in terms of bringing down costs, as you said.

And then the second question is more--

Mr. Cohen. Wait. That was only one question?

Commissioner Jacobs. That was only one question.

[Laughter.]

Commissioner Jacobs. The second element of this is the employer on the group side of things--the employer group's offering. You said there were roughly 11,000 groups with about 2 to 2.5 million certificates. So I am getting a ballpark average of 200 to 250 certificates per group.

What are the characteristics of the employers that are offering, and how do they differ from the employers that are not offering?

Mr. Cohen. On the last question, there is a terrific paper that was written by Jeremy Pincus and put out by the SCAN Foundation that really summarizes exactly that question. So I am going to defer because I will just be scratching the surface.

On your first question, you know, one of the challenges

that the industry has is that it has to file this insurance in 50 different--in 50 states. And there is what is called a National Association of Insurance Commissioners Model Act, which is an Act that basically allows for the most part a company to have some certainty about what is required in each of the states.

However, it is a difficult process, and there are state variations, and there are certain requirements that a state may have that another state may not have.

Typically, though, most companies do not price on a state-by-state basis. They come up with a policy. They have a price. And they file that policy across the states.

Sometimes the amount of time required to actually get approvals is a year, year and a half, and so on. So it can be cumbersome.

In terms of take-up rates, there are differences across states in take-up rates. I can say that those differences are not explained very well by differences in tax incentives provided by those states, and that is--

Commissioner Jacobs. Are they explained by differences in income?

Mr. Cohen. Yeah. So I would probably say income, concentration of individuals.

And your last question was premiums, regulations--

Commissioner Jacobs. Ratings.

Mr. Cohen. Yeah, I would say there may be some occasions where you have to have different ratings, and there are certain requirements around definitions of policies within the policy.

Chairman Chernof. With that, this concludes our first of several public meetings around long-term services and supports.

On behalf of the entire Long-Term Care Commission and all the commissioners, I really want to thank our four panelists today. You all presented on absolutely no notice, and we really respect and value your time. You have given us a great foundation and a lot to follow up on.

So I want to, on behalf of all of us, really from the bottom of my heart--our hearts--thank you for your time.

[Applause.]

Chairman Chernof. For the folks in the audience--just to answer some of the common questions we get asked all the time.

Again, we are really committed to open and transparent meetings, taking lots of open testimony. We think part of what we can do, besides try to answer our charge, is to help raise public awareness.

All of you are part of the soul that this is an issue crowd, but to the degree that you can help get that message out, the better. And to the degree we draw people in who

are not thinking about this yet, that is good as well.

So there will be a meeting schedule coming out shortly. I cannot tell you exactly when because we are still sort of finalizing how we herd all of us around here, but we will do that shortly.

We will announce our agendas in advance so that everybody will know what we will be covering.

Larry and his mighty team will be putting up a web site shortly, once we get our hands around the inner workings of the Senate, and that will allow you to find our work as well as will be a portal for other kinds of information as well as ways that we hope to take incoming information as well. So I would ask you all to stay tuned for that.

And I want to thank you all for being here today.

[Whereupon, at 4:19 p.m., the Commission was adjourned.]