PUBLIC HEARING:

STRENGTHENING PUBLICALLY AND PRIVATELY FUNDED

LONG-TERM SERVICES AND SUPPORTS

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THURSDAY, AUGUST 1, 2013

Commission on Long-Term Care

Washington, D.C.

The Commission met, pursuant to notice, at 8:33 a.m., in Room SD-562, Dirksen Senate Office Building, Bruce Chernof, Chairman of the Commission, presiding.

Present: Chairman Bruce Chernof and Commissioners Judith Brachman, Laphonza Butler, Henry Claypool, Judith Feder, Stephen Guillard, Chris Jacobs, Neil Pruitt, Jr., Carol Raphael, Judy Stein, Grace-Marie Turner and George Vradenburg.

Also present: Staff Director Larry Atkins

OPENING STATEMENT OF CHAIRMAN CHERNOF

Chairman Chernof. Well, good morning, everybody. I am Dr. Bruce Chernof. I am the Chair of the Long-Term Care Commission.

Our Vice Chair had a family emergency and is not with us today, but Mark Warshawsky sends his greetings as well.

We have most of the commissioners here. A couple of folks are on their way, but we are determined to start on time this morning.

We have a very busy day ahead of us. So, before we hop into the first panel, I just want to talk a little bit about the rules of the road for all of the folks down in here and the folks up here.

We have asked each of our speakers to present for 10 minutes this morning. That will be true for all the other panels.

We are going to try to stay right on time. So you will see the yellow light and then the red light come on. I will ask you to stop, even if you are not completely done with your presentation, when the red light comes on.

For commissioners, we are going to allow five minutes of questions per commissioner. That will allow a more extensive Q&A than we have had previously. You will see the red light come on at four minutes, and I will ask you to stop promptly at five minutes, in your line of questioning.

For those of you in the audience, I want to remind everybody that there is the opportunity for the general public, stakeholders and others with interest in this area to provide feedback to us. There is a comment portal on the Commission's web site, and we strongly encourage all to send in their thoughts and ideas. Those will be reviewed by all the commissioners.

With that, I want to hop right into the first panel.

I want to acknowledge the first panel for being

available to us on really very short notice.

This first panel will focus on what we can do to strengthen the Medicaid Long-Term Services and Supports Program, and I want to begin with Diane Rowland, who is the Chair of MACPAC.

Thank you.

STATEMENT OF DIANE ROWLAND, CHAIR, MACPAC AND EXECUTIVE VICE PRESIDENT, KAISER FAMILY FOUNDATION

Ms. Rowland. Thank you very much, Bruce and Panel, for having me here today and for the ability to provide insight into the work that we have been doing on Medicaid over many years at the Kaiser Family Foundation. So I am testifying today in my capacity as the Executive Vice President of the Kaiser Family Foundation and will be presenting some of the findings from the work that we have done over the years.

Medicaid is, today, a mainstay of long-term services and supports in both the community and in institutions for a diverse and very high-need, low-income population. So my testimony today will focus on the population Medicaid services, the role the program plays in our long-term care system and the gaps and potential improvements in the assistance Medicaid provides to individuals of all ages.

The Medicaid long-term care beneficiary population is exceedingly diverse in terms of the demographic composition, the array of daily health needs and the availability of informal caregiving supports in the community.

What is not diverse is the need for assistance due to ongoing and persistent cognitive and physical impairment and chronic conditions that result in the need for assistance with the activities of daily living and the lack of adequate income and resources to secure the required assistance.

In 2010, 3.8 million individuals accessed Medicaid's long-term care services and supports at a cost of $159 billion in Federal and state dollars. Slightly more than half of the users were over age 65, but 43 percent qualified for Medicaid as individuals with disabilities, and 6 percent were nondisabled adults and children who were on the Medicaid program but did not come in through the eligibility portal for disability.

Much attention--in my second slide notes--has been recently focused on Medicaid's role for those dually entitled to both Medicare and Medicaid. In 2010, 69 percent of Medicaid beneficiaries, both under and over age 65, who use long-term care services were dually eligible, and they accounted for 64 percent of total Medicaid long-term services and supports spending.

Medicaid coverage of long-term care does include an array of services and supports that assist individuals with performing daily health and personal care activities depending on an individual's need. These activities range form providing assistance with eating, dressing and toileting to assisting with household chores or managing prescription medications.

Medicaid covers a continuum of long-term care service settings. While many prefer to remain in the community, some individuals with extensive needs require nursing home

care, which is covered by Medicaid.

With limited coverage options available under Medicare and few affordable options in the private insurance market, Medicaid continues to be the primary payer for institutional and community-based services and supports.

But Medicaid, we must remember, is a means-based entitlement requiring people to meet both an income and disability test to obtain assistance. To qualify, an individual must be totally and permanently disabled or over age 65 with significant cognitive and physical limitations, have limited income and few personal assets. Although there is variation in the eligibility rules across states, to receive Medicaid assistance with long-term care essentially requires impoverishment, which is often the result of ongoing long-term care needs and health needs.

Two myths, however, persist about Medicaid and long-term care.

The first is that large numbers of long-term care users qualify for Medicaid by transferring their assets to gain coverage. The reality is that few senior citizens and people with disabilities have large sums of assets to transfer.

A Kaiser Family study found that most frail seniors who receive Medicaid benefits were poor prior to enrollment, and then when individuals did make transfers the amount of

assets transferred by those individuals was, on average, small. One-half of study participants had asset, cash and deed transfers of less than $5,000. Additional studies have confirmed these findings.

The second myth is that once eligibility for Medicaid assistance for institutional care is obtained, Medicaid pays the full bill. In reality, Medicaid requires that beneficiaries continue to contribute available income from pensions and Social Security toward the monthly cost of their care and allows individuals to retain only $60 a month as a personal needs allowance while institutionalized.

The problem that most Americans encounter when they or a loved one needs long-term services and supports is that such care is unaffordable. Annually, nursing home care averages more than $80,000; care and assisted living facilities, over $40,000; and home health care, over $21,000. It is hard to save for such significant and often unpredictable expenses. And it is hard for elderly Americans living on Social Security and barely getting by to be able to afford the cost of ongoing chronic care and long-term care.

A Kaiser Family Foundation national study found that nearly half of all seniors live with incomes below 200 percent of the poverty threshold, approximately $21,000.

In the third slide, which is there, Medicaid obviously

continues, therefore, to be the long-term care safety net for millions of Americans because there are few alternatives. In 2011, the Nation spent $357 billion on long-term services and supports, with Medicaid covering 43 percent.

Medicaid also has increasingly shifted the balance in long-term care services and supports from heavy reliance on institutional care to much greater availability of home and community-based care that allows the elderly and people with disabilities to live at home among their support networks, shown in figure 4.

The share of spending on long-term care for community-based services has grown from 32 percent in 2002 to 45 percent in 2011 due, in part, to the U.S. Supreme Court Olmstead decision that mandated the availability of integrated community-based care alternatives to nursing home beneficiaries. We are just about to celebrate the anniversary of that decision from 1990.

Yet, there is still considerable variation among states in the share of Medicaid long-term care dollars spent on home and community-based services, with the national average as shown in figure 5, close to 45 percent.

The Olmstead case and the push for community care settings has been particularly important for individuals under age 65 with disabilities. Half of elderly long-term

care users rely on Medicaid for institutional care compared to only 21 percent of nonelderly individuals with disabilities, as shown in figure 6.

For nonelderly beneficiaries with disabilities, community-based care accounts for 63 percent of total expenditures whereas, for the elderly, 72 percent of spending on long-term cares is for institutional care--a very important point to recall as you look at the distribution of use.

New models of care delivery and greater focus on community-based care in Medicaid have helped to provide an alternative to institutional care that has been especially important for younger adults with disabilities. Community case workers are critical to the ability of many to live in the community and coordinate their needs. Medicaid's Money Follows the Person, or MFP, demonstration is also an important lesson in how to enable institutional individuals to transition to the community.

The experience of Medicaid beneficiaries--and I have included in my testimony some examples of Kelli, Don and Edward from interviews we conducted as part of the Kaiser Family Foundation study--reflects the importance of having strong community-based alternatives in Medicaid and the importance of keeping institutional care as a last, not a first, option. And I have included their stories inside of

this testimony.

But I wanted to focus now on the future, and in figure 7 we can look at the challenges.

As Baby Boomers, like me, age into older adulthood, with increased life expectancy, we hope, and advances in medical care, we can also expect the demand for long-term services and supports to increase in the coming decade. Those aged 65 and over, the age cohort most likely to need long-term services and supports, is expected to increase by almost 70 percent in the next 20 years.

So, with that, we really need to begin to look at how to strengthen Medicaid's role as a source of care and financing for people with disabilities, and a key is building a strong foundation for long-term services and supports to make sure they are available and accessible to those in need.

So I would recommend this Commission consider:

First, development of a single point of entry for information and referral systems, where individuals can gain information about long-term care and advocates can help to provide supports, to go for an easy-to-understand format, greater uniformity in eligibility criteria and scope of services across states.

And, finally, to look at streamlining the new and expanded home and community-based long-term care services

and supports options into a comprehensive, optional state benefit, for all states to be able to have broader Federal support for this but to be able to combine and streamline what we now do.

We need to enhance the ways to provide community-based supports, especially for individuals with cognitive impairments.

And we need to improve the metrics to measure and improve quality of care in both institutional and community-based settings.

And, finally, there needs to be wide recognition that care improvement and provision of additional community-based resources will require increased funding and broader incentives at a time of severe budgetary constraints. Cuts to Medicaid and reduced funds will impede, not promote, ways to improve quality and access to care for this population.

Medicaid is, today, and will probably remain, a cornerstone of our Nation's approach to providing assistance to the elderly and people with disabilities who need long-term services and supports. We need to invest and strengthen the capacity of Medicaid to meet the needs of today's population and, in the absence of broader changes, prepare for future demands. However, the best way to strengthen Medicaid is to provide alternative sources of support for those in need of long-term services and

supports, to reduce the pressure on Medicaid and enable Medicaid's resources to continue to be directed at those most in need.

Thank you very much.

[The prepared statement of Ms. Rowland follows:]

Chairman Chernof. Thank you, Diane.

Next, Patti Killingsworth from Tennessee, please.

STATEMENT OF PATTI KILLINGSWORTH, TENNCARE

Ms. Killingsworth. Good morning, Mr. Chairman, members of the Commission. Thank you for the opportunity to be with you today.

By way of context, I would like to say that these are proposed fundamental transformations of both the Medicaid and the Medicare programs that have significant potential to accomplish the Triple Aim--to improve the experience of care for those who need long-term services and supports; to improve the health of those individuals, in particular dual eligible individuals, by providing the right care in the right setting; and for reducing the per capita cost of health care across both of these programs.

The Triple Aim can only be accomplished, and Medicaid long-term services and supports can only be strengthened, within the context of the broader health care system, which is why I will talk today about both Medicaid and Medicare.

Also, by way of context, as you probably know, the majority of Medicaid nursing facility residents are:

Aged 65 or older--in Tennessee, that is 84 percent.

They are medical eligible. In Tennessee, that is 92 percent.

They are typically admitted to a Medicaid nursing facility following a Medicare skilled nursing facility stay. In fact, the primary driver of how Medicaid long-term

services and supports are utilized is how Medicare benefits are utilized.

And they are predominantly in Fee-for-Service Medicare with little, if any, coordination with their Medicaid long-term services and supports benefits.

I would also like to note that these proposed transformations have significant potential to assist states in their efforts to comply with the Americans with Disabilities Act, to rebalance their long-term services and supports systems, and to ensure that services are, in fact, provided in the most integrated setting appropriate for individuals.

I would like to start with a set of recommendations that involve fundamental changes in the Medicaid program, that would help to eliminate or reverse the institutional bias that has long existed in that program design, beginning with long-term services and supports benefits.

We would recommend that nursing facility services become an optional, rather than a mandatory, benefit and that states be allowed to limit the number of individuals who are placed in institutional settings, divert individuals to more cost effective home and community-based services, and maintain waiting lists for nursing facility services as they do today for home and community-based services, when applicable.

To ensure that the system continues to grow and there continues to be more capacity to serve individuals, we would recommend a requirement that any reduction in institutional slots or capacity be replaced with one or more community-based slots so that individuals continue to have access to more integrated care.

We would also recommend that we continue in the Medicaid program to offer flexible HCBS authorities. Rather than mandating home and community-based services, give states flexible options that allow them adequate time to develop community-based infrastructure and to manage programs within state resources.

And, finally, we would recommend that we mandate an individual cost neutrality cap for home and community-based services in order to stretch limited resources across more people. While it is almost always possible to demonstrate cost neutrality in the aggregate, the reality is that some individuals who receive lots and lots of services make it impossible for everyone to receive services, leading to the creation of waiting lists and systems where some people have a lot of services and others have none.

Moving from benefits, I would like to focus on recommendations pertaining to long-term services and supports settings by recommending that freedom of choice requirements be changed to default to home and community-

based services rather than institutional care.

In other words, a person could not be placed in an institutional setting without being advised by a neutral entity of their freedom of choice of available home and community-based alternatives and affirmatively choosing that institutional placement over those alternatives.

Next, we would recommend that perhaps the Commission consider requiring enrollment in home and community-based services first, before permitting institutional placement, absent extenuating circumstances, which would ensure that when a person is placed in an institutional setting that it is, in fact, the most integrated setting appropriate for that individual.

And then, finally, we would recommend that we allow Federal financial participation for limited room and board supplements in a community-based residential alternative setting, not just in an institution as it is today, particularly for people with income at or below the SSI Federal benefit rate.

There is a tremendous barrier to moving people out of institutions that exist in the lack of access to affordable housing. And, while this is the only recommendation that I will make that has the potential to add a benefit or add an increased cost to the program, the reality is that this, particularly combined with an individual cost neutrality

cap, would save money in the long run by allowing more people to move from institutions into home and community-based settings.

Moving on to long-term services and supports quality, we would encourage the requirement that:

States develop values-based purchasing for long-term services and supports across settings, both for nursing facilities and for home and community-based services, and that they align payment with key measures of performance, which include how members experience care.

And then, particularly for states that are not a part of managed care programs for long-term services and supports, that states be permitted to grant an exception to any willing qualified provider requirements and freedom of choice provider requirements for nursing facilities with lower quality rankings, including all special focus facilities.

I would also then like to talk about recommendations that would help to integrate funding, integrate benefits and really improve coordination of care for Full Benefit Dual Eligible beneficiaries who are receiving long-term services and supports. And I want to acknowledge the tremendous work that Melanie Bella and her team have done to move us forward in that regard.

We believe that all Full Benefit Dual Eligible

beneficiaries who are receiving long-term services and supports should be enrolled in integrated and coordinated programs of care, including D-SNPs, including financial alignment demonstrations and, hopefully, models yet to be created that include long-term services and supports and coordinate care across the continuum.

We would recommend the permanent reauthorization of D-SNPs that are contracted with state Medicaid agencies, to deliver long-term services and supports in addition to Medicare benefits and, again, to coordinate care across the continuum.

We believe that there needs to be a clearly defined role for the state Medicaid agency in both the contracting and oversight of D-SNPs, who are delivering the coordinated care across the continuum, and that administrative requirements for those programs need to be streamlined, supporting a more seamless system of care for dual eligible members.

Finally, I would like to recommend a few fundamental changes in the Medicare program that would help to support the delivery of both Medicare and Medicaid long-term services and supports in a more cost effective and more integrated setting.

First, we would recommend the implementation of a prospective utilization review process for all Medicare

skilled nursing facility benefits that includes consideration of more integrated home and community-based options first.

We would recommend that there be a freedom of choice requirement in the Medicare program for skilled nursing facility benefits, again, with a default to home and community-based services rather than to SNF. A person could not be placed in a skilled nursing facility without being advised by a neutral entity of their freedom of choice of available HCBS alternatives, including not just the Medicare home health benefit but Medicaid long-term services and supports to which they might be entitled and eligible to receive, and affirmatively choosing that institutional placement over those home and community-based options.

We would recommend that Medicare payments be restructured to incentivize hospitals to discharge from Medicare inpatient stays to home, with home and community-based services, rather than automatically to a skilled nursing facility, or to also consider disincentivizing hospital discharge automatically to skilled nursing facilities.

And, finally, we would recommend, particularly from a health perspective, that dual certified facilities be required to create a medical home within the facility for long-stay nursing facility residents, with accountability

for avoiding hospital admissions when appropriate.

Again, I thank you for this opportunity.

[The prepared statement of Ms. Killingsworth follows:]

Chairman Chernof. Thank you very much.

Gary Alexander will be speaking about his work from Rhode Island in Medicaid.

STATEMENT OF GARY D. ALEXANDER, FORMERLY, RHODE ISLAND OFFICE OF HEALTH AND HUMAN SERVICES

Mr. Alexander. Thank you very much, Chairman Chernof and the other distinguished members of the Commission on Long-Term Care, for the opportunity to testify on the subject of strengthening Medicaid's long-term services and supports.

My name is Gary Alexander. I am most recently the Secretary of Public Welfare for the Commonwealth of Pennsylvania. Prior to that, I served as the Secretary of Health and Human Services for the State of Rhode Island. Presently, I am in the private sector--in business for myself, just to make that clear.

Long-term care is a key factor driving up Medicaid costs, which are not just a Federal concern but have become the largest budgetary item for the states, affecting both recipients and taxpayers.

I was asked today to offer my perspectives on how Rhode Island's global waiver could provide states with a framework to reform long-term care and offer quality long-term care supports that are cost effective.

When I served in Rhode Island, reform was imperative. At the time, more than 20 percent of the state population was on Medicaid, Medicaid comprised more than 25 percent of the state budget, and Medicaid expenditures were growing

annually between 7 and 8 percent. Without reform, Medicaid would command more than half of Rhode Island's budget by 2025.

Rhode Island was doing little to lower Medicaid costs in general or in the long-term care system in particular. Our focus was more on administering a myriad of home and community-based waivers, each with varying rules, regulations and service definitions, rather than on concentrating on the people we were attempting to assist.

Like other states, we had sought waivers--11 across our enterprise--to avoid Medicaid's historic institutional bias and a one-size-fits-all system.

Rhode Island was the first, and only, state to apply for and secure a global waiver covering acute and long-term care and supports, with a capped allotment on overall funding, in exchange for flexibility. The idea was to gain flexibility to administer Medicaid in ways that made sense. Part of that flexibility was used to consolidate and streamline all 11 waivers to create a person-centered and person-focused system.

Our goal was to shift from a fragmented provider and setting-focused system, in which patients must adjust to providers' time and practice patterns, to a person-centered focus for every recipient irrespective of age, care needs or eligibility. In essence, the global waiver was all about

improving care for the person.

CMS approved our global waiver in 2009, with broad parameters and broad goals, rebalancing the long-term care system, ensuring access to medical homes, realigning payment and purchasing strategies with person-centered programmatic goals, and encouraging and rewarding healthy outcomes, among others.

The waiver enabled Rhode Island to become a smart purchaser, striving to make sure that every public health dollar spent delivered better value. Indeed, according to a 2011 study by the Lewin Group, the Ocean State's reform was highly effective in controlling Medicaid costs and improved access to more appropriate services. The report noted a decline in the number of low-need persons entering or remaining in nursing homes.

Indeed, Rhode Islanders were choosing to obtain the care they need at home or in community settings, like assisted or shared living. Level of care redesign, focused on preventive care, drove thousands of individuals into appropriate community settings. Nursing home costs were reduced as a result of improved program management and acuity-based adjustments to the state's payment methodologies.

Nursing home bed days continue today to decline, and long-term supports and services are on the increase.

Contrary to earlier projections of 7 to 8 percent growth, Medicaid expenditures came under control. Expenditures grew 5.2 percent in fiscal year 2010, 1 percent in fiscal year 2011 and decreased 1.1 percent in fiscal year 2012. The state has not finished calculating the growth rate for 2013, but our estimate, based on preliminary reports to the state legislature, indicated a growth rate of about 1.2 percent this year.

Rhode Island's achievement in lowering Medicaid spending trajectory came about despite the fact that the case load increased by 4.5 percent in 2010, 3.5 percent in 2011 and a little over 2 percent in 2012.

The efficiency gains can be best measured by the Per Member Per Month costs, which were $813 in fiscal year 2001, $794 in 2011 and $770 in 2012.

These trends should continue now that Rhode Island is implementing the global waiver plan to integrate care for its nearly 40,000 dual eligibles and piloting innovative models like capitated telehealth.

If we compare the state's growth rate to the Federal growth rate estimated today, Rhode Island's growth rate over the five years at this point would be 1.6 percent growth compared to CMS actuarial estimates for national growth at a little over 4.5 percent.

However impressive, the savings could have been

greater. As with any negotiation, CMS did not approve our initial request.

We initially requested a block grant, which would have taken an act of Congress, with a gain-sharing system based on performance measures and reinvesting a portion of the savings into preventative health care. We sought flexibility on mandatory populations and full relief from burdensome Federal red tape in order to further the program goals of slaying the institutional bias.

Although these requests were denied, we accepted and worked within the parameters granted by CMS. We cannot know for certain what the savings would have been, but we can only estimate that the potential savings could have doubled.

What are the lessons learned from Rhode Island?

Lesson No. 1: Multiple waivers create inefficiencies and poorer outcomes. Global waivers do just the opposite, allowing the state to adapt to change quickly and efficiently.

Deviations from Federal preconceived notions of how Medicaid long-term care should operate force states to seek multiple waivers or state plan amendments, which can be cumbersome and a difficult process. Moreover, managing multiple waivers creates huge silos within the system.

As an example, Rhode Island was able to quickly implement shared living as a service for elders and adapt

rapidly. Without the waiver, this cost effective service could have taken years to implement.

Lesson 2: The spending cap toppled the foundation of the Medicaid culture of continually increasing spending.

Before the global waiver, the state government rightly presumed that if the state spends a dollar it cannot afford the Federal Government is happy to match it with dollars they do not have. Bringing about a rethinking of the modus operandi, the five-year spending cap forced the state to immediately reform, redesign and be cost conscious.

Without an urgency to save, government will never be cost effective. The spending culture was not unique to Rhode Island. It emanates from Washington, D.C. States, to one degree or another, have adopted this same irresponsible thinking.

Lesson 3: The global waiver originated in the State of Rhode Island with a Republican governor and a Democratic legislature.

The global waiver idea was not developed here in the corridors of Capitol Hill or in the office suites of CMS. No, it was a bottom-up solution that came from the people and the providers and the stakeholders of a small state.

One-size-fits-all solutions rarely work. Every state is different, having unique demographics, history and institutional settings. Rhode Island's solution originated

from the hard work of Rhode Island officials and employees and the people. It would be a mistake for the Federal Government to take Rhode Island's model and try to impose it on other states, however, assuming what works in Rhode Island will work elsewhere.

Lesson 4: While CMS approved of Rhode Island's global waiver, it also limited its total success.

Had CMS allowed Rhode Island to implement all aspects of its current waiver and had it granted its initial request, the state could have fully transformed its Medicaid system and long-term care system. Although we were grateful to CMS for our partnership--and the state is, I am sure, grateful--more could have been done.

Lesson 5: Allowing states to keep a part or a portion of the Federal savings will incentivize savings and innovation.

The current design of Medicaid encourages states to maximize drawing down of Federal dollars. States may abhor spending their own money, but they feel good when they spend more Federal money instead. The only way to beat the system is to change it. States need to be encouraged to save Federal money, and nothing will work better than gain-sharing.

Lesson 6: Redesigning long-term care takes dedication and hard work and lots of it.

Speaking from my professional experience in 2 states and over 15 years working in the system, bureaucracies have created tremendous inertia. Our governmental systems are not designed for encouraging innovation. More often than not, they stifle even the slightest notion of it.

Layered on top is the maze of competing political interests and advocacy groups. Our systems--welfare, Medicaid--and all of our public programs are complex, requiring expertise from many different fields. So it also takes knowledge on how to put all the pieces together to make it work.

Nonetheless, we can be very innovative. There are many knowledgeable and talented persons, some serving our Federal and state governments. Part of being successful is knowing how to motivate and move people. You need commitment from a governor, the state legislature and the Federal Government in order to change, to make that happen.

That the current Medicaid system is inefficient is an understatement. We can run a more effective Medicaid system at lower cost if we are willing to allow states to reform and redesign the system.

The Rhode Island global waiver does show a better way. It was a Rhode Island solution and a state solution. Every state should have that opportunity.

With that flexibility, Rhode Island was able to segment

patient populations, which is something we need to do, reduce administrative burdens and quickly implement proven solutions. Even with its limitations, the success of the Rhode Island global waiver demonstrates that change is possible if CMS would allow the states to innovate and lead.

In the Ocean State, the net result was better health for recipients on both the acute and long-term care continuum, and that is no small feat for a small state, because better health is what all Americans want.

Thank you.

[The prepared statement of Mr. Alexander follows:]

Chairman Chernof. Thank you very much.

And, finally, on this panel, Melanie Bella from the Center for Medicare and Medicaid Services.

STATEMENT OF MELANIE BELLA, CMS MEDICARE-MEDICAID COORDINATION OFFICE

Ms. Bella. Thank you, Mr. Commissioner, members of the Commission.

My name is Melanie Bella. I am the Director of the Medicare-Medicaid Coordination Office at the Centers for Medicare and Medicaid Services. I appreciate the opportunity to be able to talk with you this morning.

While the focus of my work and my remarks are on individuals who receive both Medicare and Medicaid, clearly, if we are going to be successful in our goals of developing person-centered models that meet the totality of individuals' needs, a strong long-term supports and services system is critical. So, again, appreciate the opportunity to be here.

Many of you are familiar with the work of the Office. So I apologize if this is boring, but I am going to start with just a brief overview of what we do because I think it provides important context to the foundation we are trying to build, to improve beneficiary experiences and develop payment and delivery system models that have a positive impact on both quality and cost.

So, starting out, this Office was created through the Affordable Care Act, and there are a number of goals and responsibilities of the Office. It really boils down to two

very simple things. The first is make the Medicare and Medicaid programs work better for our people that depend on both of them, and the second is improve the relationship between states and the Federal Government as we are partners in the delivery and financing of the care today.

I should also note that the Affordable Care Act gave CMS several other tools that are very relevant to the conversation today, including the Community First Choice Option, balancing incentive programs, enhancements to Money Follows the Person, health homes for people with chronic conditions and mental illness, and other modifications to allow states to more easily pursue HCBS services.

So focusing on our work, we are looking in three different areas--next slide, please--that really help define what it is and where we want to attack the challenges and opportunities.

The first is very simply looking at alignment between the two programs--looking at statutory, regulatory and subregulatory areas--to understand where the programs are working together and where are they not working together and how do we want to use that to inform our efforts going forward.

We have spent a considerable amount of time in this area, looking at the prohibition on balanced billing of beneficiaries, looking at problems created by services that

are overlapping between Medicaid and Medicare, especially home health and DME, and looking at how to work with states and D-SNPs and some MIPPA contracting issues. But this is an ongoing effort.

The second area, and a personal favorite, is all about data and analytics. Until we have a very thorough and granular understanding of this population and the subpopulations, we are not going to be as smart about developing the models that we want to test, the new payment policies, the new measurement systems and all of those things.

So I am proud of our work in this area.

Our efforts include having the first ever, integrated data set within CMS that has beneficiary-level, integrated Medicare and Medicaid data.

We have developed state profiles for the dual eligible beneficiaries--so a profile in every state of demographics, utilization costs and, important for this audience, a context of the LTSS, both institutional and community-based care in every state. Those are posted on our web site and will be updated annually.

We have made enhancements to CMS's Chronic Condition Warehouse. So this is sort of a master tool that CMS and other researchers use to explain care opportunities and utilization and all sorts of things.

But there were some very important what are called condition flags that were not in there that we have added. So those would be condition flags around serious mental illness, schizophrenia, bipolar, as well as for intellectual and developmental disabilities. We have also expanded those flags to the Medicaid part of the CMS database.

So those are important tools when we are thinking about LTSS services and how to understand where to attach opportunities to improve care and control costs.

Then the last thing I would mention in the data realm is really focusing on how to get Medicare Parts A, B and D data to states to support care coordination purposes. So, to date, we have 30 states who have either received or are in the process of receiving Medicare Parts and B data, and 24 states who have received or are in the process of receiving Part D data.

And I think what is relevant for this conversation is we spent a lot of time making sure that all the privacy and confidentiality mechanisms are in place to share those data, but now we are doing that to try to share those data with downstream users--so the care managers, the in-home personal care attendance, the folks who are really going to interact with the beneficiaries on a daily level and can really benefit from making sure that they understand what is going on from everybody who is touching that particular

individual.

So the last area has to do with models and demonstrations, and it really is:

How do we take what we see in the alignment area?

How do we leverage what we have learned from the analysis?

How do we listen to stakeholders?

How do we look at the state environment and then understand where we want to test various things?

So the first demonstration I want to talk to about is targeted at individuals who are in nursing facilities.

So what are some things we know?

We know that payment policies between Medicaid and Medicare create incentives for cost-shifting.

We know that research has shown us that 45 percent of hospitalizations have been avoidable for this population.

We know from beneficiaries, caregivers and those who advocate on their behalf that these are not good transitions and that they are sometimes harmful. And they are not good for nursing facilities. They are not good for hospitals. They are not good for the taxpayers.

So what are we doing?

We are trying to focus on a demonstration that improves the interaction between acute and post-acute care in a way that is positive for the demonstration entities, for the

participating nursing facilities and, obviously, first and foremost, for the beneficiaries.

So we have a demonstration that is active in seven states. We are live in all the states as of about February of this year.

We require that the entities who are participating in the demonstration partner with nursing facilities. So in those 7 states, we have about 144 nursing facilities that are partnering with the care organizations who are trying to provide resources onsite, to address things like pneumonia and urinary tract infection and pressure ulcers so that possibly we can prevent some hospitalizations.

So we are pretty excited about that demonstration, and we think there is a lot of opportunity to expand it.

The second area of demonstration activity for us is focused on states.

So, again, what do we know? What do we know about the kind of alignment landscape?

We know that incentives are far from aligned for either Medicaid or Medicare to invest in care management for this population, and we see that. We have had very little coordination and integration activities on the Medicaid or Medicare side.

We know that there is no accountability for person-centered care in today's current system. There is not a

rigorous focus on making sure that LTSS is available, that facilities are accessible, that care is provided in a competent way, that we are supporting rebalancing. None of that is existing today, or very little.

Or, maybe it is growing. I should not sound so negative. But we know we can do better.

And we also know that states have very different delivery systems. They have different degrees of current managed care penetration. They are at different points on the institutional versus community-based long-term care continuum. So that tells us that a one-size-fits-all approach is not going to work.

And so we really focused on developing models to work with states, where we have some core parameters, but they can be tailored to meet the particular state environment. And so the core parameters are around the financing.

One of our models is a capitated model, where an entity is at financial risk and the state and the Federal Government combine financing to give that pot of money to that entity to manage the totality of medical and nonmedical services.

Then the second model is a managed Fee-for-Service model. There is no capitated risk per se, but there are incentives in place for states to make investment in care management. And, if savings accrue to Medicare, we will

align those incentives and share in some of those savings with the states to promote further investment.

Today, we--well, let me talk just for a second about the beneficiary, what we think is good for the beneficiaries, on the next slide, which is many enhancements compared to what we think is happening in today's system for most of these beneficiaries.

You all can read the slide. I just really do want to emphasize we place a great--we spend a lot of time working on the care plan and the care team and the assessment, and we very much work to make sure LTSS is a part of these models.

There is a big fear that there has kind of been a medicalization and that these models are going to promote medical care over nonmedical care. And so a lot of our focus is on making sure that LTSS is front and present, both institutional and community-based, so that we can get people what they need at the right time.

In addition, we are very focused on a lot of training and competency around ADA and around Olmstead and looking at things, how do we use ombudsmen, how do we provide other support services to really make sure that we are meeting the totality of beneficiaries' needs.

So the status of where we are on these, on the next slide, is we have approved six demonstrations to date.

Five of those are in the capitated managed care model, and you can see they are Massachusetts, Ohio, California and Virginia. Those are all pegged to start at various times over the next few months. Our first one is targeted for October of this year, and that is the State of Massachusetts, with the rest following in January and then additionally in 2014.

Washington State is our first managed Fee-for-Service model, and I am proud to say it went live on July 1st. So we actually have one live model in the great State of Washington.

And then we are continuing to work with over 20 states who are interested in 1 or both of these models.

And then for some states, like Tennessee, where our model did not work, we are working with them on perhaps other options to support their efforts at integration.

So I guess in the last seconds I have to spit out a few things--we really see great promise for these models in terms of if we can improve quality but, more importantly, if we can control costs. We see this as an opportunity to invest those resources in strengthening our LTSS system and as an opportunity to provide services and access that is not available today.

So these are not about cutting costs for us. They are about improvement in quality and beneficiary experience and

reinvestment.

Thank you very much.

[The prepared statement of Ms. Bella follows:]

Chairman Chernof. Thank you, Melanie Bella.

Thank you to the entire panel for a great presentation.

I would like to start with Commissioner Claypool, please.

Commissioner Claypool. I would beg the Chair's indulgence and maybe go the other way around. I arrived late.

Chairman Chernof. Fair enough. Let's start with Commissioner Stein.

Commissioner Stein. I guess I should not yield my time to Mr. Claypool.

[Laughter.]

Commissioner Stein. Thank you very much, all of you.

I notice an obvious theme, and that is that community-based services should be first choice.

I am wondering--when I heard from Ms. Rowland--good to see you today.

You talked about people under 65 with disabilities receiving, under Medicaid, more of their care in home and community-based services than people who are over 65. My tendency is to think people are people regardless of age, and I am wanting to think of a system that would meet people's needs in the least restrictive environment regardless of age.

I am wondering if you could tell me why, am I right in

that assumption--that lower aged people are receiving more Medicaid dollars outside of institutions--why that it is and what you think we might be able to do about it.

Ms. Rowland. Well, certainly, in looking at the users of long-term care services, the point that I was making is that among those over age 65 about 52 percent receive their care in institutional settings and among those under 65 it is about 21 percent, so really a big difference.

And I think it results in two things. One is that the age distribution of many of the elderly for the post-80 and 85-year-olds tend to end up needing more services in an institution because of the lack of community-based care that is available to them, and some of that results from some of the severe cognitive impairments that come with physical impairments at that level, whereas there is a much broader distribution of service needs among those under 65 in the disability community. But I would say it applies to some of the young elderly as well.

So I think within those over 65 you really have to look at the differences as you go up the age spectrum.

Commissioner Stein. And that would help us know what needs to be focused on in community-based services, perhaps, in order to allow older and more vulnerable, frail people with cognitive impairments to remain in the community.

Ms. Rowland. To remain in the community. And I think

that is a very high priority--of how do you make those kinds of resources available and the support.

Commissioner Stein. Ye. I am particularly cognizant of that because in Connecticut we had a lot of mental health institutions close and people just dumped on streets, which we really do not want to have happen.

Ms. Rowland. I would say that I think one of the huge gaps in home and community-based services is how to provide for the behavioral health aspects of it.

Commissioner Stein. Okay. Thank you. That is very helpful to me.

With regard to, Ms. Killingsworth, I want to make clear; you have in your commentary some comment with regard to the three-day hospital requirement. Were you suggesting that be extended to a longer period of time or that UR services be provided--I perhaps did not understand that point.

Ms. Killingsworth. Thank you for the opportunity to clarify.

No, simply that it is not sufficient in terms of accessing a skilled nursing facility benefit, that there needs to a much more extensive utilization review process to ensure that a skilled nursing facility placement is, in fact, the most integrated setting that is appropriate and to ensure that home and community-based services are

considered.

Commissioner Stein. Not that we--I am looking at my time clock, so excuse me, all.

Not that we have a longer than three-day hospital stay?

I am personally wanting to get rid of the three-day hospital stay requirement to get SNF care. So are you suggested that it be extended to longer than three days?

Ms. Killingsworth. I am not suggesting that it be extended. I am suggesting that there needs to be a much more comprehensive review process looking at medical necessity for skilled nursing facility stay than three days in the hospital.

Commissioner Stein. Okay.

Ms. Killingsworth. There needs to be a much more in-depth process that includes consideration of home and community-based services, which I believe rarely happens.

Commissioner Stein. Yes. Thank you.

Ms. Bella, I want to thank you for the work you are doing. And amen to actually having CMS have a whole office focusing on coordinating Medicare and Medicaid.

As you may know, my organization does a huge amount of work with regard to dual eligibles, and I was particularly interested in that you actually talked about integrating the appeals system. I am also a little worried about it.

Did you have a sense of what--have you all been working

at all on what that system might look like--because the current one in Medicare is really failing people.

Ms. Bella. We have been looking at it. We have a couple things underway.

So, as a first step, we actually have an integrated Denial of Payment Notice that is available for use. We have--

Commissioner Stein. People get a lot of those notices.

Ms. Bella. Yeah. We also have--in the President's budget, there is a legislative proposal to allow the Secretary to give her discretion to develop an integrated process.

Our efforts are being informed by what we are doing in the demonstrations. So, in each of the states, there is some variation.

I would say one of the things that we are proudest of in those demonstrations, though, is we are trying to orchestrate the first level of appeals in a way that will provide aid paid pending on the Medicare side.

And so, you know very well, and if you would like I am happy to--we can follow up and give you the examples in each of the states on what--there are different models in every state, working toward the same goal. We can be happy to provide you with that.

Commissioner Stein. Yeah, I would appreciate it.

Also, we offer our assistance.

Ms. Bella. That would be great.

Commissioner Stein. Thank you.

Thank you.

Chairman Chernof. Thank you very much.

Commissioner Turner. Thank you all very much.

And I do also hear the theme that we really must have more flexibility, as Diane said, to allow more flexibility in Medicaid for home and community-based services.

And, Gary, you said that you found that that had actually saved money over the long term in your demonstration in Rhode Island.

And, Melanie, I also want to commend you for the work that you have done, really following on our work on the Medicaid Commission, where it was clear that doing a much better job of helping duals with getting coordinated care can not only save money but improve quality in the long term. And you have just done a really fabulous job of really taking that to the ground level.

So my question, Melanie, is what does your data show across the board for the ability to move to more flexibility for home and community-based care in Medicaid--because there is always such a resistance in Congress to what they perceive as adding a new benefit for Medicaid.

But, yet, if in the long run that can be demonstrated

not only to keep people happier and provide better care but also to save money in the long run, I think that is something that we certainly need to know as part of making our recommendations here.

Ms. Bella. I think, unfortunately, there is not--I mean, there is not enough data, not as much as anyone would like, so that it is a slam dunk that if you do X-Y-Z then you are going to produce this kind of ROI. So that is not there. I think a lot of efforts that are underway are testing and are going to be evaluating that.

And, certainly, it is fair to say that especially in places where there is not a strong community-based infrastructure already it is going to take an up-front investment.

And so we have to, I think, have an eye toward the long term and looking for a 12-month investment, or even a 24-month return on that investment is probably fairly unrealistic, I would say, is one of the big take-aways from what we have seen to date.

And so I think we have to look at it as being able to understand that we are going to spend some out here to save some down here, and we are going to spend perhaps in Medicaid to save in Medicare in the short term, and perhaps later we will spend in Medicare to save in Medicaid.

But we have to look at it together, and we have to look

at it over a decent enough time period to be able to--I mean to do the right thing. It is a good thing to do. But it is not going to provide immediate budget relief. In many cases, it will actually cost in order for us to get ourselves onto more stable footing, going forward.

Commissioner Turner. Diane, how do you see getting past that hurdle?

I mean, you really also live with this data all the time. What do you see as a way of helping Congress, convincing them that this up-front investment needs to be made in order to be able to move to a more flexible system?

Ms. Rowland. Well, you know, I think that, as Melanie mentioned, there were a lot of new options put in place in the Affordable Care Act that have not received as much attention as other features of the Affordable Care Act. But, certainly, the states do have the opportunity to test different ways now of trying to move people through.

The Money Follows the Person demonstration is a very important one to look at, and that one has had some very positive evaluations. Yet, that program is due to expire.

So trying to keep that going, trying to look at some of the other options--I think when you see success in one place, it helps to build the momentum for other places.

But Congress has seemed very willing to move forward with various demonstrations as opposed to with a wholesale

revision of the benefit.

And what we are recommending is maybe that is too many different buckets to try and tap and too much time being spent on waivers and that we ought to have a more global, streamlined kind of approach to being able to try all these different approaches.

Commissioner Turner. And then in my last few minutes, Gary, I wonder if you could help us understand some of the specifics of the policy changes that you made in Rhode Island that allowed this to happen.

Mr. Alexander. I guess what I would say is that really what is needed is the framework, and I think you just alluded to that. Having a global system allowed the state to be able to adapt and make changes quickly over the time period. Five years is not a long period of time, as we can see.

And so the state was able to implement, for example, new services or new programs for new populations. The state already had a shared living program for those with intellectual disabilities. And immediately, once the waiver was approved, we were able to extend those same benefits to the elder population.

Having worked in two states, I can tell you I have seen the difference because I worked in Rhode Island that had a global waiver with flexibility and then I went to

Pennsylvania and when I got to Pennsylvania I tried to make the exact same change on day one.

I called in the staff. I said, are you doing shared living for the elderly community? It is a great benefit for our elders, to be able to stay and live with a family.

And they said, no, we are not.

So I began the process.

And between the state itself, the inertia in the state and the roadblocks that the state put forward, and the Federal Government, two years later, Pennsylvania still does not have shared living for the elder community.

Now the advocates wanted it. The stakeholders wanted it. The lobbyists wanted it. Everybody wanted it. But we could not get it done in time.

So it will happen, but it will probably take that two and a half to three years whereas in Rhode Island we were able to get it done relatively quickly.

It does not work that way all the time. There are always pitfalls. In a small state like Rhode Island, we tried to do selective contracting for durable medical equipment. The state is a little bit too small for that model. It would have worked probably in Pennsylvania.

But having that flexibility to be able to adapt quickly is what states need because we have to balance our budgets. And every year, no matter who the governor is, whether a

Democrat or Republican, they are constantly looking to see how they are going to make the budget.

Commissioner Turner. Gary, my time is up, but thank you very much.

Chairman Chernof. I am going to interrupt at this-- thank you very much for helping me, Commissioner Turner.

And I am going to turn to Commissioner Feder, please.

Commissioner Feder. I am watching that clock. It does not say five yet. And excuse my cold, please.

I wanted to pick up on this issue of flexibility and your global budget conversation and, I think, distinguish between the way in which global is used. I think Diane may have been using it in a different sense than a fixed dollar amount or a block grant-like approach to financing.

And so, Diane, I wonder whether you would talk a little bit about the implications of block grant proposals, which have been alive and well in the Congress, and what you see as the potential there.

And just to note, on the discussion of the Rhode Island experience, I think one of the issues with comparing Rhode Island to proposals that have been particularly active in the House are the dollar levels that we are looking at in these block grants.

So I wonder if you would speak a little to that issue.

Ms. Rowland. Well, I certainly think that some of the

negotiated global caps that states like Rhode Island and Vermont have negotiated have been on, what we would say, the generous side to provide for greater flexibility but also not to constrain the resources to any significant level, in the way that some of the proposals to put a cap or a block grant into the Medicaid program have been set up to achieve overall savings, which would, over time, substantially reduce the share of Federal dollars going into many of these programs.

And the concern for the long-term services and supports side is that, as all of us know, that actually is where the bulk of the spending in the Medicaid program resides.

And, therefore, if there are constraints over time on the Federal dollars being made available to the states, as Melanie said, you cannot achieve savings overnight, and that could severely hamper the ability to really do some of the up-front investment that is needed to provide better home and community-based services.

It is always a challenge to move people out of the nursing homes, and that is going on quite significantly in the states, but certainly we do not want to strip the resources there, to make sure that the quality of care can at least stay for the people that need it.

Commissioner Feder. Thanks.

And, staying in that vein, another active movement that

we see in states is a move toward managed long-term care, and the demonstrations that Melanie is describing are heavily moving in that direction and, as I understand it, do depend on cuts up front in Medicare and Medicaid funding as they go forward. That was the authorization of the demonstrations.

And I know that you and your colleagues at Kaiser have done a lot of work on managed care--Medicaid managed care, in particular--and wondered if you would speak a little bit to the pluses and minuses of essentially an active movement of people with long-term care needs into managed care.

Ms. Rowland. Well, clearly, Medicaid has a long history now for the low-income families with managed care and the development of delivery systems that are appropriate there, but obviously, long-term services and supports have not necessarily had to be part of those networks.

So I think the real challenge going forward, as you have a population increasingly needing both kinds of services is, how can those managed care plans then put together the appropriate networks of services?

And there has been a lot of concern about whether they are really integrated or whether mental health services are still contracted out to a separate entity or whether there are still the kinds of networks of providers that have been very important to people with developmental disabilities and

other problems that are not necessarily included in all of the managed care.

So I think there what we see is it takes time to figure out how to do appropriate capitation, it takes time and a lot of effort on the part of the managed care plans to develop the appropriate provider networks, and it takes a lot of work with the beneficiaries to be sure they know how their care is being transitioned and to make sure that their medical records and other information are there.

And there are states that have done it well and have been down the road, but it is really a newer venture for many of the other states.

Commissioner Feder. Okay. And, just to close it up, I think that I appreciated, Melanie, your straightforwardness about the need for investment in home and community-based services and not to expect savings in that area, where we are so underfunded in so many places.

But, to come back to you, Diane, I wonder what you think--and you raise it in your testimony--about the capacity of states under current funding mechanisms, or matching rates, to be able to deal with what will be a growing need of an elderly population and whether you think perhaps we need some more Federal bucks in this system.

Ms. Rowland. I, clearly--

Commissioner Feder. Just one note is that we know that

for many years the NGA--the governors--has advocated that the Feds take over duals, and that seems to have disappeared. I suspect that has got more to do with politics than the reality of resource needs.

Chairman Chernof. And if I can ask for a very brief response to that so that I can move on to the next commissioner.

Ms. Rowland. I think that if you move on and look at other ways to support long-term care needs for people, other than Medicaid, you do the most to help reduce the pressure on the Medicaid program for the future.

Commissioner Pruitt. Thank you, all. Your testimony was very insightful.

I agree there are some themes that came across, and one of the themes I am particularly interested in is the interaction of services between settings.

And, Ms. Bella, I appreciate the work that CMS is doing in some of these demonstration projects.

One that is particularly interesting to me is as we talk about demonstrations and we talk about the readmissions and trying to decrease friction when you transition setting, one of the stumbling blocks, historically, has been the assessment of care and communication between providers.

Does CMS contemplate any work to further the CARE tool or to look at its efficiency and the role that a uniform

assessment could play in decreasing readmissions and improving overall health outcomes.

Ms. Bella. I completely agree with you; it is a critical piece.

Some of the demonstrations sites are testing different tools. We are very open to having an ongoing conversation about opportunities that maybe we are not yet exploring. So that would be something we would be happy to follow up with, to have a more extensive conversation.

Commissioner Pruitt. Is there currently a plan to further the CARE tool? Where do we stand on the uniform assessment from a CMS perspective?

Ms. Bella. That is something that really comes not from our office. It comes from other colleagues within CMS. So, again, if it would be helpful, I would be happy to gather that group, and we can have a more detailed conversation.

Commissioner Pruitt. That would be extremely helpful.

Ms. Bella. Okay.

Commissioner Pruitt. My next question--Ms. Killingsworth, it is good to see you. I am from Georgia. It is always good to see a neighbor. And Tennessee has been very progressive in regards to managed care and has accomplished some great things.

How would you respond to those literature works that

say that manage care does not actually save money?

What has Tennessee's experience been? Have you seen actual savings from managed care?

Ms. Killingsworth. I think, as Melanie pointed out very clearly, savings is not something that you typically realize in the immediate short term of change of any fundamental system transformation, but I think the savings is there.

Clearly, better coordination of care results in better quality of care, which results in more cost effective care, and our program has absolutely demonstrated that over time.

We had a lot of growing to do in the early years, but now we run a Medicaid trend that is about half the national average. Our average cost of care is half the national average health care spend. So our cost of care is significantly less, and our quality measures are very high, and our satisfaction rate is at 95 percent. So the program is doing very well.

From a managed long-term services and supports perspective, we have been able to nearly triple the number of people receiving home and community-based services by simply using the existing funds in the long-term care program to serve people in more integrated and more cost effective settings.

There is savings to be realized. It takes time. So I

always worry about a state going into managed care with an expectation or--a financial alignment demonstration--going into a demonstration with an expectation of savings on the front end.

You have to invest on the front end in order to achieve those savings in the long run. It is absolutely there.

Commissioner Pruitt. Thank you.

And, Ms. Rowland, I was very interested also in your comments on the asset transfer and the studies that have been done in that regard.

As we look at more coordinated system of long-term supports and services, how do we address patients that may prefer a particular setting, such as a nursing facility, but really could be serviced in the community--because there are those patients that could be serviced in a more cost efficient, least restrictive setting, but there are barriers to transitioning those patients to the setting. Have you thought about that at all or have an opinion?

Ms. Rowland. Well, certainly, I think a uniform assessment so that you can really provide for knowing what level of care an individual needs and what kind of a care plan they need, and then to, as we have talked about, make sure there are available resources in the community to give people an alternative. What the problem is today is that those resources are not always available because there are

waiting lists to get into some of the home and community-based services.

So I think any way that you can really give people a better choice--encourage them, work with the advocacy community--to try and make sure needs can be met in the community, that that should be the first line of where they go rather than into an institution.

You know, that takes an investment up front, and in many states there is still not that level of availability. So it really requires changing the eligibility for who gets access to home and community-based services.

Commissioner Pruitt. Great. I am out of time. Thank you.

Chairman Chernof. Thank you, all, for your presentations and helping us with these questions.

Actually, the questions so far have been terrific.

I want to start with the state folks first. So this is a question for both Ms. Killingsworth and Mr. Alexander.

So I come from a state, one of those states, that is just about read to implement its duals pilot. I spent my entire personal life in the state, and professional life, and so I actually watched when we, in California, went through this effort to de-institutionalize individuals with serious chronic mental illness--a perfectly sort of laudable goal, which is to try to help people live in the most

barrier-free environments possible.

There was one little problem when California did this. This was several decades ago. We sort of mainstreamed people, some of whom had been in institutions for very long periods of time, back into a community for which there was no real delivery system. So, for many of those people with serious chronic mental illness, there was nothing substantial there to catch them.

And, if you were to look at a city like Los Angeles, where I live, a substantial number of people who are homeless and a substantial number of people who are in the jails and prison system are actually chronically mentally ill.

So our sheriff, for example, would say he is the largest provider of mental health services in the state. Now whether that is true or not is a different question, but that would be his perspective on a previous effort.

The reason why I raise this is, speaking only for myself for a second, I think this notion of getting folks into the least restrictive environment of care and helping people live successfully in ways that are person-center in the home and the community are totally right, but I also totally understand why folks are very concerned about these sorts of transitions.

So I think at the state level part of this is knowing

that there is enough infrastructure there and creating enough trust that there are appropriate beneficiary protections, in a process that is timed in a way that makes sense to get people from a current system to a new system.

Both of you have had some experience with that. So maybe you could talk a little bit about overcoming the barriers--the local barriers--in actually setting up a thoughtful transition plan that does not leave people out in the cold.

Ms. Killingsworth. So you are absolutely right that there is a lot of preparation that goes into facilitating a transition into a managed care delivery system.

I will say that one of the benefits of a managed care system, where benefits are integrated, though, is that for the first time you can bring responsibility and accountability to a single point for care across the continuum.

So, rather than behavioral health services being accessed through one entity and physical health services through another and long-term services and supports through another, there is one entity who is really responsible for coordinating care across the continuum. And that helps to achieve the kind of development of infrastructure that you are talking about--that one entity needs to have the full continuum of services.

Does that take time? Absolutely.

I would say that it also takes the involvement and leadership of the state. Most states have mental health systems. They have long-term services and supports systems. And, when you transition them into a managed care program, you really want to begin with the framework that you have and work to transition that over time in a way that is seamless for members in particular but also as seamless as possible for providers.

There is a way to provide continuity of care requirements, to ensure that members continue to receive the same services, to ensure that they continue to receive them from the same providers for a period of time. That allows time for care planning. It allows time for additional providers to come into the network that may not have opted to come in, in the first place.

There needs to be accountability for monitoring those networks before go-live to ensure that they are adequate, to ensure that transition plans are adequate and services have been authorized for continuity for those members.

All of that takes, at a minimum, at a bare minimum, six months from the day that you know exactly what all of the final approvals are to full implementation, and that is if you have experience and a lot of infrastructure already developed. There is no way to do it faster than that. If

you do not have all of that, it takes significantly longer.

Mr. Alexander. What I would say, not to repeat what she just said so eloquently, is that you asked, I think, are we ready to do this in every state, every setting? I would say no because this is a very fragile population.

Having visited many institutions over the years, a lot of these individuals consider these places like their homes. And having visited their families, a lot of the families do not want them to come out into the community. So we have to be--it cannot be a one-size-fits-all system.

I think we have to de-institutionalize, but we have to do it in a way that is coordinated, that cares for that person and for that family, because having visited some of these institutions, families would be crying just to see officials from the state coming because they think that this great place that their loved one is living in, that it is going to end.

And a lot of the supports--there are some--we demonize sometimes some of these state institutions, but there are some good employees--great caregivers delivering loving care to these individuals.

So we have to just be careful in how we move forward on that. We need to move forward, but families and individuals first.

Commissioner Raphael. First, I want to start by

thanking the panel.

And I have questions for Diane and for Melanie, and I will start, Diane, with you.

You had mentioned that there is considerable variation among the states in performance and long-term services and supports, and I would be interested in how you would tackle variation because we want the states to have flexibility and the ability to innovate; at the same time, we want some degree of equity and a sense of standardization and expectation. So I would be interested in how you would tackle that.

And you mentioned also that you think that there is a need to relieve the pressure on Medicaid by looking at alternate sources of resources and financing. Could you speak to that as well?

Ms. Rowland. Well, certainly, the first challenge you put out is the overall Medicaid challenge--where do we want variation and where do we want uniformity and what do we want in terms of flexibility?

I think the real challenge--and I would add it to the comments that were just made in response to Bruce's comment--is that states also have very different administrative capacity, and they have been struggling at very different levels with budget cutbacks. And one of the things we hear over and over from the states is how stretched their

resources are, especially to administer and to take on new and innovative challenges on this side while they are trying in many ways to implement the other provisions of the Affordable Care Act.

And so I think one of the very important things would be to provide additional resources and support to the states that have the longest climb to go, in terms of being able to put these systems into place, and to have some better way of sharing the experiences of how to do it from the states, like Tennessee, that have gone forward and to really try and build better capacity to develop the administrative structures for these programs as well as to develop the on-the-ground thing.

I think it is also important that individuals--we have to take account of the eligibility side of this. We have been focusing a lot on the services one gets once they are in the Medicaid program, but I think another variation to look at is the differences in eligibility across the states and what should the minimum eligibility be for receiving these services--how are the rules for disability going to interact with coverage in the exchanges and with coverage under the Affordable Care Act, where people can be coming in based on income and not on disability status, and how will they get access to the disability benefits?

So I think there is a lot that needs to be done to try

and look at what ought to be available to an individual with disabilities regardless of the state they live and then, after that, what benefits to have as flexibility.

Commissioner Raphael. So I am going to hold on having you answer my second question so that I can ask Melanie a question as well.

One of the keys, I believe, to integration of care will be the ability to communicate and, as you pointed out, to share and leverage data. And right now, as we look at demonstrations and managed care entities, as they build networks of home and community-based providers for their population segments, many of these providers have almost no ability to electronically collect, aggregate and share information.

How are you thinking about that issue as you try to spur the development of these integrated demonstrations and managed care options?

Ms. Bella. It is a great question.

I mean, it also goes directly to our workforce issues and capacity issues, of how we are going to enable and expand that by better use of technology.

Actually, there is a lot of innovation in the field right now going on, particularly for home care workers and nonskilled workers, with using very simple technologies that are pretty cost effective. So all of that is kind of

flourishing.

The Federal Government, obviously, is not funding any of that.

I would say the biggest thing we are doing is we are trying to do technical assistance through a series of interactions and issue briefs that are focused on issues like:

How do plans and LTSS workers worker together?

How can a plan support workers in the home?

How can we share data?

How can we do contracting?

How can we do all these things?

I guess it is a step in the process towards recognizing it is the data piece--getting information about the beneficiaries--but it is also things like billing and other things that are going to make or break some of the dynamics, to make some of these models work, when you try to bridge those two worlds.

So the best thing that we are doing right now is just trying to do technical assistance to states, to LTSS providers and to health plans, with a different angle for each of them but understanding we have to start helping them understand how to develop relationships and do training and all that stuff. And data, obviously, sits right in the middle of that.

Commissioner Raphael. Thank you.

Commissioner Vradenburg. I was struck by the common theme of the benefit and value of the home and community-based services orientation to the system, but I was also struck by somewhat different answers from the states and from the Federal Government as to what the objective might be in trying to move to that. There seemed to be a common and shared value to shifting.

The states saw both increased quality of care and per capita reductions in costs, or at least mitigation of cost increases, whereas I got your answer, Ms. Bella, as basically it should be motivated by improved quality of care and, basically, patient and family choice and not so much about cost reduction.

So I came back to Mr. Alexander's comment that, in fact, states are motivated on the cost side of this equation because of their state mandate to balance their budget.

So I guess I would ask Ms. Killingsworth and Mr. Alexander to comment on the objective of whether we ought to have, or we must have at least in the states, the objective of seeking cost increase mitigation or cost reductions.

Ms. Killingsworth. I really believe that the two things are inextricably linked and that all states are always seeking to improve the quality of services that they provide and to improve the members' experience of care in

addition to living within their budgets and managing the cost of services.

And a big part of that motivation is really about being able to serve more of the people who need care. We recognize that the demand for these services is increasing. We need the ability to stretch limited resources across more people, and so it is imperative that we manage the cost in order to be able to do that.

Again, I do think that we have seen and have experienced, and other states have experienced, that there is savings to be realized. Whether a state begins with it as a primary motivating factor or whether it becomes sort of a secondary result of that, I think there needs to be an up-front recognition that the savings is not necessarily always immediate, that it takes time to transition populations, that it takes time to establish delivery systems that care and that, once those are in place and coordination is improved and quality is improved, then the cost of care will be reduced as well.

Mr. Alexander. Just briefly, I think we are saying the same thing--there is unity in diversity.

And I think with this particular--from this perspective, we have different hats we wear, but ultimately, if we are focused on the person and doing the right thing for the person, we are going to save money.

I mean, the Rhode Island experience, the Tennessee experience, or any of the other states that have ventured out to do reforms that have really focused on individuals, whether or not they are on long-term care supports or for the low-risk population that we serve in Medicaid, if we are focused on the individual and that person and seeking independence--I mean, what is the definition of Medicaid?

The definition of Medicaid is essentially to offer supports and services so that individuals and families can gain independence or self-care. It is right in the law.

So, if we take that for what it says and follow the letter of the law, then we should be saving money and improving the lives of the people we serve.

Commissioner Vradenburg. I was struck--because I come out of a world that cares very much about Alzheimer's and dementia--by the absence of any use of the word, caregiver.

So this question goes to, I guess, the--I guess I am going to come back to the state representatives again. To what extent are we overstressing caregivers, and are not we to be relieving them of some of the burdens by increasing external supports, or to what extent ought we to be relying increasingly on caregivers by giving them additional supports for the caregiver, not just for the patient involved?

So I ask the two state representatives again.

Ms. Killingsworth. It is one of the most challenging balances that Medicaid programs need to achieve, and that is to recognize the invaluable role of family caregivers and other caregivers. I believe the studies show 85 percent-plus of all long-term services and supports is really provided by unpaid family caregivers, right, and there is not enough money in the Federal or state system to supplant all of the care.

So a big part of what we are challenged with is really understanding what it takes to wrap around those natural support networks, to sustain them over time. We cannot supplant them, but we want to provide enough services and supports that we relieve the caregiving burden and allow those networks to be sustained for as long as possible, making sure that both the person receiving supports and the caregiver have the supports that they need in order for that arrangement to work.

Mr. Alexander. We have a limited amount of dollars. We have to take care of the most vulnerable first, and that is just the way the states really operate. When we look at our dollars across the board, we would rather spend our money on our most vulnerable populations.

Certainly, you know, there are instances where people may not necessarily need everything they are getting, and so we have to be better at the state level. And we do need

more Federal tools or the Federal Government to help us in that regard so that we are delivering the appropriate services at the appropriate setting.

It is not easy to balance all of that. The system is large. The entry points into the system are large, especially in large states. And we do see a lot of waste.

Commissioner Butler. So I want to join the chorus of thanking the panel for your presentations and to stay somewhat in the vein of caregivers and really talk about workforce.

Ms. Bella, you, in your comments, mentioned the Federal Government's attention to personal care attendants and keeping them involved and informed in this new process of care integration. Can you speak to some of the benefits, what draws you to that level of integrating the providers--the care providers--talk about what in states you have seen examples of this integration happening, and what some of the results may have been, if any, up to this point?

Ms. Bella. Sure. I think that most of it is in the development. We are about to be implementing these things.

So it is really just recognizing that in these models there is a way to empower personal care workers and home care workers in ways that they have not been in the past. And they can teach us, I think, and really help add to how we get to person-centered care.

And the best example of how we are doing that is just to really integrate interdisciplinary teams, to be truly interdisciplinary, and make sure we are pulling from the care management, case management and home care supports along with what the traditional medical supports, who have tended to guide that process in the past.

And so what we expect to see is, I think, a more--again, not to overuse the phrase--person-centered, sort of respectful understanding of how to deal with some of the supportive services needs in ways that the traditional system has not in the past.

In Massachusetts, we see some of the plans really working very closely with the personal care attendants. In California, the plans are really working to integrate with the IHS program and MSSP program and recognize that there is a role for everyone.

Again, we are trying to prevent medicalization of this model and trying to make sure that everyone is delivering to their capacity. And we do not need everything to be done by doctors and nurses and PAs. We need to really play to people's skills, respect scope of practice, but push on that a little bit and have more of an integrated team that provides a more holistic medical and nonmedical approach.

Commissioner Butler. Thank you.

And to the state representatives--Ms. Killingsworth and

Mr. Alexander--your states have been on the forefront of innovation and moving to managed care services and coordinated care and person-centered care delivery. Could you talk a bit about any specific workforce development strategies that were required in order to be successful and achieve the level of goals and objectives that you have set out?

Ms. Killingsworth. So workforce development is always an ongoing effort, I think, in all states, to ensure that there is an adequate capacity of well qualified, well trained people who will deliver care in a person-center way. We continue our efforts in that regard.

I will say that I think part of this goes back to how you align payments, right. We are looking at new ways to pay for home and community-based services that really reward agencies who are delivering care in a way that improves the members' experience of care, that assign consistent staffing, that allow members to choose who will provide their care, that do some matching of workers with members--all of those things that really improve quality from the members' perspective.

I also want to just sort of tie this and your question to Melanie together and ask you to imagine a piece of technology which would reside in a member's home, where when a worker arrived to deliver care they log in that they are

there.

By the way, if they do not log in, it alerts both the care coordinator and a provider that a person who was supposed to show up and deliver care did not so that there could be an immediate resolution of that potential gap in care--that when that care is delivered, that that worker then has the opportunity not just to log in the kinds of services that they provided but to provide some quick information about how that member is doing and to potentially alert a primary care physician and/or a care coordinator if there are changes in that member's condition that would warrant someone intervening before it has a chance to escalate.

That would also allow that member, potentially, to log in once that visit is concluded and provide some input in terms of their perception of the quality of care that was provided.

And all of that data could be aggregated and made available to evaluate the quality of that provider, and that information could then be shared with members who are selecting providers to deliver care in their home.

That technology is there. That is the kind of way that we can integrate in-home caregivers into care teams today, by leveraging technology that is available.

Mr. Alexander. I am going to take a little bit of a

different perspective.

One of the things that we tried to do in Rhode Island initially, in our initial request to CMS, or the Federal Government, was to take some of the savings that we gathered in the Medicaid program and reinvest it into job training and move the money over to the Department of Labor and Training.

The reason for that, of course, is we did not necessarily believe that everybody's salaries should increase, but the salaries for personal caregivers were very low. And, if we are going to attract quality caregivers, they need a living wage.

So, from that perspective, that was part of the reinvestment back into health and prevention that the state wanted to do.

And if we had--I am not saying it would not happen today if the ask was made, but at least back then.

That type of flexibility from Washington--as long as the states are saving money and delivering money back to Washington and delivering value back, if they can have the type of flexibility to reinvest in a targeted way, into low-wage workers, to help them have a living wage because, you know, a well trained, happy worker will lead to a healthier elder or intellectually disabled individual.

Commissioner Guillard. Thank you very much. Again,

thank you all for your eloquent testimony, and I found it very, very interesting.

In particular, you know, we look to find new ways or new ideas or something different. And the thrust towards home and community-based services, while we all--I do not think there is anyone who disagrees that. We have been talking about that for how many decades, going back to certainly when I was, obviously, much younger.

So, in hearing Mr. Alexander's comments--and I really thought this was excellent because in looking at new ideas this is very tangible. And I thought it was very, very interesting because I knew a little bit about the Rhode Island project and experience, but this gave some eloquent information.

A couple comments here--that you do focus on an issue where you did look at proper placement, efficiency, really moving towards a better managed system, if you will.

One of the comments I underlined was this accuity-based adjustment, and I weave that back to the support for the comment made by Mr. Pruitt that we do need some methodology and some basis, whether driven by CMS or driven by private technology which exists today, to really evaluate--do a uniform patient assessment so that we really understand what is the condition of the patient, where should that patient go to receive care most appropriately, and what should the

resources be used and the subsequent outcome.

That is not necessarily a question, more of an observation.

Because we want do--going back to the earlier comment, we do want to get the patient's in the right place. And, if that is more home and community-based services then, again, they should go where they are going to get the best care at the last cost.

Interesting, Diane Rowland indicated that we have seen the shift in dollars to home and community-based services.

But I gather--Ms. Killingsworth, it seemed to me that you were saying we have not or we have not seen enough or something.

I will make one observation, and then I will ask you to comment.

It goes to my personal belief after 40-some years of operating in the post-acute sector--nursing homes, assisted living, home health, hospice and all the components of post-acute care--that there is a misunderstanding. And that misunderstanding is that when we say the patients are inappropriately placed or in nursing homes, who should not be there.

Research by Brown University years and years ago said 9 percent of patients were inappropriately placed, and since then their data and analysis says that the number of low-

acuity patients keeps dropping and dropping and dropping.

Conversely, there are two populations in a nursing home: the patients that come in and out, in and out, in and out, and the patients that stay long-term--obviously, the chronic, long-term, comorbidity-ridden patient.

That lower population is predominantly--the ones moving in and out, with average length of stay of 30 days, are predominantly dual eligible patients.

So isn't the system working better in terms of than what we give it credit for--because those patients who are coming, the vast majority of individuals, not patient days, but individuals moving in and out and going back to the community, going back home, which is what I saw in the many states that I operated in. I never operated in Tennessee but 32 other states.

Do you understand my point.

Ms. Killingsworth. I do. I do.

And so I do think states have made tremendous progress, and I think we have seen improvements, but I do not think we are where we want to be yet. I think there are lots of opportunities to use services in a more cost effective way and deliver care in more integrated settings.

We, certainly, recognize that nursing facility services, skilled nursing facility services, all of the post-acute options that you mentioned, are critical,

critical parts of the continuum. The real key is ensuring that it is the right care for that person at that time, and I do not think that we have the mechanisms in place today to ensure that that is happening.

I believe that there are people who go into post-acute inpatient settings that could, in fact, be transitioned to home with appropriate services and supports, and I do not think there is an effective way of coordinating care and really looking carefully at those home and community-based options before discharge.

So, when that planning is done and when those evaluations are considered, if the inpatient post-acute setting is found to be the most appropriate, that is where the individual needs to go, but only after that kind of consideration has happened, and I do not think it typically happens.

Commissioner Guillard. I looked at data for years and years and years, and the vast majority of patients are coming into skilled nursing facilities, the vast majority are being discharged in a very short period of time, and the vast majority are getting care at home. And they are getting care at home because the home health care benefit--the Medicare home health care benefit--is kicking in.

And we have seen growth in the Medicaid home health benefit which, again, is appropriate and which I do think

then helps to move the system, to getting patients in the right location where they should be.

I guess I am a believer that the system works more efficiently than what people sometimes give it credit for.

On that note, I will defer.

Chairman Chernof. Commissioner Brachman.

Commissioner Brachman. Again, I thank all of you for your comments and your willingness to come today to enlighten us.

My first question is to Ms. Killingsworth, and it is from the standpoint of increasing home and community-based services and what I thought was a very rightful recognition of the need to expand the housing that would be available, and Dr. Chernof mentioned that as well.

But beyond simply recognizing the need for it--and what I think has also been a theme, and that is everything takes time--could you address perhaps in a little more detail some programs that you are aware or that you have instituted in Tennessee to deal with the number of housing availability prospects that there are?

You mentioned the potential of paying for board and care, but that would not build new facilities and may not deal with everyone coming out of institutions or older people who may not be in safe circumstances where they are currently, even if they are at home.

Ms. Killingsworth. So one of the questions that was asked earlier as well was about the difference between the younger population and the older population in terms of where we typically see their placement, and I do think a piece of that it is the availability of effective community-based residential alternatives for people who can no longer live alone but who may not necessarily need to be in an institution if appropriate community-based residential models that provide 24-hour supports are available.

I think that with respect to housing, it is probably the single greatest barrier to transitioning a low-income individual out of an institution and into the community.

We serve a population of about 12,500 people who are seniors and adults with disabilities in our managed long-term services and supports program in community settings, and only about 500 of those people are in community-based residential alternatives; the rest are in their homes, which means that for a person to go home, for the most part, they have to be able to go to their own home or they have to be able to transition to a home to live with a family member.

We offer assisted living facility services with some of the changes that may be forthcoming in the proposed regulations around home and community-based settings. We are not sure that that will continue to be a viable benefit as a home and community-based services alternative, and we

are very concerned about the one option that we do have available.

In an effort to try to make some housing resources available, we work closely with our State Housing Agency and have recently entered into a memorandum of agreement with the State Housing Agency to take some of our MPF rebalancing funds, some of the State Housing Trust funds and create a dedicated housing resource for people who are moving out of institutions and into the community. It will be set aside for Medicaid beneficiaries to receive a housing supplement over a period of up to five years to help them transition to permanent housing.

It is the kind of thing that we think there are tremendous opportunities to do in home and community-based programs and to draw down a Federal match that would allow those dollars to stretch across even more people.

Today, if you go into an institution, the Federal Government will match your room and board charges at your standard FFP rate, and if you receive care in the community you get nothing in order to assist you. And for people who have an SSI income only, that can be a tremendous barrier to de-institutionalization.

Commissioner Brachman. And so you see that saving money, again, over the longer term or over the shorter term in terms of the de-institutionalization and putting people

in some sort of a more residential setting?

Ms. Killingsworth. It is an immediate savings, actually. We require individual cost neutrality in our program so that the cost of care in the community cannot be more expensive than care in an institution, and so the moment that someone leaves the institution there is either a savings or, at the very least, a cost-neutral situation.

Commissioner Brachman. And I am going to switch gears for a minute but, again, both to Ms. Killingsworth and to Mr. Alexander. In terms of state initiatives, looking at what happens after a surviving spouse passes, do you actually go back and get the funds that may be still in the estate once that second person is gone, or what happens?

We hear a lot about the question of people who are transferring resources in order to get on Medicaid, and there is a lot of discussion back and forth on that, but the question of what happens after the surviving spouse is gone and whether states actually chase the money that might be available.

Ms. Killingsworth. In Tennessee, we do. When estate recovery is delayed due to a surviving spouse, upon that spouse's death, we would then pursue recovery of any assets to offset the cost of the Medicaid program. Certainly, there are very creative attorneys who help people do all sorts of estate planning to try to avoid that whenever

possible.

Mr. Alexander. I would echo the same comments.

I just think there is great diversity across the states in terms of what states have implemented TEFRA liens and the like, but certainly--you know, I think the states need to be a little more aggressive in terms of in that aspect, but I think there is great diversity amongst the states in terms of what they have implemented so far.

Chairman Chernof. Thank you.

Commissioner Jacobs.

Commissioner Jacobs. Thank you, Mr. Chairman.

Mr. Alexander, I am kind of curious--and we talked a little bit about this in the workforce discussion a few minutes ago--if you could provide some examples of things that you potentially were not able to do as a result of the parameters and the negotiations in the waiver with CMS, either through negotiations or statutory prohibitions that CMS just did not have the power to waive.

In Governor Herbert's famous case, you know, it required a personal intervention from him to the President to get CMS to approve communicating with Medicaid beneficiaries by e-mail. I do not know if you have stories like that, but some things that you felt you could do better if there was more flexibility.

Mr. Alexander. You know, I think it is always going to

be a challenge. I think the Federal Government is very large, and states, except for probably Texas, California, Florida and New York are relatively small.

So Rhode Island, you know, really wanted to push the envelope. We had a governor who was, what I would say, aggressive in terms of wanting to change the system and a state legislature that realized that every year we would come back and CMS would want changes to our state plan; we want waiver changes, and CMS would tie us up for months and months and months.

Now that being said, these things are easier said than done. Rhode Island started out asking for a block grant. We, obviously, knew we could not get that. We were really interested in this gain-sharing model of being able to utilize, in a performance-based way, some of the Federal savings to reinvest back into the state.

I mentioned workforce development simply because our lowest wage workers--we had a lot of difficulty trying to rebalance the long-term care system when you cannot pay our lowest wage workers a little more money.

The state asked for health saving accounts across the population. That was not granted.

We did come to the agreement of creating healthy choice accounts, which was very innovative, with an electronic scorecard for individuals. The Federal Government did not

allow us to implement that.

You know, there were a number of things, other items, but clearly, in my mind, the issue of having greater flexibility on mandatory populations rather than just optional populations--being able to utilize the healthy choice accounts which were in the standard terms and conditions--really would have done something to change the culture in terms of--and we see now in Tennessee, not in Tennessee, in Arkansas, that they are looking to move low-risk individuals onto the exchange, into private health insurance.

And we really wanted to push the envelop with that because we believe that it was the only way to engage the recipients in the cost of their health care.

Commissioner Jacobs. I think that is helpful.

And the gain-sharing idea is an interesting one because Dr. Rowland pointed out that Rhode Island got a flexible, generous cap on the waiver, but I think your point in your testimony is the results thus far showed that you did not need that much money and you have not spent that much money.

And so the idea that you can trade, or are potentially willing to trade, some of the flexibility in exchange for a lower--are willing to trade a lower cap in exchange for the flexibility is an interesting one.

Mr. Alexander. Yes.

Commissioner Jacobs. My last question is I believe Rhode Island, if memory serves, had prior to the waiver a higher percentage of beneficiaries in institutionalized care. Do you think this model can be effective in states that have been more effective already in transitioning to the home and community-based services model?

Mr. Alexander. I think so because this is about a framework. It is about a flexible framework. So, if the state wants to do something else, they should have the flexibility to do that.

This model can work anywhere because it is not specific to Rhode Island. We set out to create a flexible framework that any state could model and then do whatever they would like to do to be able to reform the system.

Each state is different. I have always said that I am not a proponent of a single payer, but if the state wants to do that, that is the state's business. And any state should be able to take that flexibility and be able to do what they need.

States do not need barriers, and that is one of the reasons why we advocate for--a lot of us advocate for block grants--because it gives us that flexibility to be able to move money around. One of the examples is, again, I go back to our low-wage workers, that we wanted to reinvest a little bit of money.

If we had that type of model from Washington, where Washington created broad parameters based on health and safety, and let us really do the innovation, you would see some great things happening nationally. I mean, there are some great models out there right now that, if we had them implemented on the long-term care side, would be saving a lot of money and would be improving the quality of care.

But it takes a long time for states to get this done, and it is not just the Federal Government; it is our own inertia at the state level.

Commissioner Jacobs. Thank you, Mr. Chairman.

Commissioner Claypool. Thank you and forgive me for arriving late. Traffic conspired against me on the 14th Street Bridge, and I did not get the benefit of hearing Diane's and Patti's testimony. Nonetheless, I did read some of it, and I just have a few questions.

Diane, could you help us with a basic understanding of how state fiscal effort in drawing down Federal match in the Medicaid program might affect the states' ability to provide these home and community-based services, these kind of optional community-based services?

And then I will have a follow-up question around MFP.

Ms. Rowland. Well, certainly, I think one of the issues that we ought to put on the table is that home and community-based services are an optional benefit and are

mostly provided through various waivers, which different states take up to a different extent, so that this has been a benefit that many states have elected to continue to use the waiver services so that they can cap enrollment and so that they can constrain the amount of dollars that are going into these services.

So one of the reasons that they are not as available in all states is because of some of these decisions.

Obviously, all of that relates to the state fiscal spending and to what they are able to do. And it helps when there is a 90 percent match instead of a typical FMAP to provide an incentive to states to, for example, implement some of the home health or the health home demonstrations.

And, clearly, states always operate in a fiscal environment as well as in a policy environment. But I think that home and community-based services have been one in which some states have feared that making them more available will tremendously increase their spending and they will not have the state resources to do it.

Commissioner Claypool. And, just to underscore, it is my understanding that there is a considerable variation in how states actually spend money on their Medicaid programs. Some states invest more than others. And so individuals that are interested in receiving long-term care services, that are eligible for Medicaid, may be able to receive a

certain set of supports in one state, but they would not be able to in another. Is that accurate?

Ms. Rowland. That is actually accurate in, as one of the slides that I used in my presentation shows, there is wide variation in the distribution of spending between home and community-based services and institutional care across the states.

You have heard from two states here that have really moved to be much more aggressive at the way in which they use managed care and integrated services, but there are lots of other states in which there still remains a stronger institutional bias.

Commissioner Claypool. And so one tool that the Congress has given the states, basically--and a bipartisan tool--in that the Money Follows the Person Program was part of the Deficit Reduction Act of 2005 and then reinvested in, in the Affordable Care Act, seems to be a tool that is of interest to states. They are looking to this program to capture that additional Federal investment. It is 90-10, I believe, for that first year of transition.

And, from the slides that you showed, from a beneficiary perspective, it does seem that there are individuals that are living in these institutional settings that really do prefer community-based settings.

So maybe there is not much of a question there, but

this program--and I do note in your testimony that these programs are expiring, and so perhaps we should be looking at how to extend them.

Patti, quickly, to--

Ms. Rowland. Henry, I would also say that we should also be looking at whether they should be waivered programs or actually features of the program itself.

Commissioner Claypool. Great. Thank you.

And, Patti, just a quick question about your work in Tennessee to rebalance your Medicaid program, could you talk to us about some of the barriers that you encounter, just at the state level, in trying to move a system away from one that relies more heavily on institutional services towards community-based services?

We often hear from consumers that there is a preference for a community-based setting. What prevents you from moving more rapidly towards providing more home and community-based services for the population?

Ms. Killingsworth. So a big part of my previous testimony was really around, I think, some very fundamental design flaws, if you will, in the Medicaid program that I think are a big part of the barriers that states face in their rebalancing efforts--things where there is an inherent institutional bias around a mandatory nursing facility benefit but optional home and community-based services.

So, essentially, if you qualify for nursing facility services and you want them, you get them even when there might be more integrated community options that would be appropriate, that would be more cost effective and that you might prefer if you really understood them.

There are biases around Federal match for room and board in an institution but no FFP available to support any kind of housing assistance for a low-income individual in the community.

There are additional challenges always with any waiver request in terms of securing approval to be able to move forward. Our program design, which was passed unanimously in the Tennessee General Assembly without a single no vote in any committee or any subcommittee, and supported across the stakeholder community, took over a year to secure approval from the Federal Government before we were actually able to move forward with implementation.

All that said, we have been able to move from 17 percent of that population being in home and community-based settings to now approaching almost 40. We are at 39 point-something as of July 1st--so significant change over what is--we are almost coming up on our 3-year anniversary of statewide implementation.

And a lot of that has been achieved by appropriately aligning incentives in the program, creating a single

capitation payment across home and community-based, and nursing facility, settings so that managed care organizations are incentivized to want to provide care in the community whenever that is appropriate, but they are also incentivized to ensure that the level of services that they provide is sufficient because they are responsible for the more expensive institutional benefit otherwise.

We mandate that MCO's have nursing facility diversion programs. We mandate screening for transition to community. And through MFP, which has been an important piece that we have layered on to our MLTSS program, we have been able to provide a unique incentive structure that has really further aligned incentives to move people into home and community-based settings.

And we have moved in the first 2 years of the program 1,300 people, not all of them in MFP, some of them just in the managed care program broadly--so significant change that we have seen just by appropriately aligning incentives.

But I do think that many of the things that we talked about previously, including changes in how the Medicare benefit is utilized because that is primarily the driver of how people come into Medicaid nursing facility services--if we can make those changes, it would significantly enhance states' efforts to rebalance.

Chairman Chernof. And, with that, I am going to thank

the panel. That is actually a nice segue because our next panel will be focusing on opportunities to strengthen Medicare.

Before we release all of you, I just want to thank you for outstanding presentations and great information.

[Applause.]

Ms. Rowland. And, Mr. Chair, I would say that while I did not appear today on behalf of MACPAC, MACPAC is anxiously awaiting the results of your deliberation so that at our September meeting we can take up where you have come out on long-term care and move forward. So, thank you.

Chairman Chernof. Thank you very much.

If the next panel could come right up and take their seats, and we will get started momentarily.

[Pause.]

Chairman Chernof. Commissioners, if you are in the room, if you would start to make your way back up towards the front.

[Pause.]

Chairman Chernof. Okay, I am going to ask commissioners to take their seats, please.

[Pause.]

All right, I want to be respectful of people's time and leave time for questions. So we are going to begin our second panel now, which will be focusing on strengthening

Medicare.

You guys have a tall act to follow. We had a really good discussion on strengthening Medicaid. So we look forward to your comments.

I am going to begin with Joseph Antos who will be speaking from the American Enterprise Institute.

STATEMENT OF JOSEPH ANTOS, AMERICAN ENTERPRISE INSTITUTE

Mr. Antos. Thank you. I appreciate the opportunity to testify today before the Long-Term Care Commission.

There is very little time allowed for testimony. So this is a rare opportunity.

How do you make the slides move?

Chairman Chernof. [Off microphone response.]

Mr. Antos. Okay, so let's move on to the first slide.

I am just going to say a few things about Medicare's role in financing long-term care and then give some suggestions about strategies, not necessarily specific policies, but strategies.

So, you know, basic facts. I think the commissioners all know this, but it helps me center myself when I say these things:

That Medicare's primary function is, in fact, to finance medical care, not long-term care services and supports.

The program is a very large program--50 million beneficiaries, almost $600 billion in spending this year, over $600 next year, $8 trillion over the next 10 years.

Post-acute care services is what Medicare finances, and that is mostly--most of the money is in skilled nursing facility care and home health care.

Post-acute care definitely means that you had to have had an acute incident that was substantial, not necessarily that you had to have been discharged from a hospital, but that is the most common approach. You need a skilled level of care, and there has to be a prospect of improvement as well.

So, when you look at the money here compared to $600 billion--skilled nursing facility spending, about $30 billion; home health spending, about $20 billion. This is clearly a small part of Medicare funding.

Medicare, of course, also finances medical care for dual eligibles. There were 10 million dual eligibles--people who were eligible for both Medicare and Medicaid--in 2011. This is a population that has very diverse needs, ranging from people who are relatively healthy to people who have multiple chronic conditions or have serious disabilities or cognitive impairment.

In 2009, according to the Medicare Payment Advisory Commission, for dual eligibles enrolled in Medicare Fee-for-Service, Medicare spent roughly $15,800 per dual whereas Medicaid spent $13,000--about $13,600.

Since Medicare is spending its money on medical care and not long-term care, clearly, what that says is that many duals in fact do not use long-term care services, at least in a given year.

Next slide, please.

So the goal here is to coordinate medical, social and long-term care services, clearly. Medicare has had, over the years, several experiments and several ongoing organizational functions to try to bring that coordination together.

As everyone on the panel knows, Medicare started out as an uncoordinated traditional program, Fee-for-Service, and it largely stays that way except for these kinds of plans, especially Medicare Advantage plans which are meant to be more organized health plans.

But plans that have a closer connection to long-term care, social managed care plans--that is a new term to me. I call them social HMOs, betraying my age. There are four of these excellent ideas. They are excellent ideas, but the question is, could we do them anywhere else? Why are there only four?

And I think the answer is pretty clear. Seniors tend to already have connections to physicians and other medical treatment, and so moving into a social HMO means moving into a network plan that is often pretty tight, and that is challenging for a lot of people.

And it is just as challenging if you now have a chronic condition or you have a need for long-term care services. It is still very difficult to make that change.

Similarly, PACE, Programs of All-Inclusive Care for the Elderly--they are more available, more widely available. They provide a mix of medical and social services. Again, it is a network plan. Again, it strikes me as a good model because it is attempting to coordinate these various services.

And then, finally, special needs plans which also--actually, I think in a more sophisticated way--recognize that, as the earlier panel said, one size does not fit all. You need to have different modalities of management to deal with the vastly different needs and vastly different patient reactions to what is going on with their health care.

And then, finally, the ACA demonstrations to integrate care for dual eligibles running through the states.

So, the big question, of course, is do any of these things actually work? And that is a very difficult question to answer.

And, even worse, what does work mean?

Does it mean saving money?

Does it mean improving the quality of care?

Does it mean avoiding hospitalization, for example, which is one of the primary goals, I think, of coordinated care in Medicare?

Hospitals are the big cost centers in health care, an dif you can avoid a hospitalization, then you might actually

break the cycle of services--hospitalization, discharge to a skilled nursing facility; next incident, a little tougher, discharge to skilled nursing facility, ultimately ending up in a nursing home where the cycle continues. And that is something we would like to avoid

And then the other question is, are these ideas replicable plans? I think that is a real question.

Next slide.

So, you know, there are things we can do, obviously--more care treatment, trying to catch medical issues in time, especially paying attention, close attention, to prescription drug use and making sure that people are prescribed the right drugs in the right way, keeping in mind that the average dosage requirements are really not geared to an 85-year-old, 90-pound woman. You need to calibrate these things, and if you do not have the experience, it is difficult to do.

Obviously, we need the coordination across the entire spectrum of services, and that does not just mean putting all the money in a pot and saying, okay, somebody do something with it. It is also coordinating care, and that is not easy to do.

A point I would like to make is that top-down solutions, even the ones that seem like a good idea, may not work out. So we need to have flexibility. Your earlier

panel made this point too.

Next slide.

You have seen this slide before. I am just going to make the fiscal point for Medicare. Medicare is, indeed, the program that is driving our budget problems.

Next slide.

You can see that the CBO estimated--this was last year--that Medicare spending would rise more rapidly than any other major budget category except, of course, interest on the debt. So Medicare is, in fact, in the crosshairs of budgeteers.

Next slide, please.

And the world of Medicare financing is looking like the world of cuts and co-pays. The Medicare Physician Payment Fix needs pay-fors.

MedPAC, a couple years ago, made a list. They were not making recommendations. They just said these are the things you could look at. Twenty-two percent of their cuts were from post-acute care services.

The President's budget for next year--modest cuts in the budget. However, 25 percent of those cuts come from post-acute care in particular, not just cuts in payments to providers or changes in the way we deal with providers, but also phasing in home health co-payments.

Next slide, please.

On top of that, Medicare and health care are moving towards a consolidated model, not a Fee-for-Service model. ACOs, clearly, are moving that way.

One last quick point--clearly, we need proposals that do a lot of things in long-term care in the Medicare context, but certainly, saving money and improving care quality are right at the top of everybody's list. Cost estimates are usually pretty optimistic about saving money. And so the idea of giving health plans or providers or organizations fixed amounts of money, not telling them what to do precisely, and letting them work that out is going to have more chance of success because they are going to be far more motivated to find the solutions that work for their populations.

Thank you.

[The prepared statement of Mr. Antos follows:]

Chairman Chernof. Thank you very much.

Next, we will hear from Barbara Gage from the Brookings Institute.

STATEMENT OF BARBARA GAGE, BROOKINGS INSTITUTE

Ms. Gage. Thank you, and it is an honor to be here today.

You have several materials in your handout. There are a set of slides which we will be going through as well as a table highlighting some of the funding for the Administration for Community Living, often called the third leg of the stool for long-term care populations, and an overview of some of the types of programs that Melanie was talking about this morning.

I would like to highlight that we are here to talk about the Medicare program in this panel, and as Joe just pointed out, it is an acute insurance benefit. It is traditionally targeted acute services.

Many of the users are long-term care populations, but when we talk about the services that the long-term care populations use, I would like to emphasize that some of them are medical services and some of them are social support.

So it is an honor to be here today. I have been studying the Medicare post-acute care populations all of my career, most of which has been providing either Congress or CMS and ASPE information on the patient quality and outcomes associated with the post-acute services.

My dissertation, which I completed over 20 years ago, addressed the issue of fragmented financing and delivery for

these populations, and I thought it was a trite topic then because the work started in the 70s and now we are here in a new century and still talking.

One difference today is that the conversation has changed. Instead of discussing cost constraints and ensuring access to services and thinking about the costs of individual parts of each insurance program, we are now, as a Nation, focusing on people, on developing patient-centered systems of care. And this is not just semantics. This focus underpins an entire revolution occurring in the health care delivery today.

The Medicare program and the private insurers are all moving towards value-based payment and delivery models. Payments are being tied to outcomes. In the traditional Fee-for-Service programs, providers are losing payments if their patient is being hospitalized for avoidable adverse events. People are starting to recognize that adverse events that lead to hospitalization, many of these issues that the long-term care population face--dehydration, falls with injuries, nutritional deficiencies, medication complications--those hospitalizations associated with those adverse events could all be avoided with a little social support.

By holding the hospitals and others in the system responsible for avoidable hospitalizations that occur within

30 days after hospital discharge, the Medicare program is already forcing the providers to look beyond their front door and think about care coordination and patient support--so really focusing on the person and not just the role of that individual provider.

Many initiatives are underway in both the public and private sectors to redesign the health care and achieve the Triple Aim of better population health, improved outcomes and lower costs.

Both public and private insurers have established accountable care organizations and primary care medical homes, which give the physicians and the hospitals responsibility for monitoring the outcomes and reducing rehospitalizations, as well as managing chronic diseases and providing preventive services.

Certain of these programs have targeted the dual eligibles, and we heard from Melanie this morning about some of those.

In addition, the Administration for Community Living has supported programs that focus on transitions and pulling together the medical and the long-term care communities to create safer environments for the populations at home--the long-term care populations.

Many resources are being brought to bear as long as you or your physician meets one of these program parameters.

But the problem is broader than a select payer group. The long-term care population are the frailer, less healthy portion of the Medicare population. They are not necessarily impoverished, but most likely, they are among the providers' high-cost beneficiaries.

These Medicare populations--these long-term care users--are using the physicians and hospitals participating in the ACOs and other redesign initiatives, and all of them are using hospitals that are now being held accountable for reducing rehospitalization and infection rates as part of their traditional Fee-for-Service program. So these value-based approaches, or outcomes-oriented incentives, are changing how the providers practice medicine and giving them an incentive to be accountable for the patient outside of the office visit or the hospital admission, and this is changing the discussion.

So this is a very timely time to be looking at long-term care populations' support needs.

So who are the long-term social support populations?

Long-term care has long been synonymous with Medicaid, with dual eligibility, because Medicaid has traditionally been the primary insurer for long-term social support services. And, here, we are talking about those that Diane talked about this morning--the nursing facilities, the personal care services, the group homes, the other

nonmedical supports that Medicare and other insurers do not cover.

Almost 70 percent of the Medicaid spending for long-term social support populations is for long-term social support services, as shown in figure 1.

But, as shown in figure 2, the majority of these costs are for community-based services, which is a big move from where we were in the 90s when states were being encouraged to take home and community-based waiver programs.

There has been some successful movement, but the population is aging, and not all people who need long-term care services are impoverished. Some are just older or disabled and need some support to remain safely in the community.

The Administration for Community Living, formerly the AOA, sponsors support services for all older adults and persons with disabilities regardless of income or other qualifying medical conditions, but historically, this is a very limited program.

As you can see, in the 2012 budget, there were $2.2 billion authorized to the states to cover the types of services that provide nutrition. Much of that went to nutrition services--Meals on Wheels--a smaller amount to senior centers, where you could be identifying some of these problems that the long-term care populations might be having

in the community, and $1.6 million did go to caregiver services.

I think somebody was asking about that this morning and the importance of caregiver services.

But these are pennies compared to the long-term social support costs.

So, looking at the next slide, who are these populations? Who are these long-term social support populations in the Medicare program?

They tend to have multiple chronic conditions, such as high blood pressure, heart disease, diabetes, cancer, stroke, and their Medicare costs per person increase with the number of those conditions. About 37 percent of all Medicare beneficiaries have at least 4 chronic conditions, as show in figure 3.

The average Medicare cost per person, for the person with 4 to 5 chronic conditions, is $12,174 compared to only $9,738 per the average beneficiary.

And, if you look at the 14 percent of benes who have 6 or more chronic conditions, Medicare is spending over $32,000 a year.

So the issues of the long-term care populations are important to the Medicare program and to those providers that are now being held accountable for avoiding rehospitalizations and other things.

As show on figure 5, much of the spending is accounted for by hospitalizations. Hospitalizations trump all costs just because of the average cost of a hospitalization.

And, when you look at these hospitalizations by the different complexity groups, those with 4 to 5 chronic conditions, among those populations, almost 30 percent are hospitalized at least once. And among them, 3 percent have 3 or more hospitalizations a year. So these are our ping-pong populations that perhaps you could control a little better if you were actually worrying about them between visits.

Those who have 6 or more chronic conditions have even higher hospital use, and the rehospitalization rate within 30 days is even higher. Ninety percent, as show on the next figure--ninety percent of the readmissions were among those with four or more chronic conditions.

And that top part of the figure, that purple part is just for the 14 percent who had 6 or more chronic conditions.

So we are talking about a lot of high-cost Medicare populations.

The next slide shows that they also use a lot of post-acute care. Those who have 4 or more conditions, compared to those on the left, 19 percent have at least 1 post-acute visit. And among those with 6-plus, almost half have at

least 1 post-acute visit.

And, as shown on the next slide, we are using home health among those populations as well. So home health may be a lower cost, but if you are looking at somebody who has 6 or more health conditions, 27 percent of the benes had 13 or more visits per home health episode.

So I would suggest that we reframe the issue. Instead of asking how to fund long-term care services, I think we should start asking how providers--how the health care community--can use long-term social support providers better to manage their Medicare populations.

The providers in today's world have the same incentive as insurers to manage their patient outcomes for those 30 days following hospital discharge, which is where most readmissions occur.

So hospitals could put a case manager in place to avoid later being penalized for a readmission. Or, rather than hiring one, they could contract out with a community-based organization to send a nurse into the home following their discharge to the community. Or, if the patient qualifies for home health, they could be referred to home health. The relative cost of one nursing visit following a hospital admission would be $115 compared to $8,000 for an admission.

By reframing today's discussion to focus on helping the Medicare providers better achieve outcomes and improve the

outcomes, the providers have an incentive to work with the long-term care community.

Some of these initiatives are underway right now in the ACOs and the other initiatives. They are contracting with community-based organizations to do simple things like making sure the patient is safe in their home after discharge. They are reconciling the meds. They are checking the home for structural barriers to avoid a fall, setting up transportation for follow-up visits to the physicians and groceries--many of these things that can avoid adverse events.

But your question to me today was focused on the Medicare benefit and whether there were changes need to the SNF or home health benefit to better meet the needs of these populations.

Again, these benefits have been traditionally acute care benefits. Medicare covers up to 100 days in the SNF following a related hospitalization of at least 3 days in length.

Some argue the SNF services could be more effectively used as a lower cost inpatient resource for nursing or therapy if the three-day prior stay were removed. This suggests that eliminating the three-day stay would allow short-term inpatient nursing to be provided in a SNF without the hospitalization, but this would only benefit patients

whose medical needs require 24-hour nursing care because that is the definition of SNF. Any changes to this requirement would need to be defined on a basis of medical complexity so that you did not have a woodwork effect with the rest of the beneficiaries.

The other area is the home health, and I will just quickly suggest that while there are many services that are currently being provided under the home health benefit to the long-term care populations--in fact, the last slide has a table that shows the differences in Medicare home health use between those who are community-based and those who are coming from the hospital--you can see it is effectively a part of the long-term social supports system right now. But there is room for growth, and there are savings to be had by coordinating services.

Thank you.

[The prepared statement of Ms. Gage follows:]

Chairman Chernof. Thank you very much.

And, finally, Marilyn Moon from the American Institutes for Research.

STATEMENT OF MS. MARILYN MOON, AMERICAN INSTITUTES FOR RESEARCH

Ms. Moon. Thank you. I appreciate being here today.

I am going to take a little bit different tack, however, than some of my colleagues. I guessed correctly that Barbara, who is clearly the world's expert on post-acute care, would bring you up to speed on a lot of those issues, and Joe did a nice job of talking about the overall size and issues and the challenges there.

But I wanted to stress today that our current makeshift patchwork of public and private programs for long-term care leaves many people without adequate care and contributes to inefficiencies and perverse incentives for behavior. You already heard some of those in terms of increased hospitalizations, for example, that are unnecessary, but we do not provide very basic services for people, and they end up then costing the system enormous amounts of money.

Recognizing that the current system is seriously flawed, therefore, my focus today is on a broad solution rather than piecemeal reforms. And I know that puts me way out there. It means that, unlike Joe, I do not put saving money at the top of my list of what to do. I wanted to think about this in terms of what should we be doing in terms of improving the long-term care system in the United States, if you can even call it a system.

The Medicare program could be a good place to start a viable long-term supportive services program. It is different than Medicaid because it is not predicated on being incredibly poor nor does it demand that you, therefore, spend down everything before you get any benefits. And, in that sense it is going to be viewed a lot differently by individuals, both in terms of how they approach the program and in terms of its chance for success, I believe.

Medicare, despite the criticisms leveled at it, is a remarkably successful program. It is probably the most popular public program that we have, and it certainly out-polls private insurance and almost everything else you could imagine.

Certainly, there are improvements needed in the program to meet its acute care needs, and we heard some suggestions about that this morning already. But it could offer a number of advantages in creating a more comprehensive environment for providing care for those requiring long-term supportive services.

We have only recently come, as Barbara talked about, to the understanding that coordination of care will bring lots of benefits with it, and that means bringing a number of things under the same umbrella.

It does not mean, as Joe talked about, simply

capitation. It means that you must actually have coordinated care.

Nonetheless, we are in an environment in which the philosophy to cut Medicare that is currently in vogue contributes to what is wrong with our health care system for the elderly and disabled in the United States. Too often, by focusing on reducing costs of specific programs--how to cut the home health benefit, how to cut the skilled nursing facility benefit, for example--does not pay any attention to the needs of the beneficiary population or the overall cost to society when you do that. You can push them out of Medicare, but that does not mean the costs or the problems go away.

Nowhere is this more evident than in the long-term care world, where the gaps in the system lead to extraordinary costs on some individuals and to others being deprived of much needed care.

The issue, I would argue, is not one of ability to pay. We have the ability to pay. It is a question of willingness to provide public resources for these needs and of whether we will do so collectively.

The Medicare program has always had an uneasy alliance with long-term care services. We have had years in which home health and skilled nursing facility costs have grown enormously. Then we have tamped them down because of the

fear that they are getting too close to long-term care.

Nonetheless, with these as being skilled services only, there are many artificial distinctions, as Barbara has already pointed out, in terms of how home health benefits now get into the world of long-term care, and lack of such benefits causes enormous problems and costs for the acute care side.

I would also argue the private sector is not the answer. There are mountains of evidence that suggest only a limited number of private plans operating under Medicare Advantage actually do very much to coordinate care, and they have not been very successful in holding down costs. They are not the solution that people often are looking for in terms of a magic bullet.

Moreover, when you look at private long-term care insurance, I have a very good colleague who is on a panel of this Commission, who talks about the infancy of the private long-term care insurance world, which has been in infancy since I began working in this area, and since Judy did as well, more than 20 years ago. I do not know when it is going to grow up, but I am not holding my breath.

It is equally undesirable, I would argue, to turn the responsibility for dual eligibles over to the state Medicaid programs, as is currently underway with coordinated care demonstrations and other actions. Why should the most

vulnerable beneficiaries in Medicare, those that are incredibly expensive, that are greatly at risk, be handed over the state governments that are generally ill equipped to handle them and where there is likely to be enormous variation in the quality and quantity of the care that these people receive?

Perhaps most important, creating a comprehensive system of acute and long-term care services is of critical importance for middle-class families, not just for the poor. And we all know that Medicaid, with its wacky notions of spend-down and a deductible that is essentially your life savings and a co-pay that is your entire income, is a really foolish way to go to provide benefits to the middle income. And then we are surprised, shocked in some cases, that those individuals turn around and try to game the system.

So how could a program work through Medicare?

I think there are a number of intriguing options that we should look at, we should talk about, we should begin to think about. It is not something that I expect to happen overnight, but I think we need to, nonetheless, face up to it. And where better than a Commission that is tasked with doing exactly that?

If Medicare offered a fully comprehensive system of care, it could achieve the efficiencies that are currently touted for coordinated care, in which the right level of

services could be provided at the right time. That is what we all should be seeking, and that is not something that is really under any discussion for the most part at the moment.

This could lower the overall cost of care to society. Certainly, it would increase costs to Medicare. Certainly, it would mean new resources would be needed to fund that program. But, as society is affected, it really would not necessarily raise costs, particularly if you put into the equation the foregone care, that happens that hurts individuals and that sometimes leads to misuse of other types of services in our system.

Medicare could income-relate a long-term care benefit. It has now gotten into that world. It could do so by asking individuals to pay both higher premiums, to pay higher deductibles and co-pays on an income-related basis. But it should not, and would not, have to do it in the punitive way that Medicaid does. And, as a consequence, I think you would not see the kind of gaming of the system.

This would also allow Medicaid to continue to be a system in which it is a safety net for the poor rather than trying to strain itself and be a system, albeit a very harsh one, for middle-income individuals.

And, although the issue of hiding of assets, I think, is overblown already, certain Medicare could handle this, I think, in a more fair and reasonable fashion and use some

additional resources.

A well managed program that coordinates care but steers patients in the direction of the most efficient services could be offered to all beneficiaries. It should be tough. It should be evidence-based. It should be carefully done. If you want to make sure that individuals have an option when they want to have their own families provide the support, when they want to go in other directions, you could allow them to have a cash opt-out, which is being done now in certain other countries. Those, I think, are reasonable ways in which you could then have a very tough and fair, but carefully drawn, program that would not then simply open the floodgates to services as people demand them.

I think that is a way of dealing with some of the issues that Joe raised when he said that people do not like all of the controls that come with some of the more formal managed care options that people sometimes talk about.

There are a large number of other issue that would have to, of course, be dealt with here, but I think they are doable, and I think we ought to begin thinking the unthinkable.

Like Barbara, I have been working on this issue for many years, and I wrote an article many years ago called "Taking the Plunge" that is a little bit more optimistic than today when I said thinking the unthinkable, but I think

it is still something that ought to be on people's agenda and that we ought to think about.

As Barbara talked about, there are ways to improve the current benefits under Medicare. They are all, in many ways, putting ribbons on pigs and lipstick on pigs because until we deal with the fact that this is an arbitrary distinction, to go from acute to post-acute to long-term care needs for the population we are talking about, we are always going to have arbitrary limits and problems.

We can certainly improve those. I would recommend that that happen, but I do not believe that this is the way to go, to talk about strengthening long-term care over time.

And I would defer to Barbara on a lot of these issues, but I would be happy to talk about them as well.

Thank you.

[The prepared statement of Ms. Moon follows:]

Chairman Chernof. Thank you very much.

Commissioners, we are going to try to stay as close to on time as possible--five minutes a commissioner.

Commissioner Claypool, will you start us, please.

Commissioner Claypool. Thank you and thank you, panel.

Well, seeing the Administration for Community Living is refreshing, and it raises a number of questions.

I would like to start with Barbara or any of the panelists that care to pick this up. We have not seen real investment in, what I would argue, the community-based infrastructure, which maybe be characterized as social, but I would argue that it is health-related.

And, to Marilyn's point that she was ending on, these are lines of distinction that really might not be beneficial to us in the future and that talking about the community-based infrastructure that it is necessary to support high needs, particularly Medicare beneficiaries, is critical. Yet, we have not seen a will on the part of the Congress to make investments in this infrastructure.

Do any of the panelists about how we build a more robust support system in the community so that we can help individuals with chronic conditions reduce their reliance on inappropriate encounters, or unnecessary encounters, with the medical system?

Ms. Gage. I guess I have been voted to take it first.

[Laughter.]

Ms. Gage. I would point out that when the Medicare program was established and later on, the Medicaid program, that the Administration on Aging was established at the same time, and the thinking was that together the three of them could support people in the least--I forget the language now, but the most appropriate setting at the lowest cost.

And so many of the social support services that are Federally funded have landed in the ACL budget, but historically, it is the tiny bear at the table. So the funding is consistently very low.

The infrastructure is in place. You now have Aging and Disability Resource Centers in almost every state, which is a great center for both the aged and the disabled to come in, find out what types of services are available in the community. Some of them even provide assistance for determining Medicaid eligibility.

There are resources out there, but they are not heavily funded, and when you look at the direct services covered under the AOA, we are talking about pennies compared to the number of people who need them.

Commissioner Claypool. And, if I can just jump in there, in fact, the mandatory money that was going to support the Aging and Disability Resource Centers is going away. They have largely been grant dollars.

And I think we have to be much more serious about making investments in this, and more strategic. Shrinking the spending in post-acute is not going to magically make these needs go away. They are just going to pop back up in an acute setting.

And why begin to make more of an investment in a community-based arena?

Marilyn, did you--

Ms. Moon. I was just going to agree with you and just say that one of the challenges is that as you push down on the funding for things like community-based infrastructure, then the demand is to inappropriately use post-acute care services.

And one of the challenges is we do not look at this together. We certainly do not even look at Medicare and Medicaid together most of the time, much less other kinds of things like community-based services.

I think that the other thing, sadly, in the United States is that those programs that have done better are the programs that are devoted to individuals and for whom individuals feel they have an entitlement. And although that is a dirty word, what it means is that those benefits get protected over time and things like the benefits under the old AOA do not get that kind of protection.

Commissioner Claypool. And, just to pick up on that

point since my time is fleeting, the charge of this entity, this Commission, is quite limited. If were to make a recommendation about what comes next, you have raised some points here today about our inability to really take a comprehensive look at the needs of people that are entitled to Medicare services.

What would you recommend to our Commission in terms of its recommendations about what would come next?

Is there a way that we can take a more integrated look at health care and long-term services and supports?

Chairman Chernof. One quick answer from somebody, please.

Ms. Moon. I think one way to do that would be to provide resources and funding to do exactly that--raise that question and deal with it--because until somebody is actually mandated to look at it these programs are just going to limp along as they are and we are going to deal with them individually.

Ms. Gage. And the infrastructure is being built. You have it out there. Do not lose it.

Mr. Antos. I would just add looking for more money in the current climate is going to be very difficult.

Chairman Chernof. Commissioner Jacobs.

Commissioner Jacobs. Thank you, Mr. Chairman.

The theme of this panel, notwithstanding, I would like

to ask Dr. Antos, who, as a former CBO director, is a longstanding of the Green Eyeshade Brigade around here, a little bit about some of the discussions in the last panel--and I know you were here for some of that--specifically, on the Medicaid institutional bias.

One of the issues with trying to eliminate the Medicaid institutional bias is, at least from a scoring purpose, you always end up getting CBO saying that there will be a woodwork effect, and if you expand home and community-based services, people who take care of family members on their own will now start to take these services, and therefore, it will actually cost more money to expand home and community-based care.

Given your experience as a former CBO person, have CBO actually modeled some of the suggestions and recommendations that Ms. Killingsworth talked about, about making nursing facility services an optional benefit and/or to potentially have an affirmative opt-in to a nursing facility or skilled nursing facility so that to make the bias more towards home and community-based services?

Would that potentially mitigate some of the budgetary impact of a woodwork effect?

Mr. Antos. Well, CBO certainly has looked at those kinds of proposals in the past. I am not completely familiar with their latest work in this area, but as you

know, there was about an 800-page budget options volume that had some proposals in Medicaid and the long-term care services.

You are absolutely right that CBO has traditionally said that there would be a woodwork effect. I think that reflects what all of us saying here--that we do not have an organized and coordinated system.

If we could move in that direction, then maybe CBO would be a little bit more generous in its scoring but probably not any time soon because, in fact, the problem is not the scoring. The problem is the lack of a system.

Commissioner Jacobs. I just was intrigued by the idea of not only increasing home and community-based services but then trying to have affirmative options to reduce the institutional care and whether that would mitigate some of the budgetary implications, you know, in the short term. And the hope is you would drive further savings in the long term by improving quality of care.

Mr. Antos. Well, certainly, any proposal that reduces hospitalization or institutionalization in a nursing home is going to be something that will at least delay spending.

I mean, there is a process that many of us go through, but if we could delay it, we are going to save some money and people are going to live happier lives.

This critically depends, I think, not so much on

government-financed services but really families. I think families are really the critical element here.

And unfortunately, in many cases, families do not live in the same community anymore. They fly in. It is a very challenging situation.

Commissioner Jacobs. Thank you, Mr. Chairman. I will yield back.

Commissioner Brachman. Good afternoon. I guess it is still morning.

[Laughter.]

Commissioner Brachman. My question is addressed to Mr. Antos, but before I ask him, I just want to make a statement about the Older Americans Act because that has come up.

What is so interesting about that is that it is very, very flexible, and it does not have the tremendous overlay of regulations that both Medicare and Medicaid have, which enables it to be much more locally based and much more sensitive to local needs.

Now my question for you, Joseph, is whether a market-based system--and you have talked about managed care--can produce care coordination, quality of care and of services to the populations that are being directed to with Medicare, or does it have to have a large overlay of regulation and other kinds of structures in place?

Mr. Antos. Well, there is no getting around the need--

when we are spending massive amounts of money, there is no getting around the need for Federal regulation for the concerns of the taxpayer and the concerns of the taxpayer as well.

That said, I think what we are seeing now with the special needs plans is that--especially the special needs plans that address institutional patients--this is not a very popular area. I do not believe that the number of special needs plans in that category has grown. It may have shrunk in the last few years.

For duals, it is a little bit easier because, of course, as we discussed, duals are a very diverse population. Not all of them need that kind of heavy-duty care that is very difficult to give.

And then there is the question of, are the special needs plans or--I will focus on them. Are the special needs plans, in fact, successfully coordinating the services in a way that really works out?

I think all of these questions remain to be answered.

I am somewhat optimistic that if you--since there is an awful lot of money at stake here, I am somewhat optimistic that with the right combination of appropriate Federal regulation, appropriate program development that does not go too far in the direction of telling everybody what to do--I think the Accountable Care Organizations' early foray into

this is a good example of what you do not want to do, and the Administration corrected itself a little bit in this area.

So I think it is possible to see some work in this area, but the problem is that it is not just within the purview of a private plan, no matter how broad it is. They still have to be able to coordinate with other kinds of services that are administered through other entities--government entities or other types of entities.

I would not want to minimize the difficult of doing this, but I would not want to argue that having regulations written in Washington is really the way to go here.

I think we need to bring in the good ideas from the local communities, and we need to try them out in the local communities and not think that they are necessarily going to transplant to another coast.

Commissioner Brachman. Thank you.

Commissioner Guillard. Mr. Antos, I want to follow up on something that you just said, and I share your--because you said it several times. I do not know if everyone picked up on it--your concern about we have limited resources. You know, there is not a lot of money out there to do some of the things that everyone would like to do.

Inpatient acute care length of stay for Medicare Advantage patients is less than Fee-for-Service patients.

Okay.

So, when you focused moments ago about lowering utilization in nursing homes, I would think that a major approach should be how to utilize the lowest cost provider, whoever that provider is--home and community-based services, home health care, skilled nursing versus acute care, et cetera.

Can you just explain?

I mean, I am a little confused by your previous comment in that context.

Or, do you agree with that, I guess.

Mr. Antos. What did I just say?

Absolutely.

Commissioner Guillard. Thank you.

My next question--

[Laughter.]

Mr. Antos. Using the lowest cost-appropriate provider, but that is looking a little narrowly, it seems to me.

So I think my view of this is that the people we are really talking about have multiple needs. It is not just hospitalization. It is not just physician services. It is certainly not just appropriate housing and diet. It is a whole bunch of other things.

It is socialization as well. I mean, if you get people to have a more positive outlook on life, they are going to

be able to respond to lots of challenges they have physically. They will be able to do a lot better. I speak from experience in my family.

So, in fact, I did not mean to say do not go with the low-cost appropriate provider, but the appropriate provider might not be the low-cost provider, and the appropriate way to deal with it might not be--in fact, is not--to do it the Fee-for-Service way, to let's pick one from every category and get the cheapest one. I do not think that works.

Commissioner Guillard. No, I agree with you. I thank you for your clarification.

The other point--you made a point here that kind of the approach that we see today is cutting provider payments and cutting provider payments. We have seen 800,000 skilled nursing beds taken out of the system since 1982 or 1985, somewhere in that park. We have seen 10 percent of home health agencies recently go out of business.

And we are on a trend, and that trend is accelerating, not decreasing.

I mean, so what happens when--what is the real impact of a continued policy like that?

Mr. Antos. Well, certainly, when we lose capacity, then you have to ask not just what is it going to cost because, of course, people are going to end up somewhere, but also what does it mean in terms of the kind of quality

of life that we want for our loved ones.

But, on the cost scale, it is pretty obvious that when appropriate home and community-based services are not available, then patients will end up in more institutional care. When families can no longer handle the load, that is where you go.

Ms. Gage. Can I jump in on that?

Commissioner Guillard. Sure, Barbara.

Ms. Gage. A lot of the cuts that were raised were actually the result of analysis of the margins in the different provider communities. While it resulted in a large--apparently large--dollar value, the proposals that MedPAC was putting forth were based on providers having higher than average margins. And, when you are talking about the public dollars being spent, there is always a question, of course, of a provider needs to make a bit of a margin, but it does not need to be a 12 percent or 15 percent margin.

Commissioner Guillard. But those margins are Medicare margins alone and do not take into effect the total margin when combined with care to Medicaid patients.

Ms. Gage. And so I would then follow up my comment that there are questions about supply and capacity in all different parts of the country, and the numbers would suggest that where volume of providers has gone down, it may

be in areas that have more beds or more agencies than needed.

Commissioner Guillard. And I have, very quickly--Marilyn, you had a comment in here that other countries tried to provide cash support and services, and I have read a number of comments recently from the European countries that tried that, that they are running into problems with those programs and curtailing benefits significantly.

Ms. Moon. There certainly can be problems.

I was trying to get at the issue that when you are trying to provide some benefits and you want to be very careful about what kind of benefits, for example, and if it says you should be in a nursing facility and if the patient really does not want to do that, then I think that it is good to think about a cash-out option that would be at a lower level and let people then make their own choices.

I think that you have to look very carefully at what those are, but I think that the idea of it is a good idea.

And it is my understanding that a number of places have been successful at doing that, but I would bow to you if there are some places with problems. It is not something I am quite as familiar with at the moment.

Chairman Chernof. Commissioner Butler.

Commissioner Butler. Mr. Chair, I was prepared to not have questions for this panel, but Mr. Antos said something

so demonstratively that I decided to get in. And I wanted to get the reaction from Ms. Gage and Ms. Moon.

Mr. Antos said that the problem is that there is a lack of a system. And there has been some debate about whether we actually lacked a system. So I wanted to hear from Ms. Gage and Ms. Moon--your response to Mr. Antos's statement about the problem is that there is a lack of a system.

Do not take the words back now, Mr. Antos.

Mr. Antos. Oh, no, no, no. No, I completely agree with myself, at least at the moment.

[Laughter.]

Ms. Gage. There are many systems. The problem is that they are not integrated and effectively coordinating care for the people.

So I think this is an exciting time in health care because of all of this discussion in both the public and the private sectors about person-centered care. It is the time where perhaps the doors are open to start talking about pulling together the different financing streams in order to meet the needs of that person and not just that program.

So one of the reasons you could never worry about the long-term care dollars to reduce the Medicare dollars was because Medicare did not pay for the long-term care dollars--so if there was some way to address that coordination.

Ms. Moon. I agree with Barbara.

I think the way in which you could think that there is a system is there is a system if you, as an individual, sit down and figure out how you are going to get benefits from 12 different places and how you are going to deal with 25 different providers and figure out how is the best one and so forth.

We have left this as this incredible piecemeal, patchwork system that no one has the expertise to do. I cannot tell you how many of my colleagues who are experts in this area, when their own family members get into this kind of a pickle, find that it is just unbelievably difficult to deal with because of the complexity and the different financing streams, the lack of coordination across different types of care.

We are now talking, for example, about having hospitals think about telling you when you are discharged, what might happen to you and what you might do when you go home and that it might be a good idea, for example, to talk to your physician. These are radical ideas to hospitals--

[Laughter.]

Ms. Moon. --whose reaction is, you know, we provide hospital care. What is this talking out there after the fact?

So I do think, with Barbara, that we are beginning to talk about those things and breaking down those barriers,

but there is still a lot of barriers in place, and they are going to be there until we also think about trying to make the system more rational in terms of how it is financed as well.

Commissioner Butler. Thank you.

Commissioner Vradenburg. Do I get her extra two minutes?

Chairman Chernof. No.

Commissioner Vradenburg. No.

[Laughter.]

Commissioner Vradenburg. I am intrigued by the notion that we need a more comprehensive system that better integrates acute care services and long-term supports and services, and so I would be curious, Ms. Moon, whether you would favor Federalizing the duals so that, in fact, we put it under one system, so that you had both acute care and long-term supports and services in one system--slightly different populations, but is that a step towards a more comprehensive system?

Ms. Moon. I am in favor of thinking about the duals as Medicare beneficiaries first and Medicaid beneficiaries second, as opposed to the other way around, which is where we are going now. And, by that, I mean I think there is a role still for Medicaid to supplement, to provide, to fill in the gaps where there are co-pays and things of that sort.

But this is a Federal program that is presumably trying to provide good acute care for all people with disabilities and over the age of 65, largely. And to do so by saying, well, we are going to take the sickest and the poorest and the frailest, and we are going to let them be the problem of the states seems, to me, to be a very bad precedent to set.

So, yes, I would--I think that we should Federalize them in the sense that we should think about it as a problem for Medicare and a problem of then the coordination with the long-term care needs. That allows you also to move up further into the middle income which is where I think most people have the fears of long-term care.

If you have no resources, then you do not have to worry about spending down and so forth. If you have some resources that you would like to share with your spouse or children, we have set up a system where we are asking people to either violate the system or to suffer the consequences by getting no care. That seems to me to be a very poor choice.

Commissioner Vradenburg. But I do not know why you sort of hedge on the notion of just removing from the responsibility of the Medicaid system, those over 65. Why not, with a comprehensive system, simply Federalize it all and put all those benefits into--

Ms. Moon. Well, if I were Medicare Queen, I probably

would be happy to do that.

I think part of it is that we have a world in which we think of the Medicaid program as providing an additional base of benefits with some additional generous and more comprehensive things, but I would indeed go in that direction more, the way you are talking about it, than in the other direction.

So, yes, it might be possible to totally Federalize.

Years ago, I did research in which we looked about what if the Federal Government took on the seniors and gave all the responsibility for younger people, for example, to the states and Medicaid and the swaps and all of those things. Whew! What a mess in terms of who wins and loses on the state level. That is one of the reasons why we do not talk about it very seriously.

We have set up a system in which some states are very generous for their seniors and less so for younger people, and vice versa. And then if you start about taking one group away from them and giving them full responsibility for another, that is one of those political nightmares that people do not get very far along in.

Commissioner Vradenburg. As opposed to raising resources, which is easier.

Ms. Moon. That is true, too.

Commissioner Vradenburg. I am going to follow up with

another question, and this comes out of my experience in working with Prime Minister Cameron on putting Alzheimer's and dementia on the G-8 agenda. And one of his hot headlines is care innovation and coordinating at least exchange of information on the experience of different countries, in terms of dealing with the long-term care needs of their populations. He is concerned about the viability of the National Health Service, which is an integrated and comprehensive system.

So I am curious. Is there any systematic effort to do transnational analyses of exactly how countries have approached this problem, which is shared by most developed countries and now increasingly developing countries, about how they take care of these populations and who is doing it in terms of either quality or cost or whatever other measure?

Ms. Moon. I am a good case in point. I do not think we do a very good job of looking to other countries for their innovations. We have a tendency to think in the United States that we can solve our own problems without doing that. And I think we could benefit a lot from more of that type of interaction, particularly in long-term care, where a number of other countries have been bolder about the whole activity of dealing with their seniors and their persons with disabilities than we have.

Commissioner Vradenburg. Well, we have noticed statistics on how many people would like to know whether they are likely to get Alzheimer's, that the number is significantly higher in Western Europe than it is in the United States, and in part, that is because people have a greater faith that they will be taken care of in some fashion in Western Europe than in the United States. So we feel there seems to be a sense that, in fact, the confidence that people have in their system affects their willingness to look at preventive services and/or detect diseases well before they might get them.

So my time is up. Thank you very much.

Commissioner Raphael. This morning, we heard from Melanie Bella that 45 percent of the hospital admissions from nursing homes could probably be avoided. And we also know, if we do surveys, that there is a much greater prevalence of depression among the Medicare population, particularly those with multiple chronic conditions and often unstable social situations that ultimately land on Medicare's sort of budget.

I am wondering if each of the panelists could say what you think is the most important thing we could do in the coming year to two that could really address avoidable hospitalizations and social conditions that really reverberate to Medicare.

I will start with you, Dr. Antos.

Mr. Antos. I was hoping you would start at the other end.

So, obviously, this is a problem. Some people think it is a financing problem, and it certainly is the case that some of this sort of repeat hospitalization is related to shifting the cost between programs.

So this is not a practical suggestion for the next year or two--I am not sure there is one--but certainly doing something to increase the bundled payment so that the nursing home, the hospital and the rehab facility can have more of an incentive to work together.

This is something that is not happening with Accountable Care Organizations.

Commissioner Raphael. No.

Mr. Antos. But you know, you have to--it is not clear that Accountable Care Organizations can really move in this direction.

But, certainly, the idea of trying to create greater coordination within Fee-for-Service Medicare is a place that you would start, but you would probably have to wait a year or two to see whether ACOs actually get off the ground.

Ms. Gage. I would argue that a very inexpensive, but perhaps mandatory, change to the Medicare benefit to require that somebody follow up after discharge if you are in a

high-risk group would be highly valuable. We know enough about the factors associated with readmissions to be able to identify who those populations are.

Certainly, the work that I and others have done with CMS over the years--we know who they are. The simple things that I outlined on page three of the testimony can prevent many, many hospitalizations.

Commissioner Raphael. Thank you

Ms. Moon. I agree that we should be doing those kinds of things. I think that is particularly important.

But we should also be working at helping to educate both providers of services and beneficiaries themselves. A great number of people do not know what is possible, do not know what they should do, do not how they should behave, and that goes to a lot of physicians as well, as well as other providers. So I would like to see us be much more aggressive in terms of trying to find ways to get the information out there, to make it available.

I know, for example, the state health insurance counseling organizations do a lot of good things. They could do more. They are paid a pittance to do very little in this area. When you think about the kinds of complexities of this program and how little we pay per person to try to make information available to people, there is a lot more we could do there without spending a great

deal more right away.

Commissioner Raphael. I do not know if I have enough time, so I am just going to say one thing.

There is a study that came out this week that showed--I think Joe Newhouse head the group at the Academy of Sciences that looked at variation in Medicare payments, and I thought it was very striking that most of it was attributable to variation in post-acute payments. It was something like--I do not remember it well. Like 63 percent of variation in Medicare payments was attributable to that.

So, in my 37 seconds, I do not know if any of the panelists wants to comment on that.

Ms. Gage. Those numbers that Joe produced are consistent with the numbers that we have been producing for 10, 15 years.

There is high variation in the use of the post-acute benefit. What I would have liked to have seen in that was a case mix-adjusted analysis of the variation because we see things come down, but again, supply drives a lot of use in some cases.

Ms. Moon. We also need to know more about what works and what does not and when it is appropriate or not. And like so much of health care, we do not do those kinds of studies very well and very often, and we certainly do not put the money into them, given the amount of money we spend.

Commissioner Raphael. Thank you.

Ms. Gage. But the value-based programs are moving towards that. So times are changing.

Chairman Chernof. So, with that, I am actually going to defer my time to Commissioner Pruitt.

I just wanted to say that Laphonza asked my question.

And I wanted to highlight, Barbara, what you said because I think for me, just as a physician, we do not pay for care coordination in a really robust way for this population. Until we figure out where that lives and until we really are person-centered, we are going to have a problem getting our arms around this.

Commissioner Pruitt. Thank you. Thank you all for your testimony. It is very insightful.

Dr. Gage, my question is for you. I was intrigued by the concept that you mentioned of a nurse following an acute visit in the home, and it reminds me very much of a program that we have in Georgia known as SOURCE, which actually takes caregivers and they sit down with the physician and go to the patient at home and do simple things like count medication to see if they have been taken. And there have actually been studies where that reduced cost.

If you take your concept--and you also mentioned the three-day stay, which lends me to think of site-neutral payment.

If you take your concept of--I will not call it your concept, but if you take the concept of eliminating the three-day stay, that would be more of a coster than it would save money. That is not true?

Would you elaborate on that, if you do not mind?

Ms. Gage. Certainly. That is not necessarily true. An uncontrolled removal of the three-day prior hospital stay is a cost driver. You would have all sorts of benes who are over in the Medicaid-covered beds flipping over to Medicare coverage at will.

But a removal of that requirement for the skilled benefit and a requirement--currently, you have to have the need for 24-hour inpatient nursing to qualify for an admission to a SNF, as well as the related hospital, et cetera.

So, by restricting the patients who could go in without a prior hospital stay to those who meet a certain level of medical complexity, you are not opening the door wide. You are simply improving the care for that person so they do not have to get into an ambulance, have the movement across town, have the wait in the ER room, et cetera.

Commissioner Pruitt. Okay. And the concept of the nurse following the visit from the acute care--what type of services would be provided, and how do you believe that would decrease readmissions, more specifically?

Ms. Gage. Research has shown that if you look at the MS-DRGs for the populations that are readmitted, there are often things like nutritional deficiency. Well, if someone went into that home after the person went home from the hospital, opened the door to the refrigerator and saw that there was no food, they could predict that that person was probably going to have a problem in a few days.

So having somebody just go into the home, look around for that loose rug that the person is going to trip over, break their hip and end up back in the hospital, look around for the medication, just reconcile what they were on before they went in and the doctor took them off their Warfarin because they did not want them bleeding during surgery and what they are on now, to make sure that they have everything in the house, that they have eliminated those meds that no longer count--there are very simple things that could be done with a one-hour visit by a nurse or social worker.

Commissioner Pruitt. Would this be bundled with the hospital payment, or would you see it a separate service delivered by a different provider?

Ms. Gage. I leave that up to the program to determine. You know, there are many ways to set up payments.

And they do not really--although you do want to give the hospital the incentive--and that was my point earlier. They are getting the incentive these days, and perhaps that

is additional incentive and payment.

Commissioner Pruitt. And my last question is, do you have an opinion on site-neutral payment, where you are paid on the services delivered instead of necessarily the setting?

Ms. Gage. Site-neutral payment is a very loaded term that has come out of those interested in post-acute care, and I would define it first, to say that if we are talking about site neutrality of the rate associated with the case mix, then it makes sense. Why would you pay a different amount for a PT under home health than you pay for that PT in the outpatient department?

There are additional facility-specific costs that also need to be taken into account. And when people talk about the site-neutral, they often throw all that into one. Those should not be standard.

Commissioner Pruitt. Okay. Thank you very much.

Commissioner Feder. So I wanted to start--I cannot help myself by addressing the pints you raised, George, and then I will get to them.

When you talked about the--asked Marilyn about the Federalizing duals or Federalizing--one can also think about Federalizing long-term care.

I just would note that it does not have to be a swap. It could be an enhancement of the match all the way to 100

percent and could entail having states make a continued payment, just as they do in the drug benefit for what they would have paid, but not hold them accountable for the aging of the population.

So I would like to submit for our record a paper that we have written on that topic and urge us all to look at it.

So that was the first thing.

[The information follows:]

Commissioner Feder. And the second thing is in terms of the international I think we do have evidence, and Marilyn, I think, is quite right--that we need to look at other countries' experience.

The European nations are investing more heavily in long-term care. They are already dealing with populations as old as ours will be, and their investments exceed ours. And I am delighted to hear and learn more about what you think are positive results of that.

So, okay, now moving to you guys.

Barb, I thought your saying how can providers use social support services to manage medical costs for people with long-term care needs is a very good way to frame the role of our acute care system in Medicare as it currently is, in addressing these problems.

You showed that people with chronic care needs are among Medicare's most expensive patients. And I think you know that work we have done and others have done shows that if you focus directly on functional impairment, functional impairment trumps chronic care as an indicator of high-cost patients.

So, that said, I think you all have recognized that very little is being done in Medicare's payment reform to focus on the functionally impaired population, even in the medical care coordination area that has been handed off to

Medicaid.

And it is particularly odd when we look at dual eligibles since 80 percent of dual eligibles' costs are, in fact, Federal; most of those paid by Medicare, but some of them a Federal share of Medicaid.

So I would be interested in your responses--brief, please, because I want to ask Marilyn one more question--to the proposal that Medicare, in its innovations, be focusing its innovations, some of its innovations, on the functionally impaired population as an ideal way to target high-cost patients and better coordinate not only their medical care but their long-term services and supports, even if they are being paid for out of pocket.

Ms. Gage. I agree.

[Laughter.]

Commissioner Feder. You could say a little more.

Ms. Gage. Okay. There is an innovation grant--a set of calls for proposals--out right now, where one is focusing particularly on post-acute care in ambulatory populations, and so it is up to whoever puts in their grants, what populations they are focusing on.

But, certainly, functional impairment is probably the big crossover between the long-term care services and the acute care services because right now nobody covers having a therapist go in just to strengthen the person in order to

avoid deconditioning.

I say that with hesitation because the recent court case of last year--

Commissioner Feder. Correct, correct. Absolutely.

Ms. Gage. --does support that you do not have to be improving in your function in order to--

Commissioner Feder. This is the lawyer who brought this case, right. Good job.

Ms. Gage. But it is not really used very widely.

So you have the infrastructure with the home health benefit, which does not require the prior hospitalization. It does require the homebound.

And to broaden that type of service to people who are neither in the home health benefit or in one of the institutional settings is one way to go.

Commissioner Feder. [Inaudible.]

Ms. Gage. They can access them in outpatient therapy. All they need is a physician's referral. So it is there, just not used, not recognized for the important role it can have in reducing medical need.

Commissioner Feder. So, really quick, Marilyn, Diane Rowland talked this morning about the best way to preserve Medicaid's fiscal viability was to have another program or something else that was paying for long-term care. And I think your Medicare proposal, or idea, fits that bill.

And I wondered among the other advantages of Medicare whether you would see it more appropriate for Medicare to have a Federal responsibility for the costs associated with the aging of the population rather than leaving that to the states.

Ms. Moon. I think the broader the risk pool the better in this case because of the challenges that we are facing.

We also know that we have a very mobile population. And it does not, to me, seem to be very fair to have a world in which someone can have decided to move to Florida and live there for a long time, and then suddenly they need resources, and so they move back to New York State where they came from many, many years before to get better resources.

I think there are a lot of reasons to think about a Federal program rather than just a state-based program.

Commissioner Feder. Thanks.

Commissioner Turner. Thank you all.

It seems to me the theme of today's both panels has been the great need for better coordinated care, more patient-centered care, more efficiency and more spending on appropriate setting. So I think there is really broad agreement that that is what we want to do.

But I would like to focus on what I really see as a contrast between, Barbara, your comment about we are really

beginning to move forward as a Nation with focusing on people--patient-centered outcomes through new programs, Accountable Care Organizations, primary care medical homes, Administration for Community Living, et cetera--but then, Joe, in your testimony, you talk about the ACOs in particular as a weak model with no savings for enrollment, no push on providers, one-sided risk, share savings only allowed.

And I am particularly interested in something else that you said about the need to move from top-down solutions to market solutions.

And the fact that so many--well, a number of the organizations, the health systems that were models for the ACOs in the Affordable Care Act, actually decided to not participate and particularly because the rules. The rules were not the same rules that allow them to develop those systems and become more efficient.

So I guess this is my question for you, Joe. Help us understand more about whether or not you think the Affordable Care Act does, in fact, provide a platform for these goals that we all agree on and particularly whether or not you think we need to look at the rule-driven model of the current system.

Mr. Antos. Thank you.

Of course, the ACA's primary goal was to expand access

to health insurance for medical treatment. It did not really have much to do with long-term care services and supports.

The ACOs also really were focused pretty much exclusively on, in essence, creating a virtual HMO that Medicare beneficiaries in the traditional program would be unaware that they were in. So they would not be disturbed about actually enrolling in something and participating in decision-making about their own health care, or at least the financing of their health care.

So I do not think that the ACA provides any strong basis whatsoever for this area.

You know, I think, to me, the problem is that we cannot really point to--there is no Geisinger Clinic alternative that we can say, oh, that really works. If there was such a thing--and, for example, in the special needs plans or in the social HMOs, there may be some isolated examples.

But, you know, even in the case of Geisinger Clinic it took them 30 years or 40 years to get to where they are now, and I am afraid that that is where we are going to end up, maybe worse, when it comes to long-term care services and supports.

So I do not think there is a magic bullet here, and the ACA does not--I do not believe opens any doors in this area.

I think what it does say, just kind of to go back to

this whole business about dealing with the community--you have to deal with the patients who are there. You have to deal with the resources that are there.

So it seems to me that we need to just make it possible to take the money that we are now spending in an inefficient way, look at the total amount of money that we are spending and ask ourselves, well, how can we put that out there, not expand it necessarily because these are tough budgetary times, but how can we put that out there in a way that will allow creative thinking in the community and creative cooperation among these many actors, to produce a good plan?

Commissioner Turner. Joe, do you think that that could include some of the ideas that Marilyn was talking about, about giving Medicare a larger role so there really is not one program but more coordinated care for these particularly vulnerable populations?

Is Medicare really able to handle that added responsibility?

Mr. Antos. Well, Medicare--

Commissioner Turner. Financially.

Mr. Antos. If we are talking about traditional Medicare, we are talking about a program that is not--

Commissioner Turner. I am talking about just the overall financial ability of Medicare.

Mr. Antos. Oh, so my guess is that this would be very

expensive, and so I would argue that we need to find economies in the Medicare program if that is the way we are going to do it.

It makes more sense, as Barbara has been saying, to look a little more broadly because if we are really going to bring all these different services to bear on the patient, then you want to be able to account for the savings that will occur there.

Everything is synergistic. The one point that I failed to make earlier, that I really wanted to make, is that if you expand a subsidy program you will inevitably substitute away from whatever else is there, and whatever else is there that is not the subsidy program is, of course, going to be money out of people's own pockets and family help and community help.

So, if you do put in a big, new subsidy program, I believe, Judy, that this is in fact the story of the Medicaid program, to a pretty substantial extent.

Commissioner Feder. The evidence is counter to that on the substitution on the family side.

Mr. Antos. Okay, on the family side, but we are talking human nature here. People go to where the subsidies are. It is inevitable.

You cannot argue that--the whole point of a subsidy is to get people to do what that subsidy is aimed at. And so,

if you create a new program, if it is a more generous program than something that now exists, that is where we will go.

So I do not think that money is the answer. I think that creative thinking is the answer.

Chairman Chernof. Let me go to Judy Stein, please.

Commissioner Stein. Thank you very much.

I am somewhat confused about where to begin.

I think that the goal of this Commission and the conversation this morning is so important and so indicative of the fact that we want to do something about people of any age who have long-term care needs. And yet, at the same time, our system is, as we speak, ratcheting down the programs we do have--the coverage.

So I need to say a couple of things.

In 1980, Congress removed 100-visit limitation for Medicare's home care benefit, saying it is not an acute care benefit; it can be any duration of time as long as you are homebound or skilled.

And what has happened as a consequence is that we pretend people are not homebound, or we pretend they do not need skilled care even though they do, in order to limit the coverage that is actually granted to people.

I say this having spent 36 years representing, as a lawyer, Medicare beneficiaries. I think that is probably a

world's record.

So it is not an acute care benefit, and we hear that all the time.

Medicare does not require 24 hours of nursing to get a skilled nursing facility coverage. The regs say you need daily nursing and/or therapy, which is not 24 hours. However, we get denials all the time.

So we have to believe--we have to decide whether we really mean as a Commission, is the society--do we really mean that we want to provide care for people?

It is not--it does not come--there I no free lunch and there is no free care.

I was going to read a letter. I received four letters last night from people who have been told they have stabilized, they need maintenance care only, and they cannot get Medicare coverage for the care they obviously need, and that I know they are legally not entitled to--granted under law. So we are not doing what the system would allow now.

You do not have to improve. The law does not allow that.

I wrote a paper 20 years ago for Johns Hopkins. And there is one place in the statute that says improvement, and it is improvement of a malformed body member. Medicare will cover care for that. That means not cosmetic surgery.

So, having said all that, I would like to ask--I have

been needing to tell people some of the truths about what Medicare statute does.

Marilyn, is there--if we were to consider--and I have some ideas--Medicare as a home for at least some more long-term care, what would happen to the less than 65-year-old and less than 24 months of people with disabilities--because Medicare covers them too. Where would we house them?

And also, do you think that there would be some dollar value to lowering the age of Medicare eligibility?

Ms. Moon. You really want me to talk about spending a lot of money, don't you?

Commissioner Stein. No, I do not. I want to know--

Ms. Moon. I think that it is very difficult to think about where you place limits because limits always create problems.

On the other hand, we have in the United States decided for some time that on the acute care side that we are going to have a 65 and over population covered by Medicare, and then some people with disabilities, and that others will get their care elsewhere. And I think that that is not always a super comfortable environment, but it is an okay way to go.

What it has meant over time, though, is that we have tried pretty hard to make sure that people who get Medicare get the same kind of acute care services that the under-65 population gets.

And I think that that is one of the things that ought to be a criterion in that if you did a long-term care program through Medicare the notion ought to be to coordinate it well with all of long-term care that is out there and making sure that you do not have two systems of care that are inadequate and one which is more inadequate than the other.

So I do think that that is a doable situation. It is not as comfortable as it might be otherwise, but I think that that is okay.

In terms of lowering the age of eligibility, if you lower the age of eligibility for Medicare, I think you could get a number of good things to happen. I just do not see it in the cards at the moment. Of course, I do not see long-term care in Medicare in the cards either. That is a whole other set of issues.

But I do think that once people retire they ought to be able to get Medicare; and if they retire at age 60 or 62, they should. The world, though, is changing so that increasingly people are not retiring at 60 or 62 any longer. They are retiring later and later.

Chairman Chernof. We are there. I am sorry. I want to be respectful of everybody's time.

I want to thank this panel for doing an outstanding job helping us think about the role of Medicare.

For those of you in the audience who have additional thoughts, comments or want to contribute, the web site is www.LTCCommission--one string--.Senate.gov. So we welcome submissions, and there is a process there to do that.

For the commissioners, we are at a lunch break. I would ask you all to be back here by 5 of 1:00, so we can start promptly at 1:00. Thank you.

[Whereupon, at 12:12 p.m., the meeting was recessed, to reconvene at 1:00 p.m., this same day.]

AFTERNOON SESSION [1:02 p.m.]

Chairman Chernof. All right, commissioners, if we could ask you to move towards your seats, please.

[Pause.]

Chairman Chernof. There is a prize for the side that is fully seated first, commissioners.

[Pause.]

Chairman Chernof. All right, we welcome you all to our afternoon session of this, the third hearing of the Long-Term Care Commission.

Commissioners, you will actually find on your table in front of you a thumb drive. This is yours to keep. We ask you to bring it back at the next meeting. On it, you will find all the public comment and testimony we have received through the web site so far, which gives me another opportunity to encourage all of you in the audience, to the degree you would like to share with us, www.LongTermCareCommission.--

Mr. Atkins. Senate.gov.

Chairman Chernof. --Senate.gov. There we go.

So we invite public comment and input, and that is the process for doing so.

And just in case there is any question whether all the commissioners read it or not, you now know the answer is yes.

With that, I want to go right into our third panel.

This afternoon, we are going to be looking at the private long-term care insurance market and the interaction between public programs and private insurance. So we will begin with panel three, focusing on private insurance.

And, with that, I would like to welcome David Grabowski, please.

Oh, and I guess I would just remind everybody the rules. It is 10 minutes per speak. I will stop you at 10 minutes. It will be five minutes of questions per commissioner. Same rules as this morning.

Thanks.

STATEMENT OF DAVID GRABOWSKI, HARVARD MEDICAL SCHOOL

Mr. Grabowski. Great. Thanks, Bruce and thanks to the rest of the Commission for inviting me to address you today.

I would like to start with two facts to motivate my testimony.

The first is that long-term care is currently the largest source of unprotected, out-of-pocket spending risk for older adults. That is the first fact.

The second fact is that the private long-term care insurance market has largely remained quite limited over the last several decades. Only 10 percent of individuals currently have private long-term care insurance.

And so thinking about those two facts together, I have two goals for my remarks today. First, I am going to discuss why historically people have not purchased private long-term care insurance, and then, second, I am going to put forward a set of policies that I think in the next 10 to 15 years can begin to grow this marketplace.

So I want to start with a policy design challenge. I am going to take two options off the table right at the outset here.

First, I think it is highly unlikely in the next 10 to 15 years that we are going to see social insurance for long-term care. On the other end of the spectrum, I think it is

also fairly unlikely we are going to see major cuts to the Medicaid program over that same time period. So I am going to take those two options off the table.

I am going to think about options here that do not have a major impact on the budget. I am not asking for new dollars here. I am thinking about how we can redesign, how we sell these policies, how we buy these polices, to grow this marketplace.

As promised, the first part of the talk is thinking about why, historically, people do not purchase private long-term care insurance.

I am an economist. I think about the world in terms of demand and supply, and I have divided these explanations into barriers as to why people will not buy these policies and why firms will not sell these policies.

You have seen all of these explanations before. So I am not going to read these to you, but I do want to stress a couple of points.

One, if we are going to fix this market, we have got to overcome these barriers. So that is the first point.

The second point is I am not arguing all of these barriers are created equal. The one on the lower left there, Medicaid crowd-out, has obviously received a lot of attention. So let me take that one first--can we even begin to grow this market in the context of the Medicaid program?

Jeff Brown, who is going to be on the next panel, and Amy Finkelstein have a well publicized paper that shows that Medicaid crowds out about 60 percent of potential purchasers of private long-term care insurance. Many people have taken that study and said we will never have a market for private long-term care insurance.

I agree with Jeff and Amy's work for that bottom tercile of the wealth distribution. There is no doubt crowd-out is quite logical and likely for that population.

Where I take issue with perhaps their work, with all due respect, is for that middle tercile and upper tercile of the wealth distribution. I think there is a lot more traction in this population than Jeff and Amy do.

We have a working paper at Harvard--our team--suggesting that when you move--looking at buyer-nonbuyer data. When you move from $50,000 in assets to $100,000 in assets, you see a big uptake in insurance purchase. This is one of several pieces of evidence I will not go through right now, suggesting that there is more kind of response in that middle-wealth population.

The final point I would make on this--even if we take their crowd-out estimates at face value, that still suggests there is 40 percent of the market. We are currently at 10 percent. I would definitely argue we have room to grow.

So here are my five ideas for growing this market.

And, obviously, I see the clock ticking on me. I am not going to get a chance to spend 10 minutes on each of these ideas, but I do want to put all 5 of them forward for further treatment.

You can see the reference there. Richard Frank wrote a really nice piece for Bruce's group at SCAN that kind of spends a lot more time on each of these ideas and also puts forward a few other ideas on how to grow this market.

But, once again, I am not asking for new dollars here. I am thinking about reorienting how we buy and how we sell this product.

So let me go through each one of these ideas in a little bit of detail.

The first idea--and I really think this one is a no-brainer. Every one that purchases, or tries to purchase, private long-term care insurance claims this is just too complex of a product. It is really hard to compare apples with apples. There are lots of features of this product.

Why not make an electronic Medigap-like market in this area? This has been done in CalPERS and Minnesota, and maybe we will hear a little bit about that.

But you can simplify this market greatly, limit the number of choices so we know what is in Plan A, Plan B and so forth, much like Medigap.

We will have an unlimited number of sellers, but we

will have a finite number of plans here.

We can also use decision aids in this electronic market to push people towards those options that may best suit their health and wealth and age needs.

We can also alter state regulations to allow high deductible products. That is going to greatly lower premiums and bring more people into this market.

I think if you do one thing, it is this. I think this is a no-brainer here. This is a very simple step. Simplify this market. This addresses the complexity and the confusion with the shopping. It really makes long-term care insurance into a commodity, and it could reduce premiums by as much as a third.

The second idea is one that we have thought a lot about when it comes to the dual population--blending Medicaid and Medicare. There is no reason we could not do something very similar in this population, and that is trying to blend long-term care insurance with health insurance.

I have used the example here in the slide of linking long-term care insurance with Medicare Advantage. There is no reason you could not do that with traditional Medicare or even with health insurance for the under-65 population.

We, basically, mandate that any plan offering Medicare Advantage offers long-term care insurance.

We could also use an opt-out feature, one of those

behavioral economics, you know, to nudge people into these policies, not everybody, but for those for which we thought it was appropriate based on their age and wealth.

The impact--once again, we reduce the sales cost. We reduce premiums here. We increase take-up, and we also maybe leverage some savings across long-term and acute health care services.

The third issue--and, if you noticed on that list, we have really high selling costs in this market. That is due to the fact that it is largely an individual market. Many employers do not offer private long-term care insurance. Minnesota--the State of Minnesota, CalPERS, the Federal Health Employees Benefit Plan--those are great examples of employers offering, historically, long-term care insurance.

We could greatly increase this market, once again, if we mandate that employers offer this policy.

We can leverage economics of scale here to lower premium costs.

We can eliminate medical underwriting in the group market.

We can eliminate adverse selection to stabilize premiums.

And we could also, much like that Medigap market, use employers to filter this product and reduce complexity and confusion.

The fourth idea really stems from a lack of consumer confidence in this product. I think, historically, we have seen a lot of large rate increases, and many consumers do not believe that these companies or these policies are going to be around in two or three decades.

On the provider side, on the firm side, they have had a lot of trouble spreading risk as well.

And so this would actually fix both of those problems, much like it did in flood and earthquake reinsurance. We should allow a publically organized and privately funded reinsurance pool here.

Once again, this is going to increase consumer confidence in the long-term care insurance product, and it is going to reduce those risk premiums.

The final idea--and I am really excited about this. My colleague, Richard Frank, has put together these estimates.

Many people say we do not want to subsidize private long-term care insurance. Lo and behold, we actually do subsidize private long-term care insurance. These are, annually, how much we spend through different mechanisms in the tax code in subsidizing private long-term care insurance. You can see, annually, through these three pathways, we spend about $2.5 billion.

Two point five billion will buy you a lot of long-term care insurance.

And so those dollars are out there. The not so good news about this is that those dollars do not always go to the individuals that are at a high likelihood of spending down to Medicaid status. A good proportion of these dollars go to older individuals, and they go to wealthier individuals.

We need to target individuals that are in that age 45 to 65 range, that are at risk of spending down into Medicaid, so in that 30th to 50th distribution of the lifetime wealth. If we can target subsidies, take these subsidies that are going to sort of the "wrong" individuals and target them to the appropriate people, we can increase long-term care insurance purchased and, ultimately, lessen the burden on Medicaid.

So, to sum up, I do not think Medicaid crowd-out is by any means a deal-breaker. I think there is still a lot of long-term care insurance policies that could be sold if we reorient this market, both in how we sell this product and also the mechanisms by which we purchase it.

I outlined five steps. I think all five of these are very doable. None of them mean a large increase in spending.

In terms of thinking about what success might look like here, if we can move from 10 percent to 20 percent, I would be willing to declare victory. And I do not know about you

guys, but I would.

So I will stop on that point, and I thank the Commission and look forward to comments and questions. Thanks.

[The prepared statement of Mr. Grabowski follows:]

Chairman Chernof. Thank you, David. That was excellent.

Next, we will move to Lane Kent, please.

STATEMENT OF LANE KENT, FORMERLY UNIVITA

Mr. Kent. Thank you. It is an honor to be here with you today to offer a perspective on this important topic.

I have been working in and around private long-term care insurance for the last 20 years or so, most recently running an insurance administration company responsible for all or some material portion of the administration of over 1.3 million policies, which is about 20 percent of the policies that are in force in the market today, and I have seen this market from every angle.

I was asked to provide testimony today regarding the reasons long-term care is not working and what innovative ideas should be considered to change this dynamic.

The challenges facing insurers, consumers, regulators and legislators in dealing with long-term care are well documented. So, in the interest of looking forward, my remarks on those challenges will be somewhat brief, but of course, I will answer any questions that you may have about the past to the best of my ability.

The factors contributing to the decline in sales of private long-term care insurance are the following:

The first sellers had little experience to go by in terms of guiding them in designing the early product generations and were operating with a series of flawed pricing assumptions.

Persistency is much higher than was anticipated. Mortality is lower than was anticipated. And both of these have led to a higher incidence of claims, or expected incidence of claims, which is the number of people who have or will file claims.

Irrational market conditions made it difficult for responsible insurers to compete, and bad practices of the past included predatory pricing, unsound underwriting and agent-driven compensation models.

These flawed assumptions and practices have, in large part, been fixed, and the market has weeded out the irresponsible players. The problems are behind us, but other difficult conditions remain, which is why sales continue to be depressed.

The challenging environmental factors today include low interest rates--sorry, they are out of order here--rigid product requirements, Insurance Department approval practices and the inability of insurers to get rate increases as necessary.

These issues and poorly performing, older business or closed blocks have led to diminishing supply. With insurers exiting new sales en masse, just a dozen or so remain actively selling individual policies today, and only one group insurer remains in the business. So there is a definite supply issue.

Popular product features are no longer being offered.

Agents and brokers who sell the products are completely disenfranchised.

And the heavy surplus strain required to sell new products, new policies, coupled with the very scarce reinsurance capacity, makes it difficult to continue selling for insurers, and it also creates a prohibitive barrier for new entrants.

The troubles of the private long-term care insurance industry have taken a toll on consumer demand as well. The industry, collectively, has done very little by way of advertising and awareness, and as a result, confusion remains pervasive regarding the role of Medicare and health insurance in covering expenses associated with chronic and custodial care.

Premiums are becoming unaffordable for the middle market, and Medicaid remains the option, by design or by default, for too many. Although I agree with my colleague, David, that there is not a crowd-out issue here, but it is certainly a part of the problem.

Despite past and present challenges, however, there exists a number of workable ideas which would encourage product innovation and planning by consumers for successful aging even when faced with a dependency or disability.

With cost being the number one reason cited by

nonbuyers in their decision not to purchase, alternative funding sources and incentives to raise demand and attract new suppliers must be at the top of the list when considering different approaches, in my opinion. Tax-exempt and penalty-free distributions from qualified retirement plans would materially reduce the impact of premiums on disposable income for working populations, directly addressing the cost issue, even with the existing product sets.

Penalty-free distribution from retirement plans would allow payment of premiums without forcing consumers to find new discretionary sources of funds, again, addressing the cost issue.

Long-term care insurance should be Section 125-eligible, cafeteria plan-eligible, so that pre-tax dollars can be used to pay premiums.

And, to improve access to products through an electronic marketplace, as David was alluding to, payroll deduction, online enrollment--we have an access problem today with this product.

And also, to encourage commercial health insurance suppliers to enter the market with new, simplified plans and address the distribution costs, which are too high in the market today.

The current law allows for health saving account funds

to be used to buy long-term care insurance. However, annual contribution caps do not allow sufficient funds to be put into HSAs, annually, to cover the deductibles and costs they are intended to cover and, also, pay long-term care insurance premiums. So it is not a viable solution even though the law provides for it.

A Federal above-the-line income tax deduction for premiums, like those in place in a handful of states, would effectively lower the cost of insurance as well.

Current HIPAA rule allows for inflation index deduction but only after itemization of nonreimbursed medical expenses exceeding 7.5 percent of adjusted gross income, which is a threshold most people cannot meet because long-term care insurance holders are healthier by default because they have passed an underwriting exam.

But perhaps the most compelling ideas to consider are those which would align long-term care with the rest of health care, with acute care. As David mentioned, standardized supplements to wrap around Medicare Advantage and Fee-for-Service Medicaid would include options that emphasize post-acute care and custodial home-based care and catastrophic risk mitigation.

Standardization would also simplify the education process, reducing some of the variability and plan designs between competing insurers. This less complicated sales

process would increase buyer interest and, thereby, lower distribution costs. All these things work in favor of addressing some of the objections to buyers today.

In Israel, commercial health insurers offer long-term care insurance. It is not a mandate, but it is a competitive mandate, if you will. As a result, product penetration in that country is much higher than what it is here.

And a mandate, as David suggested, for Medicare Advantage offers would be, I think, a great step in the right direction. It, certainly, would increase the discussion and awareness around the product.

Some of the most fundamental principles in health care are nonexistent in long-term care insurance today. Preferred provider networks with negotiated rates, co-insurance, incentives for healthy behavior and the use of data analytics to facilitate early and targeted intervention are all proven to reduce costs and improve outcomes in acute care, and these principles can work in chronic and custodial care as well.

Modifications to existing long-term care insurance products should also be considered; attained-age pricing is one. Sales would increase with more widespread acceptance by regulators of short-term care and high-deductible plans, as they would also benefit from dependency-tiered benefit

triggers and reimbursement models like those that are used in Europe today, where product penetration is also about double what we have here in the United States.

Financial planning linked benefit-style products are slowly making their way into the market, and I know Jason is going to speak about this in length. But life insurance, critical illness, disability and annuity products, combined with long-term care benefits, encourage lifelong savings and planning by associating the financial risks of aging to other commonly insured financial risks such as premature death, disability and longevity.

And, finally, we should offer long-term care insurance through the new exchanges, where millions of Americans will soon shop for their insurance coverage.

Education makes a different. States conducting Own Your Future awareness campaigns have materially higher levels of requests for product information.

Industry research has identified the attributes of buyers as positive realists. Demand is strong among groups demonstrating these buyer characteristics. However, limited supply of affordable products and unfavorable economic conditions have put these products out of reach for most people who need it.

A great deal has been learned from the failures of the pioneers of the private long-term care insurance market.

Insurers entering the market today do so with sound pricing and underwriting practices. Active sellers are achieving sustainable growth, and bad actors have left the market.

The convergence of acute, post-acute and sub-acute care and a movement towards accountable care holds great promise for addressing chronic care as an extension of health care, with new emphasis on home-based support and holistic are planning.

The duals initiatives and bundled payment for care improvement initiatives being sponsored by the CMS Innovations Office will test new models of care. Let us apply those learnings to long-term care.

Providing care for those with chronic conditions and custodial needs is really not complicated. Most care, in fact, is provided by people who are nonskilled, and many are untrained. What has become complicated is paying for the care.

But the lens through which we view private long-term care insurance today is too narrow. No single product will solve this issue. The solution will be multifaceted, with a combination of funding reforms, a blend of financial planning and health insurance concepts, and a more diverse set of suppliers, creating new access and demand.

It is essential we create an environment that is conducive to collaboration and innovation to ease the burden

on Medicaid and ensure that that safety net is strong enough to catch those of us who lack the means to insure this risk.

That is the end of my prepared remarks. I appreciate the opportunity to participate.

And, if I can be of any further service to this Commission, please let me know. I would be happy to do so.

[The prepared statement of Mr. Kent follows:]

Chairman Chernof. Thank you very much.

Next, we will turn to Jason Brown from the Treasury Department, please.

STATEMENT OF JASON BROWN, U.S. TREASURY

Mr. Jason Brown. Thank you. Thank you all for allowing me to come and speak to you.

I should also say the usual caveat that I am from the Treasury Department, but my views expressed here are not those of the Treasury Department.

[Off microphone - inaudible]--here to help you.

[Laughter.]

Mr. Jason Brown. So what I would like to talk about today are a combination of long-term care products.

Ordinarily, long-term care insurance must be sold as a standalone product, but there are some exceptions, and those are what I want to talk about today, and why they are interesting.

There are a few cases in which long-term care insurance can be purchased with other polices--as Lane mentioned, life insurance. So you would buy life insurance with a long-term care rider, and that would allow you to accelerate your debt benefits in the event that you need long-term care services.

Deferred annuities, in which you purchase a deferred annuity paid premium and you have got some guaranteed return on sort of the annuity portion, but then you also have this pot of money that you can access in case you need long-term care.

And then, finally, there is the immediate life annuity,

and that would be a case--well, as I will explain further, it is called the life care annuity. In this case, in exchange for a premium or a series of premiums, a stream of income is promised with an increase in payments in the event of future disability.

Although Lane could probably attest to this better than I can, my understanding is that the combination of life insurance and long-term care is probably the most popular of these combined products.

Deferred annuities have become, I think, sort of a new and sort of interesting product.

There is less, I think, experience with this life care annuity, but that is what I am going to talk about anyway because I think it is more interesting and it is something that I am a little more familiar with.

So the life care annuity is, as I mentioned, an integrated insurance product consisting of a life annuity and long-term care insurance segments, and it was developed by Chris Murtaugh, Brenda Spillman and a man named Mark Warshawsky.

And what happens is that you pay one or more premium payments, and the life care annuity pays a stream of fixed periodic payments, which is the life annuity segment, and in the event of disability, it provide an additional payment to cover the costs associated with the long-term care.

And so there is not--you know, the power can be structured in several ways. The annuity payments can be fixed in nominal terms, increasing inflation index. In the long-term care portion, it can either be structured as a disability indemnity policy; so you have a couple of disabilities, and that triggers the benefit. Or, it can be a reimbursement for long-term care services.

And so the idea is that you would purchase this around the time of your retirement, and it would protect you from the two of the big, major risks in retirement that David alluded to. There is longevity, but also the risk of outliving your assets, but also disability costs.

Why would you want to purchase this jointly? What is interesting about the combination of these two products?

Well, there are shortcomings in both the life annuity product and long-term care insurance product that kind of offset each other when you them together into one product, and that is what I am going to elaborate on.

So life annuities--they are subject to adverse selection by low mortality classes, which raises the price level to a product without adverse selection. So people do not want to buy life annuity if they think they are going to die soon.

So the product attracts people with above average remaining life expectancy, which raises the price of the

product.

On the other hand, long-term care insurance policies are underwritten to exclude high mortality classes because the level premium nature of the product means that a person has to pay in for several years before they can actually cover their expected claims costs. And so somebody who would be expected to claim benefits immediately or in the near term just does not pass underwriting.

But, if you can combine these two products, you might come up with a sort of a situation where you have this product that pulls in people with low life expectancy into the annuity so that they can get the long-term care coverage and people with above average life expectancy into the pool of long-term care policy in order to get a cheaper annuity.

What is the evidence on that?

So this has been researched, and in principle, this really can happen.

So, currently, around 15 to 25 percent of the 65-year-old population is basically ineligible for long-term care insurance, and it is not because they are actually disabled. Only 2 to 4 percent of that population is disabled.

But there are a number of people in that, sort of at that age, who have had a stroke; they are diabetic; they have had a heart attack; maybe they have lung disease.

And what research has found is that these people with

these health histories that are often the reason for denial of long-term care insurance coverage--it is not like their expected claims costs are really any higher than people in perfect health at that age. The difference is that their claims come sooner. And so, as a result, they cannot pay in long enough to cover their expected claims, and that is why they are denied coverage.

And so what the research has found--this is actually on gender-rated terms. The reason why it is important to sort of like at least identify the separate gender effects is that women are expected to outlive men and they also have higher expected long-term care costs.

But a gender-rated life care annuity could be sold more cheaply than the two products sold separately, thanks to these offsetting longevity risks.

One other benefit aside from this sort of--or, it is actually related to the fact that you are bringing in people with chronic illness or an adverse health history into this pool is that it does allow people to delay long-term care insurance purchase until closer to retirement.

If one reason why people are buying long-term care insurance coverage at 50-55 years old is that they are afraid of being denied it at age 65 because of some adverse health sort of event that may intervene, this would allow them to push back the decision to purchase long-term care

insurance.

You can see this benefitting not just consumers because they would like to have more time to sort of assess their needs in retirement, but it can also benefit insurers because basically it shortens the contract length. They are not trying to insure somebody's long-term care risk for 40, 50 years, but considerably shorter, and that kind of just reduces the risk that they bear with regard to interest rate or investment returns, longevity. So we see there are some benefits on both sides.

Just to talk a little bit about kind of the tax and regulatory environment--so the Pension Protection Act of 2006 specifically recognized these combination long-term care insurance annuity products, which sort of confers the blessing of the government on this combined product.

Without getting too detailed, the life care annuity does have slight tax advantages compared to, say, a standalone annuity and qualified long-term care insurance purchase. And that is just for the after-tax life care annuity.

But for a qualified retired plan, Lane mentioned some of the challenges. There are probably some regulatory or statutory hurdles.

Again, without going too deep into this, basically, the distribution requirements are just sort of intended for

retirement income, and that is how the statute and the regulations were designed. So they do not really imagine policies that might have a bump-up in payments.

And so, it is something--food for thought for policy development--how you might think about incorporating a life care annuity into a qualified retirement plan.

Thank you very much.

[The prepared statement of Mr. Jason Brown follows:]

Chairman Chernof. Thank you very much.

And, finally, Bonnie Burns from the California Health Advocates.

STATEMENT OF BONNIE BURNS, CALIFORNIA HEALTH CARE ADVOCACY

Ms. Burns. Thank you and thank you for the opportunity to be here.

I have worked with consumers now for more than 30 years, who need information about this product or who needed help in getting the benefits from it. In addition, I have worked for that same period of time with state legislators and Federal legislators to enact changes to law when it became obvious that there were things that needed to be corrected. And I have worked with the NAIC since the inception of that program in 1992, as a funded consumer representative. So I have a sense of some of the issues that are involved in establishing standards that reach across the country because states have their own issues and ideas about how to do things.

People are generally confused about the whole issue of long-term care. Most people, if you talk to them about long-term care, the first thing they think of is a nursing home. So they have very poor understanding of what the whole field of long-term care is.

One of the results of that is when they need care they are pretty much on their own for finding it, and it is their family members that are the ones who are going to be dealing with that issue--trying to find care for a family member,

arrange it, monitor it and figure out how to pay for it.

And that involves a whole range of issues that I do not think you have talked about here--about the impact on families when somebody does need care, whether they have insurance or whether they do not. And it is something that you should consider--about how complex that is and how fragmented it is, that people struggle to find those services for their family members.

Attached to my testimony are examples of five of our family members who have dealt with trying to get long-term care for another family member.

Also attached to that are six examples of people who had insurance and who have come to me over the last two years with a need to have an intervention so that they could get the benefits that they bought.

So people are generally confused about the whole issue of long-term care, but they are also confused about long-term care insurance and how to pay for long-term care and what programs for it and what programs do not.

There is, generally, people looking at this across a variety of age groups. There are people who are younger, who are considering long-term care insurance and who know even less than older people do about it, and then there are older people who are looking at long-term care insurance at a certain stage of their life.

But the reality is that a lot of the people who need long-term care insurance are not going to be able to get it because they do not have enough money to pay for it or because they have a health condition that is going to screen them out, whether they can pay for it or not.

And long-term care insurance policies themselves are very complex instruments. There are variations within the same company for a variety of products that are being sold for that particular loss, and there are variations across the country within the states.

Consumers have no idea about what to buy, how much of it to buy or if they should buy it at all because there are no tools out there to help them evaluate this.

It is not simply a question of I want it; I have enough money; sell it to me.

It is a question of knowing some relationship between what it is they are buying, what their income is, what their assets are and being able to afford it over not just when they buy it but across time.

Many of you have seen in the papers, I am sure, the extraordinary rate increases that people have been getting, including the CalPERS program, which has an 85 percent rate increase coming in 2015.

And despite what we do at the NAIC, which we have done 3 times over about a 15-year period, to try to control these

rates, it seems that no matter what we do there 10 years later we find out whether it worked or not. So the NAIC has had three attempts and three failures to control these rates.

For people who get these rates increases, in these older age groups, it is a very difficult situation for them to try to figure out whether they can keep these policies, whether they have to give them up after years of premium payment and lose all of the benefits that they have been paying for.

There are difficulties getting these benefits because insurance companies interpret their benefits in a variety of ways. So people buy something that they think will pay a benefit, and when they go to use it, they find out that they are in the wrong place or the wrong person is providing the care, according to what the language of the contract says.

Now, when you are buying long-term care policy early on, you might have read it, you might have thought you understood it, but the issue is when you need to use that policy you are not the one who is going to be going out and finding those services. Your family member is going to be doing that. Your family member may not even know you have a long-term care policy, but they certainly were not there when it was bought, and they certainly do not understand it.

So, despite the changes that happen over time in

regulation, in response to things that we have seen happen, the person who has to actually use that policy is going to be uninformed about what it is and is going to have to negotiate with the insurance company for those benefits.

There is no way for people when they are buying these to figure out whether this is a good thing to do or not. They do not normally involve their families in that decision. The benefits are very difficult for people to understand, both when they buy them and when they go to use them.

I would propose standardizing the benefits in these policies rather than standardizing the policies as was suggested.

Medigap is a very different product.

Long-term care insurance is something that relates to the person's income their assets and their ability to pay for these policies over time.

They need consumer tools. They need some standardization in the benefits themselves so that when they buy a policy in one state and move to another, that they are able to use those benefits in the state that they have moved to, and that has become a problem because the services that are available across the country themselves are not standardized. And because they are not, neither are the benefits that are within a long-term care insurance policy.

It may not be possible over time to control the rates in the way that we would all like to do, and that presents some real issues for the consumers if they do not have dependable premiums to rely on in their retirement. The people who are retiring today are people who have had the advantage of the defined benefit income and pensions, and the people who are retiring later are having a different set of benefits to rely on. So incomes may not be as certain as they have been in the past.

And, certainly, when people's life situations change, their ability to pay for things changes. When a woman loses her husband, she may not be able to pay for the policy that they bought when they had both incomes.

So there is a lot to be considered here in terms of these products, how they will work for the population.

In my view, I think they are part of the solution, but they are definitely not the solution, to financing long-term care. And how much of a piece of that solution that they can be depends on a lot of individual factors.

And, with that, I will end my testimony there, and I will be happy to answer any questions.

[The prepared statement of Ms. Burns follows:]

Chairman Chernof. Well, first, my thanks to all the panelists for a great set of presentations.

Let me begin with Commissioner Claypool. We will go around. Five minutes a commissioner, please.

Commissioner Claypool. Thank you and thanks to the panel.

First, David, thank you for opening with a framing, I think of what the future holds.

And so I might want to just push back a little back and say there might be another scenario. At least maybe not in the near term but in the mid-term, there may be an opportunity for the Nation to come forward and to rally around this issue and to come up with a more organized approach to addressing a longstanding problem.

But I do appreciate that you laid that out for purposes of your presentation.

I wanted to turn to Bonnie. Since I am really not very familiar with this and I would not pass underwriting and have not really explored long-term care insurance, I wanted to see if you could help me walk through a scenario.

Say someone who purchased a product early on, a long-term care insurance product--35, 40 years old. They are paying in. They have some accident, or they become disabled in some manner, and they are eligible to draw on their long-term care insurance policy at, say, age 52. Is it likely

that that policy will pay out for any extended period of time?

Ms. Burns. Well, that is a really good question because it depends on what you bought and it depends on how long the policy that you bought said it would pay for.

Commissioner Claypool. Maybe I will take us to the more structured scenario, I think, that David was laying out--that there are these products that are a little more clear, maybe not as clear as you would like, in terms of the benefits that they offer. But I think you are proposing a little more structure to the market.

And so I would assume that the benefit that would come along with this product would be time-limited and might not extend for the duration of someone's need.

And so this person that is needing to draw on the product at age 52 is behaving rationally, doing the right things, buying a product that they think is going to cover their need, and I assume at some point that that benefit will become exhausted, and they might not be at the end of their life yet. Is that a wildly unrealistic scenario?

Ms. Burns. Oh, no, it is not because when people buy long-term care insurance today they choose how much dollar amount they want a day. They choose how many years they want the policy to last. That could be one year. It could be five years. It could be seven years. It used to be

lifetime, but those policies are not available anymore. And it also involves choosing where you want those benefits to be paid.

So there are a number of choices that people make up front and based on the offer that was available to them at that time.

We talk about long-term care insurance as thought it is a homogenous product, but it is not. I mean, it depends on what year you bought it, what designs were available in the year that you bought, what choices you made about those products or about those benefits, and then what you happens to you and where you need that care and who you are going to get it from.

And, by the way, whether or not you decided not to take inflation protection--so you now have a very deficient benefit.

Or, if you took an inflation protection offer that let you delay the cost of paying for it so that if you took a future purchase option, for instance, and you said, no, I am not going to pay for this up front but every three years you give me that offer to buy inflation protection and tell me what it costs. Well, each time they offer that, you are older. So the cost of it goes up, and they end up being priced out of that inflation protection.

So, if your cost is $150 a day and you bought a policy

10 years ago at $50 a day because that is what the cost was and you did not take inflation protection, you now have a benefit that is far less than the cost.

Commissioner Claypool. Well, thank you for that.

In concluding, I would just like to say that so in this scenario, somebody is making decisions based on lots of information. They are anticipating, hopefully, that the product will, or the insurance coverage will, last for the duration of their need.

And then that is not the case and individuals have taken personal responsibility and planned for the future, it does seem--and I am really addressing my fellow commissioners--that at some point there would need to be some type of backstop, that people who are taking responsibility for their future needs and yet run into some catastrophic type of experience should not then have to just impoverish themselves, justifying Medicaid. They should be able to have some type of access to a benefit that would allow them to continue to live the rest of their life without having to impoverish themselves to spend down to Medicaid.

Chairman Chernof. Commissioner Jacobs.

Commissioner Jacobs. Thank you, Mr. Chairman.

A couple of technical questions just to start off with--Mr. Kent, you had talked about removing the HSA contribute

cap--the statutory cap on contributions to the HSA.

Am I correct in believing that there is also a further--and it might be a regulatory as opposed to a statutory--cap on the amount that individuals can take from their HSA to pay for long-term care insurance premiums?

And, if so, I am presuming that you would want that raised or eliminated entirely, correct?

Mr. Kent. To your second question, yes.

But to your first question, I am not sure, to be honest with you, if there is a cap on the amount of the HSA that could be used to pay long-term care insurance premiums. I am not aware of that. Maybe somebody else here is.

Commissioner Jacobs. Okay. Second question, Mr. Grabowski, your reinsurance proposal--I just want to be clear. That does not involve the use of Federal dollars as a backstop, correct?

Mr. Grabowski. Right.

Commissioner Jacobs. There would be an incentive, potentially, to try to seed risks or anything else like that if you get into that, correct?

Mr. Grabowski. You could run it as a mixed public-private pool, but these have been constructed in different ways. We have a lot of good examples out there, as I mentioned--earthquake and flood reinsurance--and we can look at what has worked and what has not worked.

I acknowledge this is a very different market with very different risks, but reinsurance would actually get at some of the issues Mr. Claypool just brought up about these high spenders and what do we do about these and why don't sellers want to offer more generous policies.

Well, part of this is one of the reasons they put in all these policy constraints is that they do not want to bear the risk, and reinsurance is one way to kind of help spread that risk out.

Commissioner Jacobs. Of course, the other problem is it could turn into something similar to the flood insurance program, which does have its own solvency problems in terms of Federal--

Mr. Grabowski. Absolutely.

Commissioner Jacobs. That is what I was getting at.

One question--and, Mr. Grabowski, you mentioned it, and I think Mr. Kent. We have heard it actually in our first panel a month or so ago.

Do we know what drives purchasers or nonpurchasers of insurance? Is it based on income levels, asset levels or a combination of two?

Do we know which one is the primary driver?

Mr. Kent. I think they are linked, but certainly, assets are a key indicator of whether or not somebody will buy.

Commissioner Jacobs. Okay, but we do not know in terms of more or less, sir, one versus the other?

Mr. Grabowski. I like to look at lifetime wealth. I think looking at income a single point in time. I really think in order to understand the dynamics here, you really want to look at lifetime wealth and think about this.

I think a point in time, but you can definitely have liquidity constraints at different points.

And there are different ways to construct the sort of stream of premiums as people age, but lifetime wealth is what I think is key here.

Commissioner Jacobs. Okay. And then one other question.

I think, Mr. Grabowski, you talked about life insurance versus long-term care insurance and complexities of the two.

And my kind of thought responding to that is, is life insurance any less complicated than long-term care insurance, or is it even more complicated than long-term care insurance?

And, if so, is it the complexity that is driving the lower take-up rates for long-term care insurance, or is it lack of knowledge or some of the other characteristics?

Mr. Grabowski. So I did not touch on life insurance, but I will speak to that.

I think, absolutely, just the whole way that we have

sold these two policies. You know, long-term care insurance is incredibly complex.

Commissioner Jacobs. More so than life insurance, you think?

Mr. Grabowski. You know, I think so. I think there are just more variables here.

Think about everything. We have a daily benefit. We have a deductible. We have inflation protection. We have a potential max here.

I mean, we could go on here. There are nonforfeiture benefits.

I mean, there are a lot of different dimensions to these policies, and I think consumers' heads start spinning when they hear all these different features of these policies.

I do not know, Jason, if you want to think about life insurance as well compared to--

Mr. Jason Brown. Yeah, I just agree with that. It seems like it is a lot more complicated. There are a lot more variables that would even affect your risk of needing it.

Mr. Kent. I would agree that long-term care as a product set is more complex than life insurance by comparison, but fundamentally different. Life insurance has a lot more data behind it--hundreds of years of mortality

data.

Commissioner Jacobs. It is more longevity and mortality tables as opposed to health--

Mr. Kent. Well, it is a mature market. It is easier to price. There are more rating tables.

It is almost always issued. There are fewer declinations.

And there are mechanisms within the product that allow the insurer to adjust the return on that product in real-time. So they do not have to take the sort of rate increases that have plagued the long-term care insurance business.

Mr. Grabowski. A quick history lesson--in the early years of the life insurance market, they excluded risk, much like the long-term care insurance market does today by medical underwriting. They eventually figured out how to price that risk, and there is not the medical underwriting.

Long-term care insurance has never gotten over that hump--

Mr. Kent. Right.

Mr. Grabowski. --and we continue to exclude about 20 percent of the market through medical underwriting.

Commissioner Jacobs. Thank you very much, Mr. Chairman.

Commissioner Brachman. Thank you and thank all of you

as well.

My first question goes to Mr. Grabowski. You talked about targeted subsidies. Could you go into a little bit more detail as to what we currently have by way of subsidies and, as I understand, what you are recommending by way of substitute?

Mr. Grabowski. Absolutely. So there is a series of vehicles. I put that up. In the interest of time, I moved through it relatively quickly. So I appreciate the opportunity to return to it.

We have a series of deductions in our tax code. First, different states have their own deductions and credits that they offer, and that is on a state-by-state basis. It is estimated that about 600,000 individuals benefit from those deductions and credits at about $0.1 billion per year.

Also, individuals who itemize their medical expenses are able to take a deduction. We think a lot of individuals are able to deduct their long-term care insurance premiums. And so that is 2.6 million individuals at $1.4 billion.

And then, finally, there is also a deduction for those individuals that are self-employed with long-term care insurance.

So due to the age caps of how much you can deduct there, coupled with the fact that the marginal tax rate is different for a wealthier individual than a less wealthy

individual, it turns out that a lot of those subsidies--more of those subsidies, I should say--go to older individuals and wealthier individuals.

And so the idea here is simply to reorient or retarget those subsidies away from those wealthier, older individuals towards those middle-age, middle-wealth individuals.

Commissioner Brachman. And you would do that by?

Mr. Grabowski. Changing the tax code. You know, you can say, good luck with that, but I think it is a--

[Laughter.]

Mr. Grabowski. Details, right? Details, details.

Commissioner Brachman. Right, right.

Mr. Grabowski. Obviously, I think this is an idea that everyone can get behind. We are not asking for more subsidies here. We are asking to put them towards a group that would actually, I think, better protect the Medicaid program.

But, obviously, I am not one of those individuals currently enjoying those subsidies. They may have a different opinion.

Commissioner Brachman. Thank you.

Mr. Grabowski. Sure.

Commissioner Brachman. My second question is for Ms. Burns, and I think for Mr. Kent, but you all please join in if I am selecting the wrong people or if you have something

to add.

And my question is the role of the states. As I understand it, the states have considerable input into oversight or insurance companies within their state. So I am wondering how their current roles are involved with long-term care insurance and what you might see as changes in those roles.

Ms. Burns. Well, I will take that one.

States regulate insurance, and no two states do exactly the same thing. The NAIC produces model regulations, model acts, that guide states, and some states will adopt those regulations or those model acts in whole or in part.

With long-term care insurance the Federal Government set a Federal floor through HIPAA when they created the tax-qualified policies because they required that for a policy to be a tax-qualified policy it had to meet certain standards in the NAIC-backed regulation. And that, for the very first time, set a regulatory standard across the country. States then could, if they wished, build on those standards--and some did--but at least we had a common regulatory floor across the country.

So states do regulate the products.

And, in regards to life insurance, I just wanted to make a point about life insurance and long-term care. Long-term care in a life insurance policy is simply paying out

the death benefit early, but the trigger for that is the same as it is for a long-term care policy and, depending on the product, may even have some of the same requirements.

So the appeal of a life/long-term care product for younger people who do not believe that they will ever need long-term care, is that it is a two-for-one.

So they see that no matter--you know, no matter what, somebody is going to get something for the premium that they are paying.

But they do have some of the same complexities attached to them, and in some cases, more complexity, than a freestanding long-term care insurance policy.

Commissioner Brachman. Mr. Kent, can you just respond very quickly, too?

Mr. Kent. Two important roles for states today--approving products and approving rate increases.

And with the interstate compact, you can get a lot of states' approval--about 30-some--with a long-term care new filing, but you still have to go to each state individually to get a rate increase. That is one of their primary roles today.

Commissioner Brachman. Thank you.

Mr. Kent. Mm-hmm.

Commissioner Guillard. Yes, thank you all very much for your comments.

Dr. Grabowski, I have a quick question.

And David and I have spoken about long-term care insurance for a long time.

When you did all--and I found this very interesting. But when you did this, did you look at types of benefits that you would recommend be bought, or premium structures or anything like that?

Mr. Grabowski. Do you mean actually in terms of that Medigap-like market--

Commissioner Guillard. Yeah.

Mr. Grabowski. --what would these buckets look like?

I think, you know, obviously, having a high deductible plan is really important, I think, in there. We may run into some state insurance--state regulatory issues there, but that is something that would need to be addressed. But I like that a lot.

I think you have to have inflation protection. Otherwise, these policies are fairly meaningless.

Obviously, having kind of higher lifetime benefits, that means more expensive policies. But I think the more protection here, maybe not for all consumers, but that is where maybe we can use kind of some behavioral economics tools to kind of nudge people into particular policies that may fit their sort of profile really well. I find that really appealing as well.

Given it is an electronic market, can we match kind of attributes of the individuals with particular policies that might fit their kind of risk profile? That is really appealing to me.

Commissioner Guillard. Any other comments on that?

Mr. Kent. Yeah, I would agree with David's comments.

I would just add that also with regard to premiums and inflation protection, both could be indexed in a more real-time way than they are today.

The current regulation in HIPAA requires insurers to offer 5 percent compound inflation, and that required offer resulted in a lot of policies having that rider attached to it. But there is a much more effective way to index benefits over time, and you can do the same thing with premium, which would reduce the initial cost.

Mr. Grabowski. One of the great failures in this market--sorry to jump in again--is just these flat premiums that we started with and these huge increases that have had to occur. I know it was done to simplify this product, but it has led to these rate increases. We should have indexed this from the beginning to inflation and cleaned this market up.

I realize I have been saying to simplify everything, and here I am making it more complex, but I think it actually backfired in a big way.

Commissioner Guillard. Yeah, having worked in the skilled nursing and post-acute area for a long time, I would get constantly approached by people who would ask, should I buy long-term care insurance?

And I have been, historically, a big skeptic because I do not think people really understood accessing the care and who was paying for it, essentially.

So, rather than run the risk of increasing premiums and diminished benefits and escalation of cost and portability issues and everything else, my comment always was, why don't you just self-insure, because as the population and health care system has evolved, essentially, Medicare was insuring your skilled nursing benefit for the highest probability of your utilization of skilled nursing services.

I mean, so many people ever need more than 30 days of care. For home health, it is the same way. Medicare was essentially insuring for the home health care benefit for the vast majority of the care that you would likely ever need.

And so you were left with insuring for what real purpose? Assisted living? Or--you know.

It always seemed very--and I could understand the confusion in the marketplace because I was totally confused most of the time. You know

And so it just seemed to me, why not just self-insure?

What do you think about that, Ms. Burns?

Ms. Burns. I think that is a difficult thing for people to understand how much that may cost them over time and how they are going to access those benefits.

Medicare pays when the care is skilled. It does not pay when it is not. And most of the home care that people are getting for this kind of a purpose is not skilled, and so that money comes out of their own pocket.

Commissioner Guillard. I understand that, but again, utilization patterns just never struck me as being an insurable.

Mr. Grabowski. All those barriers that we put up on the demand side also pertain to savings. People are not forward-looking. They do not save a dollar.

I mean, you are asking a lot of individuals--I know we are trying to get them to purchase this policy, but Americans have not shown a strong propensity towards savings more broadly, and you are asking them to kind of put this money on the side and self-insure.

I also wonder if there is not--that may be true for the sort of upper tercile of the wealth distribution.

In that middle tercile, there is a group that is highly at risk, that will very quickly get into Medicaid, and I think that is the group we want to target here. That is the group that from a policy perspective is key.

Commissioner Guillard. And which I appreciate your perspective on.

And, taking it from 10 to 20, that made a lot of sense to me.

Commissioner Butler. A couple of just really quick questions, I hope, the first being--and anyone can answer.

I am a California resident now, and I have just lived through all the upheaval around the CalPERS increase, and for the life of me, I could not understand why such a drastic increase.

So, to the degree that you can, just briefly, can you just explain to the Commission what are some of the key drivers behind some of the drastic price increases and rate increases that the insurers are asking for?

Mr. Kent. Yeah, I can take that one. I managed that program for a number of years.

The most recent round, which is attributing to the 85 percent rate increase that Bonnie referenced is really just a miss on their investment returns. The product was initially priced, and I think the last discount factor they had, was over 7 percent built into the product. They are getting 3.5 and 4 percent on their invested assets, so you are way off.

The early product generations, however, did have some higher claims incidents. The first generation of products

were offered on a lifetime basis without underwriting, and they got some claims immediately. So they corrected it in the first round of rate increases.

But, like I said, this more recent round is really just a relationship between the number of policies in force and the investment returns that were anticipated on the premiums.

Commissioner Butler. Great. Thank you.

And then, Mr. Brown, since no one is asking you any questions, I felt like I will try to throw one at you.

[Laughter.]

Commissioner Butler. In our first Commission hearing, a panelist, Mark Cohen, who really critiqued combination life annuity plans as sort of putting two complicated products together to create one very complicated product.

And today, we hear Ms. Burns and Dr. Grabowski advocating and suggestion for a simplification.

So how do you square those two things?

Mr. Jason Brown. Thank you.

Yeah, I totally agree with what Bonnie and David have said about the complication of the products.

I mean, we are talking, though, about this product is designed to sort of plan for retirement security. So all of the problems associated with complexity of a long-term care insurance product still exist.

But, you know, I do not know that it is adding a lot more complexity to bring together that product and another kind of essential tool of planning your income stream for retirement.

Both need to be done. So I do not know that having this combined product, in essence, makes it worse.

Commissioner Butler. Great.

Mr. Jason Brown. But, actually, I did have one sort of question.

Talking about the inflation index premiums, my understanding is that--so CalPERS did not--I just did not want this to just sort of pass.

I mean, if premiums were inflation-indexed, that would not have stopped the increase in premiums, right?

So it was not the misunderstanding of premiums--of inflation that led to the premium increase. So they did not overestimate?

Mr. Kent. No, they did not.

Commissioner Butler. And then, Mr. Grabowski, you suggested--I understand that you suggested, and I could have a wrong understanding.

I understand that you suggested that by implementing all five of the suggestions that you presented that we might move the needle from 10 percent covered lives to 20 percent covered lives, leaving another 80 percent of Americans

uncovered.

What do you--

Mr. Grabowski. Uncovered by private insurance.

Commissioner Butler. Uncovered by private insurance.

Mr. Grabowski. Right.

Commissioner Butler. What would you suggest for moving on the rest of those 80?

And, if this--your suggestions, as monumental a feat of changing the tax code is going to be--only moves it 10, like how do we--what is the game-changer?

Mr. Grabowski. Right, and I think Mr. Claypool touched on this earlier.

I think mandatory solves everything. I think you can go to a universal plan.

I took that off the table. There is, obviously, enthusiasm for that idea in certain groups. I just do not see that happening, but I think that--in the short term. But I think that is how you would have--that is where you have to go because I think it is a lot of heavy lifting to get to that 10 percent.

Mr. Kent. Yeah, I would just add quickly; increase interest rates by about 200 basis points, and you will get a lot more supply in the market.

[Laughter.]

Chairman Chernof. Hear, hear.

Commissioner Vradenburg.

Commissioner Vradenburg. I join my colleagues in thanking you for your testimony.

What is striking about this panel is that all of you are making--except for Ms. Burns--a variety of recommendations about how to improve a product in the private market.

So, essentially, we are sitting here saying, gee, should we simplify the product? Should we make combination product? How can we change the parameters of these products?

It does not seem to be a long-term commissioner's job advising Congress about what the private sector ought to do.

Is this an industry that is immature and maturing, or is this an industry that really does not have a business model that is going to work?

So I will ask David the question.

Mr. Grabowski. Yeah, sure. I will start.

I think it is a mature market, but I think it is one with a lot of market failures, and I think on both the demand and the supply side.

And I think both on the consumer side in terms of their perception of risk and their information and all that list, plus the distortionary effects from Medicaid. There are some challenging issues in terms of the purchase of these

policies.

On the supply side, same thing--there is this series of challenges.

So I think it is those market failures, those distortions, that require intervention.

I agree with you. I am an economist. I like unregulated markets, but I think this is a market that if left to its own it is just going to kind of wither there on the vine. We need to grow this market.

And I think putting in place a standardization--that is not a dramatic regulation, but I think it is one--I think it is very straightforward, but as Bonnie said, consumers are incredibly confused by this product. Even those that buy it are confused on what they actually have in their hand.

And so we need to kind of clean up this market and kind of regulate it in terms of how firms compete. I think you could see some gains here. It is not dramatic regulations but things that allow us to compare apples with apples, for example in terms of policies. That is a very simple--

Commissioner Vradenburg. But most industry--a lot of industries have a lot of either uniform acts or industry standardization and self-correct. Why not here? Why hasn't it happened here?

There are uniform state laws. There are certainly industry associations that could suggest parameters to

simplify products and product categories and not be anticompetitive. So you wonder, why isn't this market self-correcting?

Mr. Grabowski. There are some good examples--

Commissioner Vradenburg. I keep asking the question whether or not there is a market here.

Mr. Grabowski. There is a market here, and I think you are pushing in the right direction.

But I will point to the Minnesota example. I will point to CalPERS. Those have penetration rates--15, 20 percent. Those are huge relative to sort of national averages in terms of sales.

I think when you do offer a standardized market, when you do kind of correct some of the problems we put up, you actually can see some returns here.

And so I do think we have some data points. Back to Ms. Butler's question about going from 10 to 20 percent, I am basing that on the experience in Minnesota and CalPERS. Both of those programs have some issues--the rate increases and so forth. They are not perfect, but I do think there are some data points suggesting that we can move the needle here.

Commissioner Vradenburg. Let me ask--because the question--I think I was going to ask the same question as Stephen asked about whether or not self-insurance or savings

plans is not--if we want to put in a heavy lift in terms of trying to encourage American families to provide more financial wherewithal for the possibility of long-term care in their retirement, whether going at savings isn't a proposition.

So this is a fact question. How are 529 education plans doing? Are they widely used? I mean, is there a significant amount of assets going into them?

Are family savings plans for disability and long-term care a conceivable avenue that might encourage you to get to that middle-debt tercile in a more effective way, if we provided some tax incentives for savings plans or for family savings plans?

So it is not the individual who is going to have the long-term care problem. It is the family who knows to a moral certainty that some member of that family is going to have a long-term care problem--that we might encourage more joint and family, or community-based, savings mechanisms rather than trying to, as you say, shore up or clean up, which the government does not do very well, clean up a marketplace in long-term care insurance.

Mr. Grabowski. I like that avenue as well, in terms of encouraging--it could even be tax advantage savings accounts. You know, I do not know.

Consumers may not understand. We would have to do some

education. But I think that is another kind of potential lever here. It is a different way to get at this.

Commissioner Vradenburg. Is there any constraint on using IRAs, just your 401(k)s, for long-term care issues.

Mr. Kent. It would not be a qualified distribution.

Mr. Grabowski. Right now.

Mr. Kent. Today.

Mr. Grabowski. Today.

Commissioner Vradenburg. Here is our main savings vehicle in the United States, and we are not allowing--

Mr. Kent. That was in my remarks as a primary--

Commissioner Vradenburg. Well, I endorse it.

Mr. Kent. Sign us up.

Commissioner Vradenburg. Thank you.

Commissioner Raphael. Building on what George was just addressing, I also have been pondering how we could deal with what you all have talked about.

And, David, you captured it in sort of misinformation, misperception, mistrust, combined with denial.

Mr. Grabowski. Yeah, right.

Commissioner Raphael. And how could we--I mean I know I have fire insurance. I have automobile insurance. I have flood insurance. I have home theft insurance. All are--life insurance, right?

Mr. Grabowski. Right.

Commissioner Raphael. The last one is a likely need, but the others are probably not.

Mr. Grabowski. Sure.

Commissioner Raphael. But I, nonetheless, am spending money and acquiring all those insurances.

So I was trying to get your sense of what would enable us to change the equation here and have people recognize this as a real need and maybe enlarge it to a family policy--that it just does not involve you, that it involves your entire family, and not being a burden and releasing your child.

Mr. Grabowski. Right.

Commissioner Raphael. So I would just like your thoughts on how we might tackle that.

Mr. Grabowski. Yeah, I think I really like where you are going with that and sort of changing the dynamic here because I think when you talk to middle-aged individuals they have a lot of different types of insurance. They are saving for a lot of different--you know, college, their kids' college fund and so forth.

Long-term care is not on their radar screen, given the multigenerational nature of this purchase, where in many ways you are kind of helping the next generation. I have three daughters myself, and they probably would like me to go out and get long-term care insurance and release the

burden on them, potentially.

I agree. Like trying to make this a family--either savings device--there is something that can be done here. I do not know if there--

Mr. Kent. Well, until you got to life insurance, there is something really profound missing. You cannot borrow money to buy a home unless you have homeowner's insurance. It is a mandate.

You cannot license a car or register a car and be able to drive it without auto insurance.

So, I mean, if you--what is the equivalent there or the parallel in the long-term care world?

Well, we all have Medicaid as a backstop. So, if you were prohibited from accessing Medicaid, unless you insured or tried to insure, that would be a sort of opt-in, if you will. But that does not exist today.

So anybody can defer this decision and transfer assets or not and, eventually, go on Medicaid, but there is no mandate. There is no--so, if you want to get to that level--why do people own homeowner's insurance or flood insurance?

Well, they are compelled to do so if they want to live there.

Commissioner Raphael. Right. So there is no stick and not enough carrots, right.

And then my other question--I was sort of intrigued

with the idea of offering long-term care insurance through Medicare Advantage plans, and I think I had read somewhere--and I think, Lane, you pointed out in Israel, 80 percent of the population--and my numbers are probably not accurate, but there was considerable up-take, and it is offered through the health plan.

Mr. Kent. Right.

Commissioner Raphael. And so I was wondering if, in your schematic, do you expect Medicare Advantage plans themselves to become long-term care insurers and change the nature of the industry?

Mr. Kent. Well, to me, that is the one thing that has always been missing from the world of private long-term care insurance--that the commercial health players are not in it.

Some have been in and out. Aetna has been in and out. Humana has been in and out. United has been in and out a few times. But they are not there today.

But those companies are all bidding on these duals initiatives, and in those initiatives they are assuming the total health care outcome for the people that are going to be in their populations. So those are Medicaid and Medicare-eligible people.

They are scrambling to figure out how to manage the home care piece of that--the custodial, the nonclinical piece of that. That really is the opportunity.

And I think to get to your question earlier--is this market broken? Yes.

Can it be fixed? Yes.

But that really is part of the equation.

And my opinion is we are going to learn a lot from these duals initiatives, but that is a subset of the population. It is nine million people.

Let's take what we learn from those nine million people about managing the acute all the way to the end, to the sub-acute, the post-acute, the chronic, and all the way back, and then apply that in a commercial setting. And that is where the Medicare Advantage players can make a difference, if they participate.

Commissioner Raphael. Thank you.

Chairman Chernof. So the two questions--the first to David.

Well, first, let me thank all of you for a really great set of presentations.

I want to build on Laphonza's and George's question.

So we are a Commission that has been asked to think about long-term care overall as a system, and it is a 20-odd-year-old industry, and I am hearing there are things that we could recommend that would be helpful. I am also hearing that there are a few combination products out there.

And I will be honest. As somebody who does not own

long-term care insurance, but maybe I should, Bonnie, I am one of those sort naive people who might come see you and say, so now what I do?

I do not get it. I do not see the creativity in the industry. I do not see these products being pushed. I do not see them being developed. And I am sort of wondering why we as a Commission need to own that burden.

Where actually is the industry on developing and marketing and doing this stuff?

I get that there is stuff that we could do to be helpful, but I am sort of wondering where they are.

Mr. Grabowski. Yeah, you know, I think the industry has been shrinking, as you probably heard. It is going in the wrong direction here.

We, typically, frame some of the problems with this industry as a demand problem. There is also a supply problem. They are unwilling to sell for a lot of those reasons we had up earlier.

I think the reason you should be concerned about this market is that a lot of individuals in that sort of near Medicaid status come into Medicaid, and I think they spend down, if you look at their lifetime wealth, not their wealth at time of retirement, but their lifetime wealth.

So I think there is a lot of gain if we can target the appropriate group of individuals to buy long-term care

insurance. I believe not just there are gains for those individuals, but I think there is a gain to the Medicaid program.

And that intersection--I know you are going to have a whole panel on this in a little while. That is why you want to care about this market. You do not want to just let it wither on the vine here and die.

Chairman Chernof. So, fair enough, but let me push this further.

Mr. Grabowski. Sure.

Chairman Chernof. You know, if you assume that there is a tercile of folks who are likely just to use Medicaid because they are never going to be in a place where it makes sense--it is not about discretionary income. It is just about basically surviving. You have a body of folks who are likely, if they have a need, to ultimately use Medicaid.

And maybe the upper tercile is in a place where they ultimately could buy current products or self-insure through savings or whatever the case may be. So you are talking about sort of that middle tercile, trying to help them have a set of tools that makes sense.

And I guess my question--so let me ask it again. I do not see where the industry is in delivering products that make sense. I get that the industry is shrinking. But if we were to make a series of recommendations that would

actually try to foster that market, is the market going to step up; are the products really there?

Are we trying to save a market that is not going to exist?

Mr. Grabowski. I think if you protect the sellers, in some ways--once again, using the Medigap market, if we have a Benefit A and that has inflation protection and a 90-day deductible and a set of common features that we know and they can compete on those set of features and consumers know what they are getting when they purchase that, I think the industry would step up to that.

I think some of the uncertainty on the part of the industry has led--the risk is just too great. So I think they have stepped back and said, we would rather sell other products and not this one.

So I think there would be a response there.

I would be curious to hear others here.

Chairman Chernof. So I want to ask, so I can use my time.

Mr. Grabowski. Sure.

Chairman Chernof. So 40 seconds to you and 40 seconds to Lane. I want you to describe for me what that Medigap product looks like, and Lane, I want you to describe for me what it is that a health plan would offer in MA. Forty seconds each.

Mr. Grabowski. Sure. So, for the Medigap product, you are going to have a Plan A that potentially has set of common features.

So maybe it has got, let's say, a lifetime max. I will make this a very generous policy--a 90-day deductible. It has got a $250 a day, in current terms, daily benefit that is inflation-protected. You know, I am probably forgetting.

You know, you can use nursing home care, assisted living, home health care--the whole range of different services.

And so you could think about that being a Cadillac policy all the way down to Plan H that has a high deductible and maybe looks less generous but a much lower premium.

Mr. Kent. Yeah, I would like to see Medicare Advantage suppliers offer transition in a post-acute environment, a nurse practitioner overseen by a doctor for a 30, 60, 90-day period to reduce hospital readmissions, and then custodian home care for an extended period of time to make sure that they are resituated in-home and being managed appropriately.

Chairman Chernof. Do our other two speakers have anything to add since I have 19 whole seconds?

Mr. Grabowski. He is good.

Ms. Burns. I am not sure you could standardize them in quite that way. Some elements, you could, but people have different affordability issues.

So some people could pay more per day than others. Some people could not pay for a policy that paid longer than two years. Some could pay for a policy that paid for lifetime.

So I think when you are looking at those kinds of benefits, that those are the things that do not lend themselves to the standardization.

Mr. Grabowski. And if I could just quickly, that is why I think you have different options and you allow individuals to select, much like Medigap, where you can protect for different gaps in the Medicare program. And some are very comprehensive, and some are less so.

Chairman Chernof. Thank you all.

Commissioner Pruitt. Thank you.

Mr. Brown, in your comments for the life annuity product, which I am very intrigued, to you see modifications that could be made to make it more attractive to low and moderate-income individuals, or do you believe that it is attractive to those individuals as it stands?

Mr. Jason Brown. Well, as others have mentioned, the Medicaid crowd-out is very sort of relevant here, and in order to avoid both an annuity and sort of a comprehensive long-term care insurance policy, you need considerable assets.

And so I would--you know, I think what we have modeled-

-the policy that we modeled, I think, would pay $1,000 a month inflation-indexed; in the event of disability, $3,000 a month; and severe disability, $5,000 a month. And that would cost, as a lump sum, about $200,000 for a 65-year-old.

I imagine that would be out of reach for a number of low and moderate-income people.

Commissioner Pruitt. Thank you.

And, Mr. Kent, you also mentioned the fact of asset transfer, an issue that we have talked in number of panels.

Do you have any theories of why, specifically, the partnership programs with the states have not been as successful as one would hope?

Is it the same factors that we are discussing for all of long-term care insurance, or are there other factors that may contribute, besides the crowd-out?

Mr. Kent. Yeah, I guess, there are two different ways to think about partnership. There are the four original partnership states, and then there are the partnership states per the national partnership regulations.

I think penetration--if you looked at new long-term care insurance sales over the last four or five years, you would see that there is actually quite a few partnership-qualified policies that have been issued. Of course, that is a function of the inflation benefit that was attached to those policies when they were sold.

But those products, like the rest of the long-term care market, suffer from lack of supply and some rigid regulations. The inflation protection requirements on the national partnership products make it very expensive. You have to buy 5 percent compound inflation if you are under, I think, the age of 65. And then there is a corridor from 65 to 74 where it can be indexed, and then you can opt not to have it after age 74.

So the products still are expensive, with those constraints.

Commissioner Pruitt. Okay. Thank you.

And, Dr. Grabowski, you mentioned that by having exchanges--and I think Mr. Kent mentioned similar comments--that you could have up to a 35 percent savings. And I believe you mentioned specifically that would be due to the reduction in the sales cost of the products.

Would there be any underwriting concerns?

What I mean by that is depending on the state for the exchanges, and some say that there are savings, and others say that there is hundreds of percent increase due to the exchanges, on the individual rates. How would you avoid that problem or thoughts if that may be a problem?

Mr. Grabowski. I do not think the exchanges get around the underwriting. Those are sort of separate issues, at least as I frame the exchanges.

I think they could. You know, there are examples of that--if it was done in the context of a particular employer, like many employers do not underwrite. If you join a time--when you join the firm, for example, you would have the opportunity to enroll without any underwriting. So there is an example of kind of using an exchange and no underwriting.

But I think at least as I was putting forward an exchange, it was much around just standardization and simplification, not addressing the underwriting problem, which is a big problem in this market.

Commissioner Pruitt. Sure. And, when you moved forward and talked about the employer offering, are you thinking individual ratings, or would that be a group rating?

Mr. Grabowski. Oh, absolutely group. You are offering this on a group market.

You get around a lot of the problems that we have on that individual market. And so you are eliminating the brokers. Some of the selling costs go down.

I think it is a much different marketplace. It still can be very complex. The employer can be a filter and kind of help to explain this product.

But I think there are real advantages to doing this at the employer level, and I think we have had some really good

examples, once again, in Minnesota and California, of an employer kind of really getting a lot of--getting high enrollment.

Commissioner Pruitt. When the employer offers it, you are not suggesting that the employer would pay for it; it would be simply an offered benefit that the employer does basically the market research?

Mr. Grabowski. Correct, that they mandate this be a benefit.

You are going further with this to suggest that--you know, tax treatment of it and other issues--

Commissioner Pruitt. Sure.

Mr. Grabowski. --or that the employer shares it.

I am simply that employers offer a plan and getting around some of the risks issues around adverse selection and some of the load factors on an individual policy.

Commissioner Pruitt. Okay. Thank you.

Commissioner Feder. So we have had a lot of discussion of the complexity and the number of issues that need to be addressed to address market failures as you describe it, David.

But I am going back to your initial. When you went down your list, you said that--you talked about an electronic market, and you talked about a high-deductible policy.

You then said if there were one thing you could do, do this, and it kind of surprised me because I would think that if that were the one thing you did you would still be left with all the value and reliability problems that Bonnie so eloquently laid out.

So you really think it is the ne thing we should do?

Mr. Grabowski. Not the only thing. I said the first.

Commissioner Feder. You said the one thing, but--

Mr. Grabowski. Okay, okay.

Commissioner Feder. But you can walk back. You can walk back.

Mr. Grabowski. No, no, no. First thing, and I think because it is low-hanging fruit, Judy, relative to some of the other things I put forward. Changing the tax code is very complicated. It strikes me that standardizing this market may be complicated, too. Maybe I am being naive, but I think that is actually very doable.

You know, after that, then I think the reinsurance, the employers, those are the next two steps.

I think the blending of health and long-term care insurance and changing the tax code, kind of retargeting those subsidies--those are the fourth and fifth things I would do.

Not sort of in order of importance or what I think sort of the gains would be there, but just kind of political

feasibility, I think, first and foremost, let's standardize this market. Let's allow consumers and sellers to know what they are--compare products and know what they are selling against.

Commissioner Feder. Right. So I guess what I would say is without a full package, which remains to be defined in many ways, or laid out, that the risk then is that you have improved or made more marketable a product that will have all the consequences that we have heard.

So it strikes me as a bit of a gamble, to put it mildly.

Mr. Grabowski. To only do one and not continue to sort of fix some of the other attributes.

Commissioner Feder. And to signal--to make it a priority signal, that this is where we are putting our efforts as opposed to taking some of the measures to improve Medicaid that we discussed this morning.

I am going to come back to your initial assumptions when I am done.

Mr. Grabowski. Okay.

Commissioner Feder. There was another I wanted to ask about.

Mr. Kent, you went through the changes in the--not the changes in the tax code that David was talking about, but other changes in, essentially, tax benefits.

I wondered--I mean there is a lot of concern, not only in the Commission, but in the Nation, about public spending.

And I wonder about--we spend a lot of money, as we now get attention to, through the tax code as well as in direct spending.

And so, David, I wonder if you would comment on what income levels would be the primary beneficiaries of changing the cafeteria plans and raising the level of the HSA deductible and the other kinds of mechanisms that were described.

Mr. Grabowski. Yeah, you know, once again, we ideally want to hit that middle-income, middle-aged group. I think some of that--we would hit the right age group.

I wonder if--

Commissioner Feder. The right age group.

Mr. Grabowski. Right age group, wrong potential.

Commissioner Feder. Income group.

Mr. Grabowski. Income level.

Commissioner Feder. Thank you. That is what I wanted you to say.

Mr. Grabowski. Yeah, I know. So that would be the concern there, I think, of targeting that kind of middle tercile that Bruce was pushing at.

Commissioner Feder. Judy and I would prefer you call it the middle third.

Mr. Grabowski. Sure, sure.

Commissioner Feder. May I include you in that, Judy? So thank you for that.

And actually, I had a clarification on the tax benefits that you want to redirect from the higher income to the lower, to down the income scale. I was unclear. Would you take away the entire tax--the deductibility of your health expense, health spending, for 50-plus, was it, or just the part that was going to long-term care?

Mr. Grabowski. The tax deductibility.

Commissioner Feder. Yeah, but beyond the 7.5 percent, right?

I mean, I thought you were taking away that whole benefit.

So, if a person has health expenses, they do not get this anymore. That is gone for them. Is that what you were doing to get that dollar amount?

Mr. Grabowski. No, I was just reorienting the long-term care part of that.

Commissioner Feder. Just the long-term care. That is what I had hoped.

Mr. Grabowski. Just the long-term care, yes.

Commissioner Feder. That is the way I had understood it.

Mr. Grabowski. Yeah.

Commissioner Feder. I understood the last time.

So it is time for me to go to your overall assumptions, and I wanted to tell you that, as you know, I have been working on getting everybody affordable health coverage since I was younger than you. So it is a shame to me that you would give up on improving the safety net and improving and pursuing social insurance when you are so young and we have got to get working on it.

Mr. Grabowski. That is right.

Commissioner Feder. So I hope you will reconsider. I hope you will reconsider that notion.

Mr. Grabowski. I did say I was giving up when I said it was not politically feasible.

Commissioner Feder. Well, that sounds--I mean, that is called mincing words, right.

Mr. Grabowski. Okay.

Commissioner Feder. I am a card-carrying political scientist. You are just an economist.

Mr. Grabowski. I am just an economist. That is right.

[Laughter.]

Chairman Chernof. Well, on that happy note, could we turn to Commissioner Stein?

Commissioner Stein. And I am neither. I am just a card-carrying lawyer who represents Medicare beneficiaries.

My husband is a country doctor, and just this past week

he got this notice that looked to us like it came from the State of Connecticut. And Ken says to me, do I need to do anything about this?

When I looked at it, I realize, oh, it is from somebody who wants to sell him long-term care insurance, but we have partnership program. And so, if we thought this was from the government, from the state, I am sure it was intended to look.

So that leads to this question, starting with Bonnie. With regard to increasing consumer confidence, which I think if we want to encourage people to purchase long-term care insurance or other products we have to do something about what may be the--well, anyway, about consumer confidence in spending money and expecting that it will be worthwhile.

What would be, Bonnie, your key suggestions to increase consumer protection/confidence?

Ms. Burns. I am not sure I know the answer to that one with this product.

I mean, there was a serious backlash in the press when those letters went out about a year ago.

Commissioner Stein. This just came this week.

Ms. Burns. But they mail them out periodically, and they come from the insurance companies that are selling the partnership products, and they are allowed to use the logos of the state.

Commissioner Stein. Let me just, because of time, clarify. I am wondering just generally--long-term care insurance and important consumer protections.

Ms. Burns. Oh.

Commissioner Stein. So what should those be--because I think I have been misunderstood. Thank you.

Ms. Burns. We do have to make those more--we have to make them work better for the people who have them, and that means both adding things to the existing rules.

I would add things that give people more options when there are rate increases so that they can make some choices about whether to keep the policy or not.

I would add some consumer protections that direct people more explicitly to the SHIPs, for instance, for counseling so that they can get some help with the selections that they make.

There are tools that need to be developed to help people make decisions about whether this product is even a workable product for them in their current situation, and if it is, what type of a product, what kinds of benefits they need.

Commissioner Stein. Do you see--or any of you--any reason we could not envision a time when if you had paid a certain amount of dollars or for a certain amount of time into a policy that it would be vested?

Ms. Burns. Yes, but I think that is a difficult issue with the companies, about how that would work, because insurance is regulated by the states.

Commissioner Stein. Yeah.

Ms. Burns. We have that barrier.

Anything that gets incorporated into Federal legislation, of course, and became a Federal requirement, then we would over come that barrier.

Commissioner Stein. Thank you.

I want to thank David with regard particularly to the goal to standardize and simplify. That, I do understand

And, having worked very much with Part D under Medicare when it did not happen and has not happened, and having worked personally and professionally with people trying to purchase long-term care insurance, I also agree with all of you.

Particularly, Lane has well expressed the difficulty in understanding--and David--comparing these policies.

I wonder, Mr. Kent, if you could tell me why you are suggesting that long-term care policies be part of Medicare Advantage, which is more expensive to us taxpayers than traditional Medicare.

And could you see it, if we were to go in that direction, as part of traditional Medicare?

There is my question.

Mr. Kent. I think the chasm that exists between acute care and chronic care needs to be closed in any way that it can because there is a snap-back effect. People leave the acute care responsibility of the Medicare Advantage payer, and then they are not tended to, and then they have unnecessary readmissions. So there is cost embedded in that.

Commissioner Stein. But that is true for traditional Medicare, right?

Mr. Kent. It is absolutely.

Commissioner Stein. Yeah. I mean, I agree with that premise. We need to do something about the increasing number of people who live happily with long-term and chronic conditions, right?

Mr. Kent. Mm-hmm.

Commissioner Stein. Whether they are getting Medicare under a private Medicare Advantage plan or a traditional plan.

Mr. Kent. Right. Linking chronic care and custodial care to acute care, I think, has benefits in both directions, and that is really what is missing today.

The carriers--the insurers that write the Medicare policies or the Medicare supplement Fee-for-Service or participate in the Medicare HMOS--do not have any responsibility for the chronic care needs, and so they are

largely neglected. That adds cost to the system for both.

Commissioner Stein. But they do have responsibilities. They may not meet them, but the law does provide for coverage for people who need skilled care, even if it is to manage or to care for a chronic condition.

Mr. Kent. It is for skilled care, correct. It is not for nonskilled custodial care.

Commissioner Stein. Yes.

Mr. Kent. That is the piece that is missing.

Commissioner Stein. Right, in Medicare. So I just did not understand why you were going to Medicare Advantage except that--

Mr. Kent. I was just using that as an example--

Commissioner Stein. Oh, oh, okay.

Mr. Kent. --exclusive to Medicare Advantage.

Commissioner Stein. I think that is important for us to understand.

Mr. Kent. Thank you for clarifying.

Commissioner Stein. What we are trying, I think, will be to figure out what vehicles might do what.

Mr. Kent. Understood.

Commissioner Stein. Okay.

Mr. Grabowski. Although with duals, I think managed care has been seen as a vehicle to do this management more readily, whether that is true or not. And the data do not

always support that, but I think many states like Minnesota and others have gone into these managed care arrangements.

Commissioner Stein. And Connecticut pulled out. So-- right.

Mr. Grabowski. Yeah, absolutely.

Mr. Kent. Right.

Commissioner Stein. Yeah. Thank you.

That is a very important clarification. I appreciate it.

And then, with regard to some comments from some of the other commissioners, are any of you suggesting that we consider that the government should create incentives to have people purchase these private plans, or do you think that if they were really valuable they would sell themselves?

Chairman Chernof. And if we could get a quick answer to that because this will be our last question and comment, thank you.

Mr. Grabowski. I think we could, with some reorientation of this market, incentivize some additional individuals, especially those in that middle third of the distribution, to purchase policies.

So I do not think these policies, if we allow this market to go on, will sell themselves. It is pretty obvious. We have 30 years of data suggesting they will not.

And the market is going, I think right now, on the sale--on the firm side, going in the wrong direction.

Chairman Chernof. With that, I want to thank this panel for doing a wonderful job--

Commissioner Stein. Thank you very much.

Chairman Chernof. --helping us think through a specific and difficult area as we go through our deliberations.

We are going to take a brief break so the commissioners can use the restrooms, check their phones. I would like everybody back in their seats by 5 minutes of 3:00 for our last panel.

Thank you very much, everybody.

[Applause.]

[Recess.]

Chairman Chernof. Commissioners, if I could ask you to grab your seats.

Panelists, if you could work your way to your seats.

And, for commissioners, Larry is handing out documentation for these sessions.

All right, we have the strong in the audience with us--those of you who have been kind enough to spend most of the day with us, if not all of the day.

So we are up to our fourth panel.

We have spent the day looking at ways to strengthen the

two key public programs as well as the private insurance market. As a Commission, we are sort of moving into the kind of strengthening idea generation portion of our work for our very short time in existence.

And, for this last panel, what we wanted to do is to focus a bit on the interaction between public and private markets because this is an area--between public insurance--okay, between private insurance and public programs. There we go. So it will be interaction between public and private.

We have four wonderful speakers with us.

Since I do not know if you folks were here earlier, it is 10 minutes a speaker. I will stop you at 10 minutes if you are not there. You can follow the lights, and the red light will tell you when we are at 10, and 5 minutes of questions per commissioner.

And, with that, we will start with Eric French. Thank you.

STATEMENT OF ERIC FRENCH, FEDERAL RESERVE BANK OF CHICAGO

Mr. French. All right. Thank you very much for having me.

Here are some thoughts on Medicaid insurance in old age.

Next slide, please.

So, just in terms of the health care system in the United States, everyone here, I think, has a good understanding of how both Medicare and Medicaid work, but I just want to give a few additional comments on terms of who actually benefits within the Medicaid program. So my comments will be mostly on Medicaid.

Now virtually everyone age 65 and plus in the United States is eligible for Medicare insurance, and Medicare pays for virtually 100 percent of certain services items, such as medium-length hospital stays and the like. However, for all practical purposes, Medicare does not pay for nursing homes.

And so that puts individuals who do not have private long-term care insurance in the following situation:

If they have relatively high financial resources, they will wind up paying for these long-term stays out of pocket. Otherwise, they will wind up on Medicaid.

And an individual who is initially paying out of pocket can wind up being financially destitute after a relatively

short stay in a nursing home, given the expense, and for that reason, 62 percent of all Medicaid payments towards the elderly are for nursing home expenses.

Next slide, please.

Just in terms of the Medicaid program, for the elderly, it is a program for those who not just meet the demographic criteria--being elderly or age 65-plus is one of those criteria--but also individuals who fit 1 of the 2 categories:

Either they have relatively low income and assets. This is sometimes referred to as being categorically need.

And then the second is individuals who have relatively low assets and may have high income, but because they have catastrophic medical spending they wind up being eligible for Medicaid. So this is often referred to as the medically needy program.

Now not all states actually have a formal medically needy program. However, every single state has some channel by which a person who is financially destitute through a long-term care stay can wind up getting Medicaid benefits.

Now, just in terms of the questions that I am interested in understanding, I am trying to understand to what extent do relatively richer people wind up on the Medicaid program because they do exhaust their financial resources and wind up in long-term care facilities?

So--next slide--just in terms of specifically what I am interested in, I am interested in:

How big are these transfers that the elderly actually receive?

How likely are they wind up on Medicaid?

And how big are these transfers to those who are at the top of the income distribution?

Now what we found is that actually those at the top of the income distribution receive a fair amount in the way of benefits. Rich people tend to live a long time. So they have more years to actually rack up Medicaid expenses.

Furthermore, when relatively high-income individuals do wind up on the Medicaid program, they wind up spending a lot in the way of Medicaid resources. The reason for this is that anytime an individual with relatively high income winds up on the Medicaid program it is because of catastrophic medical spending. Because it is catastrophic medical spending, they can wind up with very large medical expenses for the Medicaid program.

Next slide.

Now, just in terms of the data that I will be showing you, it is from two very large household-level data sets--Assets and Health Dynamics of the Oldest Old and the Medicare Current Beneficiary Survey.

I just want to show you some facts for retired

individuals, ages 70 and older, just singles although we do also have some results for couples as well, but singles are a little bit easier to think about.

And, just in terms of the numbers that I wish to show you, it will be broken by income where, for the most part, I am defining income as annuity income coming from both defined benefit pension plans and also Social Security benefits.

Now--next slide--just in terms of my first point, rich people tend to live longer than poor people.

So here are some facts from Assets and Health Dynamics of the Oldest Old. What it shows is life expectancy conditional on being age 70 for different groups of individuals. So, for example, what you can see from the table is that for those of the 10th percentile of the income distribution, on average, they live about 10.2 years. If it is a low-income man in a nursing home, it is only 2.2 years; much higher if it is a woman who is relatively good health.

Those at the top of the income distribution, on the other hand--they tend to live 14.2 years on average. And so these relatively high-income individuals--they just have more years to wind up on the Medicaid program.

Next slide, please.

Now, just in terms of Medicaid recipiency rates, the next table shows the Medicaid recipiency rate both in Assets

and Health Dynamics of the Oldest Old and also the Medicare Current Beneficiary Survey. The Medicare Current Beneficiary Survey data is probably a little bit more reliable because it is based upon administrative data.

Now, in terms of what that survey shows is that 69.6 percent of all individuals at the bottom of the income distribution, who are at least age 70 are receiving Medicaid benefits of some sort. Those at the top still have a 5.4 percent Medicaid recipiency rate.

Now, just in terms of what I would like to show you next, here are Medicaid payments conditional on income quintile.

Now, for those at the bottom of the income distribution, what you can see is that on average they receive $6,170 per year. Okay?

So that is a fair amount of money. That is averaging over those who are Medicaid beneficiaries as well as those who are not Medicaid beneficiaries.

And, as we move towards the top of the income distribution, we can see that those at the top of the income distribution--they still receive, on average, $900 per year in the way of Medicaid benefits.

Now the right column shows out-of-pocket medical expenses, and so what you can see from the right column is that the amount that Medicaid actually pays towards the

elderly is basically the same order of magnitude as what people spend out of their own pocket for health care in later age.

Some other interesting facts--women tend to accrue more in the way of both Medicaid payments and also out-of-pocket medical spending, and of course, those in nursing homes are responsible for the majority of all Medicaid payments.

Now, just in terms of those who are just on Medicaid, those who are Medicaid beneficiaries, amongst that set of individuals, those at the top of the income distribution receive the largest benefits.

So what this shows is that for those at the bottom of the income distribution Medicaid payments amongst Medicaid beneficiaries are $8,870; amongst those at the top, they tend to be $16,670.

So, again, when relatively high-income individuals wind up receiving Medicaid benefits, they tend to receive quite a bit.

The last slide that I have shows my effort to kind of put all these different facts together, accounting for the greater lifespan of relatively high-income individuals relative to low-income individuals and how much they get on average per year.

The final slide show how much in expected present discounted value different groups of individuals actually

receive over their remaining lives, and this is evaluated from age 74.

So what this shows is that conditional on being age 74, averaging over men and women, different health groups, those at the bottom of the permanent income distribution, on average, receive about $25,000 in expected present discounted value of Medicaid benefits over the remainder of their lives whereas those even at the top of the permanent income distribution are receiving a full $4,300.

And that concludes my statement.

[The prepared statement of Mr. French follows:]

Chairman Chernof. Great. If we could hear from Jeffrey Brown from the University of Illinois next, please.

STATEMENT OF JEFFREY BROWN, UNIVERSITY OF ILLINOIS

Mr. Jeffrey Brown. Well, good afternoon, everyone. Thanks for giving me the opportunity to be here.

I have worked with or on various commissions and boards over the years, and I know it is a lot of work, and I know you are not doing it for the money. So I certainly appreciate your efforts to solve this very tough problem.

My message today is in some ways a somewhat negative one in that I am going to underscore how incredibly difficult this problem is to solve. As I often tell my students, not all problems have solutions, and this is about as close to one that might meet that characteristic as any I have seen.

What I thought I would do is--and, by the way, you have a slide deck there. I am not going to even try to get through it all. I provided some of that just so that you had some data and statistics. I am happy to talk about it in the questions.

But what I really want to focus on in the opening remarks is this idea of the interaction between Medicaid and the private market long-term care. My views here today are based on research that I have done with Amy Finkelstein of MIT although I do not hold her responsible for the way I characterize it today.

Our research agenda really started by trying to

understand why the market for private long-term care insurance was so small because if you sort of step back and you think about it, this is a risk--a nontrivial chance--that you are going to need it. Most people do not have the resources to provide it because there is a very long tail, meaning very small probability of really expensive events--being in a nursing home for many years that can really financially devastate most of the income distribution. And, yet, people are not buying it.

And the question is, why?

So we went though a number of studies over a number of years, and I am going to try to characterize those.

First, we started off trying to look for evidence on what we call the supply side, just looking at what problems exist in the private market that might prevent these policies from being offered at good prices or might restrict the form of the policies may take.

And, while there is evidence of some of this--there are high loads and so forth--what we basically discovered is that at least for some subgroups of the population there were policies that looked quite attractive, and yet, in those subgroups of the population, people were not buying them in any greater clip than they were more generally.

So, for example, if you happen to be a reasonably healthy woman who--because of the gender-neutral pricing of

the policies and so forth, they look like these things were pretty darn close to actuarially fair, and yet, women were not really buying them in any greater proportions than men.

So what we began to think about is, okay, we recognize there might be some problems in the market, but let's assume that there was not. Let's assume that we could somehow magically wash away any problems that existed in the supply of these products.

It seemed to us that there was still something fundamentally affecting demand. For some reason, people just did not want to buy this.

Now you can think of there being a whole host of reasons why people may not buy. It could be that they view family as a substitute for it. They might be concerned about insurers going bankrupt. They might just have mistaken beliefs about the need for the insurance. They could just be making a mistake. Lots of things.

And all of those may be true. Some of them we have a little bit of evidence on. A lot of them we do not. But people are now working on it.

What we focused in on was the interaction with Medicaid, and the conclusion we came to--and I want to be careful how I state this because it has been mischaracterized by people on all sides of this debate--is that the existence of the current Medicaid program alone, in

the way it is structured, by itself, is sufficient to make private insurance look unattractive to all but the highest end of the wealth distribution.

Now I say it that way--that, by itself, it is sufficient--because we are not saying that it is the only thing going on. We are not even really saying it is the primary thing going on. There may be other things that are restricting demand as well.

But the point is as long as we have a Medicaid system that is structured like the one today, that no matter what we do on tax subsidies or on prices or on helping people make better decisions, on improving their ability to optimize and so forth, if we have the existing Medicaid system in place, fundamentally, most people are going to rationally find it in their interest to forego privately insuring against long-term care.

And I want to take a minute or two to explain why that is.

We dubbed this the implicit tax, but I want to describe what that means because it is not a tax in the sense of a statutory tax.

There are two features of the interaction between Medicaid and private insurance that lead to this issue.

One is that--these are going to seem obvious, but they actually have pretty deep implications.

One is that if I go out and buy a private insurance policy--and we will come back to partnership programs and so forth later. But under a standard policy, if I go out and buy a policy, I am less likely to qualify for Medicaid because I have now protected some of my assets and I am now going to be less likely to qualify under the asset test.

The second thing is if I have a private policy, even if I do manage to qualify for Medicaid--I spend down to that point or whatever the case might be--once I am on Medicaid, my private policy has to pay benefits before Medicaid comes in on top of it. The term for that is that Medicaid is a secondary payer, and the private insurance has to pay first.

The reason these two things together creates such a big issue for the private market is that you can go through and roughly calculate, under assumptions about how people are making these decisions and what their consumption is like and what kind of risk profile they face, and we can show that the vast majority of the benefits that they are paying for when they buy a private policy end up simply substituting for, or cannibalizing, benefits they would have gotten from the Medicaid program.

Therefore, the net benefit to the individual of buying insurance is very small relative to the real cost that it provides the insurer to provide the insurance because the insurer has to pay out, and they might be paying out even if

those are benefits you could have otherwise had paid for by Medicaid, but it is still real money out of their pocket. But, to you, it is not really of any incremental benefit if you are at a point where Medicaid would have been paying anyway.

The easiest way to understand this is imagine that you would be perfectly happy to go out and spend $35,000 on a new vehicle, but the only way I am going to let you do that is if I am going to take away your $20,000 used car and not give you anything for it in return. You might find it valuable to get a brand new car at a price of $35,000 but not if you also have to give up a $20,000 thing that is worthwhile. And that is essentially what we are asking people to do.

If you go out and you buy private insurance, you have to give up those benefits that Medicaid would have provided in the absence. And we find that this, by itself, even if everything else was functioning well in the market, is sufficient to crowd out somewhere between 2/3rds and 90 percent of the market for private insurance.

I have a slide in here that kind of calculates the implicit tax, kind of on average, for different points in the wealth distribution. And you can see that even at the median of the wealth distribution this implicit tax is well over half of the value of a private policy.

Now what can we do about it?

I wish I had an easy answer to this question. I have been asked this more than any other question since we did this research, and the problem is there is just not any easy around this.

Some have said, well, sounds like the solution is we just have to eliminate Medicaid.

Well, okay, you could. I do not think that is realistic or desirable. Plus, you have to assume that in the absence of Medicaid there would be some other payer of last resort that might come in to play that role, and in which case you might have some of the same problems.

At the other extreme, you could say, well, this just shows that the private market cannot possibly work, and therefore, we just need to socialize all the costs and fold this into the Medicare system. But I am sure you do not need me to remind you about the long-term fiscal situation that we face.

Unfortunately, though, this means that a lot of the proposals that are put forward to help encourage the private market, whether they are tax subsidies, whether it is the partnership programs, what have you--while they can help, oftentimes, they end up only operating on one of the two underlying causes of this implicit tax.

And all of our work has shown that if you only solve

one of the two problems--maybe you ignore the insurance for eligibility reasons, but you keep Medicare as a secondary payer, which is essentially what the partnership programs do--it turns out that it actually has a very small effect.

It might grow the market, but the market is so small. You know, if we went from 10 percent of people buying to 15 percent of people buying, that is a 50 percent increase in the number of people insured, but it is a trivial change in the number of uninsured.

So I have only got a few seconds left. I told you that this is going to be a somewhat pessimistic overview.

Given this fundamental tradeoff, actually, it becomes very, very difficult to think of a way to have a means-tested Medicaid program and have an active private market, and I am happy to discuss that in more detail with you during the Q&A.

Thank you.

[The prepared statement of Mr. Jeffrey Brown follows:]

Chairman Chernof. Thank you very much.

We will now turn to Rich Johnson from the Urban Institute, please.

STATEMENT OF RICH JOHNSON, URBAN INSTITUTE

Mr. Braddock. Well, thank you for the opportunity to testify today about the income and wealth shortfalls for old Americans with disabilities and those receiving Medicaid-financed nursing home care.

As you know, the prospect of becoming disabled and needing expensive long-term care is perhaps the most significant risk that older Americans face. We do not have a system in place to adequately finance these costs.

And as a result, many long-term care recipients, especially those with extended nursing home stays, end up going on to Medicaid. The drawback, of course, is that those receiving Medicaid-financed care must turn over nearly all of their income and wealth to the program.

And, as the population ages and long-term care costs rise, there is increasing concern that Medicaid will create even more pressure on Federal and state budgets.

Now, as the focus on Medicaid intensifies, questions are growing about exactly who receives help from the program in later life:

To what extent has the program morphed into a middle-class entitlement for nursing home care?

How many people who would otherwise end up on Medicaid in institutionalized care could be encouraged to save for their own long-term care needs either by purchasing private

insurance or investing in some type of individual account?

So I have been examining the incoming wealth trajectories of older adults who end up in nursing homes, and what I found--and the major point I want to make today--is that most older people who receive Medicaid-financed nursing home care have low incomes and very little wealth, not only while they are on the program but, importantly, at least a decade before they enter a nursing home.

And these results suggest that efforts to promote individual saving for long-term care, while laudable on many counts, may not end up moving that many people off of Medicaid or saving the program that much money because most users of Medicaid nursing home residents never had the means to save much. I think these findings underscore the importance of Medicaid for some of the Nation's most vulnerable citizens.

So, in my remaining time, what I would like to do is just discuss some of these findings but partly from the same data set that Eric used--the Health and Retirement Study.

And, on the first chart, what you see is the distribution of per capita household income in 2010 and how that differs by disability status among adults ages 70 to 78, who were living in the community.

So, at the median, the 50th percentile, that is the middle bar there. Those with no ADL limitations have about

50 percent more income than those with 2 or more ADL limitations.

And, if we turn to the next slide, we see the differences in wealth. Those are even more stark, where those with no ADL limitations have nearly twice as much wealth--household wealth--as those with two or more ADL limitations.

There is nothing new here. Everyone knows that people with disabilities have less income and less wealth.

But what is perhaps more surprising, on the next slide, is that we see that those who became disabled in later life also have lower incomes in their fifties, before their disabilities began.

So this chart shows the distribution of per capita household income in 1992 by their 2010 disability status, and this is for adults who were ages 52 to 60 in 1992, when they did not have any ADL limitations and when they were not retired.

And so, if we just compare, again, per capita income at the 50th percentile--the median--you see that those with no ADL limitations in 2010 had 48 percent more income back in 1992 than those who developed 2 or more ADL limitations.

And, again, going to the next slide, we see that the wealth differences, again, are even more dramatic.

So typical adults who become disabled in their 70s have

only 3/5ths as much wealth in their 50s as their counterparts who were disability-free throughout their mid-70s.

And, in fact, if you look at those with 2 or more ADL limitations in 2010, back in 1992, a quarter of them only had no more than $123,000 in total wealth.

If we look at total nonhousing wealth, which might be more relevant, on the next slide, we see that 18--rather, half of those who developed 2 or more ADL limitations, half of those folks, had no more than $18,000 in their 50s back in 1992, and more than a quarter had no nonhousing wealth whatsoever.

Finally, I would like to turn to results on Medicaid nursing home care, and so this chart shows the distribution of per capita household income in 1992 for adults ages 70 to 75 who were living in a community in 1993.

And what we see is that for those who eventually use some Medicaid-financed nursing homes, half of them had per capita household income of no more than about $20,000.

If you look at those who eventually go on to use nursing home care but do not go on to Medicaid, their median per capita income was about 25 percent more. It was about $26,000.

Those who went on to a nursing home and--rather, those who never went on to a nursing home had sort of incomes in

the middle, about $21,500.

These differences are not dramatic. What is much more dramatic, though, is if we look at their wealth in 1993 and see how it differs depending on what happens to you in terms of nursing home entry and Medicaid use in your 70s.

And here we see that for those who went into a nursing home and never went on Medicaid, they had about 4 times as much wealth back in 1992-1993 than those who went into a nursing home and eventually received Medicaid.

And then those who never went on to a nursing home had about three times as much wealth as those who went into a nursing home and eventually used nursing home care.

This is mean household wealth. It is important, though, that we look at the full distribution of household wealth, not just the mean. The means are very skewed.

So this next chart shows that half of people ages 70 to 75, who eventually enter Medicaid nursing homes, held less than $50,000 in total household wealth. A quarter of them had less than $2,700 in total household wealth. Again, this is 1993, before they went into the nursing home.

If we focus on--look at nonhousing wealth, on the next chart, a similar situation; things look just a little bit worse for those in Medicaid-financed nursing homes. Half of them have nonhousing household wealth of no more than $8,000.

Now you might think is, well, these people are on the verge of entering into a nursing home and maybe that is why these wealth holdings seem so low.

So what we then did was just restrict the sample to people who did not go into a nursing home until 2003 or later.

So now we are comparing their wealth in 1993 and looking at how it varies, depending on outcomes that happen 10 years later.

We looked at those who entered a nursing home and eventually went on to Medicaid-financed nursing home care. Their median total household wealth was only $60,000 compared to $269,000--so dramatically more for those who entered that nursing home after 2003 but never went onto Medicaid.

And a similar story if we look at nonhousing household wealth; there, we see that half of people who eventually go on to receive Medicaid-financed nursing home care, 10 years later--10 or more years later--half of them had no more than $10,000 in nonhousing household wealth back in 1993 compared to $122,000 for those who went into a nursing home but did not receive Medicare. Medicaid, rather. Sorry.

So I think, in conclusion, these results point out a lot of the economic challenges, the financial challenges, that people who eventually go onto Medicaid experience well

before they ever enter a nursing home.

And I think it raises some questions about how much money we could save by encouraging people to save more on their own because many of the big users of Medicaid actually do not have much resources to begin with.

Thank you.

[The prepared statement of Mr. Johnson follows:]

Chairman Chernof. Thank you very much.

And, finally, we would like to hear from Ellen O'Brien who is formerly from MACPAC.

STATEMENT OF ELLEN O'BRIEN, FORMERLY, MACPAC

Ms. O'Brien. Thank you very much for having me here today. I am pleased to be here to discuss the interaction of insurance, private resources and Medicaid.

You asked for comments on a number of topics related t private resources and Medicaid: the mismatch of needs and resources for long-term care among the elderly--which I think Rich has just hit out of the park, so I will not comment on that one--asset transfers, Medicaid spend-down and the effect of Medicaid on saving and private insurance purchase. I will briefly comment on some of the available research on these topics.

The bottom line conclusions are summarized on this first slide, but the gist of my remarks is that Medicaid's long-term care program overwhelmingly serves those who are poor or who have very low incomes. Few of these individuals could afford private long-term care insurance, and the safety net serves a legitimate role for them.

At least some middle and higher-income elderly--the income distribution we are talking about is the income distribution for older adults. Some of them receive Medicaid, but the numbers are relatively small, and there is little evidence that the availability of a Medicaid safety net has disincentivized savings for future long-term care needs or the purchase of private insurance.

It is tremendously important to put the issue of Medicaid's purported disincentives in perspective.

To start, I think it bears remembering that, one, there are sizeable gaps in Medicaid's protections for long-term care. It provides limited access to care and exposes people to catastrophic expenses.

And, two, that most older adults have very modest incomes and assets. The typical retired American these days relies largely on Social Security. Older adults in the middle of the income distribution get 66 percent of their income from Social Security versus 9 percent from private pensions and just 5 percent from assets. Most of these middle-income elderly would be exposed to financially catastrophic costs if they needed long-term care.

So the first thing to note about the interaction of private resources and Medicaid is that the overwhelming majority of individuals receiving Medicaid-financed long-term care lack the resources to pay for their care.

There are several studies that document the limited income and assets of older adults who receive Medicaid assistance with long-term care costs. A handful are listed on this slide.

These studies include, for example, one from the GAO in 2007 that examined Medicaid applications and the outcome of eligibility determinations associated with those

applications. More than 90 percent of those applicants had nonhousing assets of less than $30,000; 85 percent had annual incomes of $20,000 or less.

Josh Wiener from RTI has a recent study for the SCAN Foundation on the spend-down population, and he also shows that a small proportion of people who end up on Medicaid nursing home care start out with limited resources and have even less when they transition to Medicaid.

And my co-panelist, Rich, in an earlier report he did, in addition to today's hot-off-the-presses work, has also documented that people receiving Medicaid long-term care services are overwhelmingly low-income and have very few assets.

Just referring back to his earlier work, those with any Medicaid home care use, for example, were disproportionately at the bottom of the income and wealth distributions for their age group; 45 percent were in the bottom income quintile, where the median income in that quintile was roughly $11,000.

Older adults who ever receive Medicaid home care are also disproportionately in the bottom of the lifetime earnings distribution. Relatively few who ever receive Medicaid long-term care earned enough in their working years to pay for care at older ages. Eighty-five percent were in the bottom two quintiles of the household size-adjusted

lifetime earnings distribution. Only 2.7 percent were in the top quintile, where the average annual earnings in that top quintile were just $51,000 over the working years.

The findings are similar for older adults who received any Medicaid-financed nursing home care; 60 percent were in the bottom two quintiles of the lifetime earnings distribution, and 8.2 percent were in the top quintile.

So, although some middle-income older adults eventually receive some assistance from Medicaid and the percentage who do is small, Rich's earlier study does not shed light on how much they cost Medicaid. They may be mostly able to pay for their own care, and we cannot conclude that they did not save for long-term care needs.

People's income and assets at the time they need long-term care are the product of what they have earned and spent and saved during their working lives and during the early years of their retirement. By the time people need long-term care, there are many reasons why people have resources and others do not, including high health and long-term care spending.

Other empirical studies by economist Frank Sloan and colleagues, for example, investigate whether the prospect of receiving a Medicaid subsidy for nursing home care affects savings by the elderly. Those authors found that Medicaid did not crowd out savings, measured by nonhousing assets.

The wealth holdings of the elderly declined over time, but that spending out of assets had little relationship to the likelihood of gaining eligibility for Medicaid.

The authors also concluded that elderly who enter nursing homes spend down their assets, with wealth declining $20,000 on average.

I could cite other studies, but those I have reviewed find that there is a strong precautionary motive for savings. If they have enough income to do so, the elderly who expect to use long-term care continue to accumulate assets. They do not divest them.

Related to this and turning to concerns about asset transfers, on the next slide, studies show that there is little basis for the assertion that people with substantial incomes or assets are becoming eligible for Medicaid by improperly transferring their assets. The structure of Medicaid, as we have heard, provides a pathway to eligibility for middle-income people but only after they incur catastrophic expenses.

The spend-down system has fueled concerns that people transfer their assets or shelter income in trusts to qualify for Medicaid. Medicaid, thus, includes rules to restrict eligibility for people who have transferred assets within a five-year look-back period prior to application and limits how much income can be sheltered in trusts.

The GAO has concluded that few older adults transfer assets before applying for Medicaid, and the amounts transferred are small. In their examination of 540 Medicaid applications, for example, they found that 10 percent of approved Medicaid applicants had transferred assets, and the median amount of those transfers was roughly $15,000. A number of those applicants, of course, incurred penalties, and their eligibility for Medicaid was limited.

In his reason study, Josh Wiener reached a similar conclusion and found that older adults who spend down to Medicaid are less likely to make transfers to children and grandchildren than those who do not transition to Medicaid.

Urban Institute researchers, Tim Waidmann and Korbin Liu, also found few asset transfers, those that happened were small, and the nursing home population that never transitioned to Medicaid makes extensive and large transfers in contrast to the population that does eventually receive Medicaid-financed nursing home care.

When they attempted to quantify the total magnitude of the asset transfer problem, the researchers found that aggressive recovery of all cases of transferred assets would recover only 1 percent of Medicaid long-term care spending. Here, too, the magnitude of the problem is small.

On the question of whether Medicaid crowds out private long-term care insurance, the research evidence is pretty

thin. As Bonnie Burns and Jeff Brown and others have explained here today, there are a number of explanations for the low take-up of private insurance. Only a small share of older Americans have private long-term care insurance. And even among older adults in the top wealth quartile, only a quarter have it, hardly a group who could be said to be planning to rely on Medicaid.

Jeff Brown's work is perhaps the most widely cited topic.

When I say the evidence is thin, I think that in some of the work it is a simulation model that is assumption-driven, and if you change the assumptions you change the result.

There are a few empirical data-driven studies, but findings of those studies are mixed. A study by Frank Sloan and Ed Norton, for example, finds no effect of the availability and generosity of Medicaid on insurance take-up for adults in their 50s and only very weak evidence that Medicaid affected insurance purchases of adults age 70 and older.

To summarize, what I am suggesting you take away from the research findings and what we know about the operation of the Medicaid program is that:

There may be some crowd-out associated with Medicaid's long-term care safety net, but it is small.

We should not get too carried away by anecdotal reports that Medicaid is a middle-class entitlement or allows even the wealthy to easily shelter their assets. Most people who eventually receive Medicaid long-term care had modest incomes to begin with and had very little by the time they needed long-term care.

Asset transfers are inconsequential, and there is not a lot of interaction between Medicaid and private insurance or savings because there is little overlap between Medicaid's intended beneficiaries and the population that can purchase unsubsidized private long-term care insurance or self-insure.

Although concerns about crowd-out lead some to suggest that Medicaid eligibility needs to be tightened, further tightening Medicaid eligibility is unlikely to have a material impact on program spending or insurance purchases but would make an already limited safety net even stingier, and risks leaving the poor and low-income elderly with even more limited access to needed services and poorer quality of care.

Thank you.

[The prepared statement of Ms. O'Brien follows:]

Chairman Chernof. Thank you very much, all of you, for your presentations.

I would like to begin to my left with Commissioner Stein.

Commissioner Stein. Thank you very much.

We started the day with Diane Rowland from Kaiser Family Foundation, setting out her testimony, and one of the things that struck me was she said that there was a couple myths in the world that we are discussing here today. One of them was that higher-income people transfer large amounts of money to qualify for Medicaid, and the second myth was that Medicaid crowds out the field for people to purchase long-term care insurance.

And, as the day has gone on, we have had some dueling data regarding that, but largely not. So I wonder.

I will ask Ms. O'Brien first since she waited to speak, and maybe others would want to chime. Why does that myth persist and how can we manage with it?

Ms. O'Brien. In part, the myth persists because of these anecdotal stories. Some people know about somebody transferring assets.

It also persists because people misunderstand the size and the factors that account for the growth of the Medicaid program. People think that Medicaid expenditures are growing out of control, and this must be driven by middle-

class elderly.

But, in terms of what to do about it, my preference would be to leave Medicaid as a foundation for means-tested assisted for the very low-income elderly and add a social insurance program that could provide a foundation to which Medicaid would be a supplement for those at the bottom.

Commissioner Stein. And, with regard to your second point, because we have Medicaid and I think we can try to understand it, can you give us some general outline of if you were the queen of the world what your second notion would look like? Your social insurance notion. The other-- the new idea.

Ms. O'Brien. Well, I appreciated Marilyn's point about Medicaid. I can certainly see a program that expands on the Medicaid program to provide modest long-term care benefits, perhaps with some means-tested assistance.

I would prefer to see a social insurance program that includes, of course, children and nonelderly adults and the elderly. Beyond that, I have not had a lot of time to think about all the parameters involved.

Commissioner Stein. Okay. Thank you very much.

Mr. Brown, do you have a sense of how we might synthesize the different approaches differently from what Ms. O'Brien suggested was the reason?

Mr. Jeffrey Brown. So, first of all, let me say my

report does not--my studies do not say anything about the spend-down question per se. In fact, the very fact that such a large fraction of expenditures are paid for out of pocket suggests that it must not be that easy to spend down to qualify. So we are not claiming that at all.

Commissioner Stein. Okay.

Mr. Jeffrey Brown. Our story is nothing--there was nothing in my description about--

Commissioner Stein. About the transfer issue.

Mr. Jeffrey Brown. There is a tax that comes out from the transfer issue. That is not where it comes from.

Commissioner Stein. So that is one of two myths that you are not suggesting exist.

Mr. Jeffrey Brown. The other one I suggest is not a myth, and in fact I would say that the evidence that I have heard is not inconsistent with the fact that this--

Commissioner Stein. The crowd-out issue.

Mr. Jeffrey Brown. I think the crowd-out issue is very real, but let me first address two misstatements.

First of all, it is not true that if you change the assumptions you change the results. I would encourage you to look at all the robustness checks in the back that go through pretty exhaustively in thinking through the different things, different qualities of Medicaid and so forth, and you find that this general finding of a large

crowd-out effect is there.

Second is Amy and I, as well as Norma Coe, who is now at the University of Washington, do have some empirical work. We, obviously, do not observe a world in which we do not have Medicaid, but we do observe state-by-state variation in the generosity of Medicaid. And, for example, we do find that a $10,000 decrease in the amount of assets that 1 is allowed to keep to qualify increases coverage by about a percentage point, which is not large, but it does suggest there is an effect.

But the bigger point which--I actually find the data and so forth that Rich and Ellen have presented very interesting and insightful.

But, again, I would say there is nothing at all inconsistent about saying that the majority of the people on Medicaid are low-income or that the majority of expenditures in the program accrue to low-income people. That is to be expected.

Commissioner Stein. And that is true.

Mr. Jeffrey Brown. And that is true.

That is not inconsistent with saying that the existence of Medicaid can crowd out demand for people higher up the distribution.

But, even if no one higher up the distribution has long-term care insurance, you will still get that fact

because people with wealth have to spend through their own wealth before they become eligible for Medicaid. And so it is a mechanical effect.

Of course, not many of them are going to end up eligible. It is only going to be that very small percentage of people who even conditional on entering long-term care need it for long enough that they can exhaust $100,000 or $200,000 worth of resources.

And there are not that many people in that world, but the fact that they can rely on that suggests that it eliminates the catastrophic tail.

So, you know, Ellen made the point that people do have precautionary motives, and they do. And the fact that Medicaid is there as a way of taking care of you in that catastrophic case does dampen demand for insurance.

Now I am not saying we should get rid of Medicaid. I have not made any statement about that. I am just saying that I do not view anything inconsistent about that.

Commissioner Stein. Thank you.

Chairman Chernof. Thank you very much.

Commissioner Feder, please.

Commissioner Feder. Jeff, I wanted to ask you about something you said earlier because there is lots of discussion about private insurance, public insurance, but also savings.

I am familiar with and have done work on arguing that this is an insurable risk, and that is quite different. Buying insurance, or insuring, is quite different from doing your own savings because--

Mr. Jeffrey Brown. Mm-hmm.

Commissioner Feder. And I guess my view is that it is both. It is inefficient and ineffective to say because it is an unpredictable catastrophic risk, and I see you nodding.

And would you say a little bit more about that?

Mr. Jeffrey Brown. I absolutely agree. I mean, anytime you have a risk that sort of a long tail, low probability of really catastrophic events, savings is a very inefficient to deal with that.

I mean, what motivated our research at the very beginning was the fact that long-term care, or the nature of it, is such that this looks exactly like the kind of thing you want to insure against. And so, it was puzzling that more people were not doing it.

So I completely agree with that characterization.

Commissioner Feder. Thanks. I appreciate that.

And now, with a little bit of disagreement, I am thinking about some of my best friends are simulators. So when Ellen says it changes with the assumptions, I have seen that a lot. And I am glad yours are robust, but there is

always an issue with simulation.

But I had a question, as you talk about the implicit tax, and what you lay out is logical. And I follow your argument, but my problem with it is, do you really think that people think this way?

I mean, if you look at what we have heard in the previous panel about the--first of all, we know about people not thinking about the future, not knowing what their risks are. They look at the policies. As you yourself have said--in your work it says--there are lots of reasons people do not buy.

And I understood and appreciated your clarification on what you are saying about Medicaid.

So let me just stick with my question. Do you really think people think this way?

Mr. Jeffrey Brown. Certainly not all. I mean, I have lots of work in other contexts talking about people making terrible optimization mistakes for all sorts of decisions.

And so, no, that is not--but again, as I said at the very beginning of my remarks, what we were showing in this paper is that even if you somehow manage to eliminate all the other things going on here, even if there were a thousand insurers all competing and offering actuarially fair insurance, even if people were not subject to behavioral biases that might--or wrong beliefs about

coverage, even if you could solve all those problems so that in the best world we really did have people that were behaving rationally, even in that world, people are not going to buy.

Commissioner Feder. I appreciate--

Mr. Jeffrey Brown. We are not saying that this is the only reason for--

Commissioner Feder. I got it. No, I appreciate that.

Mr. Jeffrey Brown. In fact, one of the things it suggests is if you could solve the implicit tax problem you might not move the needle a whole lot if there are a whole bunch of other things that are constraining the market.

Commissioner Feder. Exactly.

Mr. Jeffrey Brown. We have always tried to be very clear about that.

Commissioner Feder. No, I appreciate that.

You are saying the could do it by themselves as well--is what you are pretty much saying. The other limitations to the product, et cetera, right? To the reliability?

Mr. Jeffrey Brown. And other behavioral issues.

Commissioner Feder. And other behavioral issues. Thank you. I appreciate that.

And what you are really--I think you are also saying--and I take issue with it not being a solvable problem. You did not quite say that at the beginning. It is certainly a

tough one.

But what you are really saying is if you believe in the safety net, and you do say you do not challenge the need for and validity of Medicare, you have got a problem. Make this market work. That is what you are saying.

Mr. Jeffrey Brown. That is correct.

I mean, it is very, very difficult to come up with a world in which you have a means-tested safety net, where Medicaid is a secondary payer and have a vibrant private market.

Commissioner Feder. Okay, I appreciate that.

So, again, in terms of relating different pieces of evidence--and I thought that Rich gave a very powerful statement on the limited resources of people who are using Medicaid.

And pretty much everybody--I think, Eric, yours too. It is primarily--and Ellen did it as well. It is primarily low-income, very low-income people who are using Medicaid, and you find a small proportion of what you call the rich taking benefits.

I wondered. I did not see in your tables here the income range that you were looking at. I know you were looking at--what is it? Seventy-year-old plus or seventy-four plus singles?

So what was rich? What was the top quintile?

Mr. French. Right. So amongst those who are rich--these would be people, I believe, who are those in the top quintile. I believe the median within them--it was--or actually, I am sorry, the threshold for being "rich." It was a little bit under $40,000 per year for total income.

Commissioner Feder. Right. I just think that that we do not usually call that rich.

Mr. French. Right, right.

Commissioner Feder. So it seems to me that your findings are less inconsistent than we might have thought with the overall pattern of the very low levels of resources that people have, who are using Medicaid.

So thanks very much.

Mr. French. I fully agree.

Commissioner Feder. Oh, I appreciate that. I am glad I did not--I was going to cut you off, but why would I?

[Laughter.]

Commissioner Feder. Thanks so much.

Chairman Chernof. Commissioner Pruitt.

Commissioner Pruitt. Thank you. Thank you, all.

You know, throughout these panels, we have had some interesting discussions on asset transfers and varying opinions on the prevalence of asset transfer.

As an operator and provider of long-term and post-acute care services, it is my job to make sure our organization

monitors our patients and make sure that they are safe at all times. Part of that is visitors that come in and out of our facilities, and many of them are lawyers that specialize in such activities.

Just for fun, I Googled asset transfer and got 412,000 responses for Medicaid in Georgia. So I assume someone is looking at it out there.

Dr. O'Brien, my question for you--in your category, I think I picked on a word that you used--improper transfer of assets. There are legal and proper ways to transfer assets. Has there been any research or look at that to know what amounts have been legally transferred?

I know that you mentioned the applications and the penalties, but have you looked at broader research?

Ms. O'Brien. Which is to say legal by an asset that occurred before the look-back period, for example.

Commissioner Pruitt. For irrevocable trusts that were set up, et cetera?

Ms. O'Brien. Right. There is some research. Frank Sloan did some research looking at this argument that people sheltered their income in trusts, and he found, again, that the behavior was rare and that it really was not meaningful for Medicaid to invest a lot in administrative oversight on that process because they would not find a lot in there. And, of course, states do have the right to recover from

those trust as well.

I believe a number of these studies look at transfers prior to--the studies that draw on the Health and Retirement Study data, for example, look at an extended period of time. So they are looking back before somebody arrived at Medicaid, and so they do include the amount of those legal transfers that may have occurred before the look-back period set in.

Commissioner Pruitt. Well, I appreciate those comments.

I think it would be interesting to conduct further research in that regard because whether you classify assets as family assets or personal assets, there are ways around that. I give that as my commentary.

My second question--Dr. Brown, we did not quite get through all of your slides, and one that I was particularly interested in was your thoughts of the Thought Experiment. And I do not have the exact title of the slide here, or the page or slide number, but where you talked about possibly providing a tax credit. Could you explain that in a little more detail to us?

Mr. Jeffrey Brown. I would be happy to, but let me just be clear that the reason it is labeled Thought Experiment is that it is not necessarily an easily implementable policy.

But, if you go back to the two underlying causes for the Medicaid implicit tax, again, it is the fact that you reduce your eligibility by protecting assets and then the secondary payer status.

Implicitly, what you want to do is separate the insurance purchasing decision from Medicaid eligibility. You want to completely separate those if you do not want the private market to be affected by Medicaid.

So the Thought Experiment is if we could find a way to calculate for each individual sort of the expected present value of all the Medicaid expenditures that they would be foregoing if they bought private insurance, and essentially give that to them as a lump sum or over time, that you would then sort of compensate them for the foregone Medicaid benefit. Then, if they were behaving rationally, subject to the constraint that maybe not every behaves that way, then you would eliminate that as a tax on Medicaid.

The reason that is really hard to implement is the information requirements to really pull that off are quite high. So you have to know a lot about that individual--the probability that they are going to need care, what their likely Medicaid expenditures would be, in order to get that calculation right.

And, if you do not get it right, then you have got problems with adverse selection, and things could go awry

pretty quickly.

But that is really the idea--is you somehow have to structure it so that the decision of whether or not to buy insurance is not contaminated by the concern about giving up, you know, free care on the other side of the street.

Commissioner Pruitt. It is a way, potentially, to address the crowding-out effect, in your opinion?

Mr. Jeffrey Brown. Yes, yes.

Commissioner Pruitt. Okay. Thank you very much.

Chairman Chernof. Great. I want to begin with my questions with Mr. French.

I want to pick up on a comment you made previously. So define for me--my understanding of your work is that rich was defined as the top two quintiles. Please tell me what the lowest income level was for the top two quintiles?

Mr. French. I believe that would be on the order of $25,000 in current income for those who are 70 and older.

So many of these individuals had much higher income during the working years, but the thresholds--I do not actually have the numbers right in front of me, but I believe it is $25,000 for the cut point in terms of the second highest quintile.

Chairman Chernof. So I would just observe that for the average person who is 70-plus, $25,000 does not make them rich. I just--

Mr. French. Right. Okay.

Chairman Chernof. We will just say it does not pass the smell test. We could go to any 70-year-old who has $25,000 a year of annual income and trying to pay for food, for heating, for transportation needs and other out-of-pocket expenses.

I mean, I just want to put that on the table.

Your study also focuses on singles over 72, and if I read your paper correctly, 82 percent of those folks are women. Is that correct?

Mr. French. Sorry. Could you repeat the question?

Chairman Chernof. The study population was singles over 72.

Mr. French. Correct.

Chairman Chernof. And the demography of that subpopulation was 82 percent women.

Mr. French. I believe that is correct, yes.

Chairman Chernof. Okay. So there is lots and lots and lots of literature that shows that that subset of folks, right--they are going to have much higher health care needs in the latter part of life. They are far more likely to have spent down substantial resources, particularly if they had a spouse who was ill and you had to blast through resources during the last few years of the life of a spouse.

They are likely to have lower incomes, too, if I

understood the paper correctly, but I am a doc, not an economist.

But I guess my question to you is I do not understand how you can generalize off of that population, which is from my perspective a highly skewed population, and make generalizations about the Medicaid program as a whole.

Mr. French. Right. So I have constructed somewhat similar tables that also do include married individuals.

There always the very difficult question of how to think about lifetime resources, couples versus singles. Of course, when a household loses one spouse, their income tends to decline. And so for that reason, I kept the tables with the spouses out.

Depending upon how you do it, those at the top of the income distribution, if you do include couples, their Medicaid recipiency rates will wind up being lower. And I definitely do not want to say anything different.

Chairman Chernof. Great. Thank you.

Mr. Brown, so walk me through this for a sec. If I heard you correctly--and I may not have, so I am asking you to correct me if I misheard you--I understood you to say that basically people choose not to buy long-term care insurance because they know Medicaid is there. Is that a correct summary?

Mr. Jeffrey Brown. It is a simplification, but yes,

that is the basic spirit of it.

To be a little more precise, many of the payments that an insurance company will have to provide in return for providing you with a private long-term care contract will end up simply paying for expenses that would have otherwise been paid for by Medicaid.

Chairman Chernof. Okay, but--

Mr. Jeffrey Brown. And, as a result, the net benefit to the policy is much smaller than the actual cost.

Chairman Chernof. Okay, but then help me with that.

That does not make sense to me because here is the simple fact; Medicaid is not an insurance program. It is a means-tested safety net program. And so, ultimately, to get on Medicaid, if you choose not to buy insurance, you actually have to spend down resources.

Mr. Jeffrey Brown. Correct.

Chairman Chernof. So there is not a tradeoff, in my mind, between purchasing Medicaid and purchasing--or getting to Medicaid and purchasing long-term care insurance because you will have to spend down personal resources to get to Medicaid.

The tradeoff is between private insurance that you could have purchased at some point in your life and the risk of spending down all of your personal resources to a point of poverty.

And my point here--and I want to push back if you disagree--is I do not know anybody who wants to be on Medicaid. Medicaid is a poverty program. So I guess--

Mr. Jeffrey Brown. Again, that is not inconsistent, but in the absence of buying--if you--let me step back.

At the very high end of the wealth distribution, you are absolutely right, and our studies show that for people that have sufficient wealth that is exactly the mind set.

I mean, I do not want to be on it.

And they have enough money to where, even in the absence of insurance, they could afford five years in a nursing home.

The median person in the wealth distribution would exhaust their resources if they spent five years in a nursing home. And, while most people do not spend five years in a nursing home, there is a positive probability that that will happen to you.

As long as Medicaid is there and is covering those most extreme catastrophic type events--the very events that Dr. Feder said are the ones that people want to insure against--and you have cut off that tail risk, it lowers the value of buying private insurance.

That is very consistent with theory, simulation and evidence. So that is all I can really say about it.

Chairman Chernof. Okay. No, that is great. I

appreciate that.

Commissioner Raphael. I have to say that I also have some problems thinking that people who do not save, do not understand their future risk for needing long-term care and, in general, do not calculate what later stages of life will mean for them, are so kind of cognizant of Medicaid that they can really do this comparison and say in their own mind that the cost-benefit is such that I will forego private insurance and really put my eggs in the Medicaid basket. That is what I have a hard time kind of comprehending.

Mr. Jeffrey Brown. Look, this does not require that people have Ph.D.s in order to do this. All that is required is for people to be able to look around and see that people that do not have insurance are taken care of, and therefore, they do not see it as a risk, right?

That is consistent with the outcome of our study.

We model in a particular way that is assuming that people have a very high level of sophistication. But, you know, it is kind of like the old billiards example of we can model people's behavior using geometry. That does not mean when they go up to hit the ball that is actually what they are thinking, but it does describe their behavior fairly well.

And so that is how I would respond.

I also just wanted to point out--sorry, I was poking

around here on my iPad, but I wanted to find the right site for it.

Norma Coe, who is now at the University of Washington, does have an empirical paper on the issue of spend-down, and I just wanted to make sure that that was on your radar screen because it is--the spend-down question is a very hard thing to study because, by definition, if you are trying to hide assets from Medicaid, you are probably also going to hide it from survey takers and the like.

So she tries to make use of cross-state variation in some of this and does not find big effects but does find some effect of spend-down, particularly for single individuals, less so for married.

And I would be happy to provide that citation to you guys after the talk.

Commissioner Raphael. Thank you.

My other question is we talk about financing. We have talked about public sector and private sector options.

I would be interested in what we know about out-of-pocket spending and what percentage of the costs of long-term services and supports come from private, out-of-pocket payments. I do not know if any of you have any knowledge about that.

Mr. French. I think the breakdowns are only about 10 percent of all long-term care payments are made through

sources other than out-of-pocket or long-term care. I am sorry--out-of-pocket or Medicaid. And amongst those two sources it is very close to 50-50.

So think of it as 45 percent of all long-term care expenses are paid for out of pocket, 45 percent by Medicaid and 10 percent, everything else.

Commissioner Raphael. Thank you.

Yes, Mr. Johnson.

Mr. Johnson. Medicare actually pays for a large percentage of the overall share.

The numbers that I saw recently from CBO, I thought, were more like 37 percent, Medicare and 37 percent Medicaid and a big chunk for out-of-pocket of almost the same amount. So, basically, it was kind of those three, I thought, were the largest shares, and then long-term care insurance picking up the rest.

Commissioner Feder. They are payments to long-term care providers--skilled nursing facilities and home health agencies.

Mr. Johnson. Okay.

Commissioner Feder. But, as several testified earlier, they are not payments for long-term care.

Mr. Johnson. I see.

Ms. O'Brien. I would just add one as well. This study now is a little dated, but the facts tend to remain stable

over time.

I think Brenda Spillman and Peter Kemper did a study of lifetime nursing home use of the elderly and found that 44 percent of elderly nursing home users paid for their care using only private funds--44 percent--16 percent began as private payers and exhausted their own resources and converted to Medicaid, and 27 percent were covered by Medicaid upon admission to the nursing home and throughout their use; the remaining 13 percent of elderly nursing home users over their lifetime use were covered by Medicaid only or other sources.

So the substantial portion of people going to the nursing home are paying their own way throughout their use.

Commissioner Raphael. Okay. Thank you.

Mr. Jeffrey Brown. But, if I could add to that very briefly?

Commissioner Raphael. Yes.

Mr. Jeffrey Brown. I think it would be really interesting to see those numbers broken down by length of stay because if you do it by stays there is a lot of very short stays that are paid out of pocket but for longer stays those numbers are going to shift rather dramatically.

Commissioner Raphael. Okay. T

Commissioner Vradenburg. This is a question for Mr. Johnson.

All these studies, obviously, are looking backward because, obviously, you are dealing with data that preexisted the current state of affairs.

And I am curious as to whether or not the dynamic of longer-living populations, which is going to produce more people in retirement, post-earnings period, and the adequacy of savings or the inadequacy of savings for post-retirement right now--whether or not we are going to see more people in the sort of middle third or somewhere in that segment eventually ending up on Medicaid because they are using their savings for the normal costs of living in their 65, 75 and 85. But at some point that over now 85 is the fastest growing segment of the population, and they are going to be in a position where they can use Medicaid.

So, if you look back in 20 years from now, whether you think that there is going to be any change.

Now I recognize you have not got a crystal ball, but I am just curious as to whether or not the dynamic you describe of only very low-income populations qualifying for Medicaid is going to be true in 10 or 20 years.

Mr. Johnson. Well, that is a very good question, and we like to think we have a crystal ball because we have this--

[Laughter.]

Mr. Johnson. --great model called DYNASIM that allows

us to project out into the future for 85 years or so.

But one of the things that we do find is, as you mentioned, there is this big debate about retirement security and just what the future incomes will be of let's say the Boomers. What does retirement income look like for future generations?

And there is, I think, a lot of hysteria around that topic.

What we find is, generally, that things are not quite as bad as what other people are saying, primarily because women are working longer; women are earning more retirement incomes in their own name, and that is offsetting a lot of the decline we are seeing in pension wealth. I would say in the DB pension wealth.

At the same time, a lot of this depends on how productivity evolves over time. But, if you assume that wages continue to grow at their historical average, or the long-term historical average as the Social Security trustees do, then that translates into much higher wages, much higher Social Security benefits over time and does kind of lift the overall numbers quite a bit.

What is also really important to this question, though, is understanding how inequality is going to evolve over time. We know that inequality is increasing at working ages, and that is going to evolve into more unequal

retirement incomes in the future. So we might see a greater share--so more unequal and more people at the bottom, which could increase Medicaid.

The length of disability is a really important part of all of this. As people are living longer, there is a question of how much of those years are going to be disability-free and how many are going to have some period of disability.

No one really knows, obviously, but a lot of the--so the informed conjecture is that, well, maybe half of the increase in life expectancy will be disability and half will be disability-free.

So, when we have done some of these projections, we do find that there is more Medicaid use going forward than there has been in the past just simply because people will be using more services over their lifetimes and spending down more. It is not dramatic, but it is an increase.

Commissioner Vradenburg. The other question--because you made a pretty powerful case that Medicaid users are low-income. But I am going to turn around and ask, what are the demographics of users of long-term services and supports--which is not just low-income populations. It is a population distribution because I assume wealthy people get disabled and cognitively disabled.

So I am curious as to the overall demographics of the

demand for long-term supports and services because one of the things clearly in thinking about Medicaid adding some long-term supports and services benefits is how on the income scale do you go.

You go, obviously, above Medicaid. You are going into the general population over 60. If you look at two ADLs and say, okay, that is the disabled population or the demand for long-term supports and services, what are the demographics of that?

What is the second quintile? Third quintile? Fourth? Fifth? Or, first?

Mr. Johnson. So, when we were looking at these numbers and looking at the Medicaid--and I should say we are just focusing on nursing home population and not other types of long-term care use.

Commissioner Vradenburg. Not assisted living?

Mr. Johnson. No. That is right. No assisted living.

When we looked at people going into nursing homes, about a third of them were getting Medicaid-financed nursing home care at some point. So two-thirds were not.

And this was following people from their early 70s to their--for 18 years, so kind of until their later 80s.

It does not mean that some of those people would not eventually go into Medicare--I am sorry, Medicaid--when they hit their 90s, but we found that only about a third of them

were going onto Medicaid.

So you are right. I mean, there is a substantial population that is using nursing homes and that is not qualifying for Medicaid.

Commissioner Vradenburg. Thank you.

Commissioner Butler. Just one question, actually, to Mr. Brown--you concluded that eliminating any one barrier may not sort of move the needle with respect to sales of the private long-term care insurance.

Since you have argued that making Medicaid less attractive is unlikely to incent sales, should the Commission then instead focus on catastrophic areas of product?

I am just trying to understand from your conclusions. So what is--and this is a question I am sort of been asking. What is the game change based on your set of conclusions?

Mr. Jeffrey Brown. If I had an answer to that, I would have provided it five years and maybe we would not need a Commission.

Unfortunately, what our research shows is that this is just an inherently difficult problem--that if you want to have a means-tested program that insures that anyone who is low-income or ends up with few resources because they have had to spend, if you want to have a means-tested program that does that, structured like Medicaid is, it is just

going to be--it is just inherent in the nature of this thing that you are going to crowd out private insurance for at least the bottom half and probably more.

So I do not have an easy answer for you.

You know, I have thought about--these partnership programs actually do a great job of addressing one of the two problems, which is that they do change the asset disregard. They, basically, ignore the insurance element or allow you to keep enough of your assets that were protected by the policy, but they do not get at the secondary payer issue.

The problem is if you want to make Medicaid a primary payer, you may actually see Medicaid expenditures go up. So you may see us spending more on Medicaid in order to get a larger private market, which sounds a little backwards, but that is exactly what could happen.

So, you know, I did not come here offering that I had any magic bullets for you, and I do not.

Commissioner Butler. Thank you.

Commissioner Guillard. Thank you very much.

I just have three quick questions.

Number one, for Mr. French, on page two of your slides, you have Medicaid does not pay for certain services, for example, nursing homes. And I assume you mean long-term, not--

Mr. French. Yeah, I should have been more precisely. Absolutely.

Commissioner Guillard. Okay. I just want to make sure about that.

Secondly, for Mr. Brown, you made a statement where you said long-term care services--it was in response to someone's question. Long-term care services should be an insurable event, correct?

Mr. Jeffrey Brown. Yeah. What I mean by that is that from a basic theory of insurance perspective, individuals are made better off when they can insure against these events rather than trying to save for them because if you save for them and then they do not happen you end up having resources that you do not consume. So it is a more efficient way to deal with these kind of events.

Commissioner Guillard. Do you say that under the context that it is unlikely that you will need long-term care services?

Mr. Jeffrey Brown. Let's say it is even--I mean, the late assessments I have seen by Mike Hurd and Susann Rohwedder just last week, coming out of RAND, say that a 50-year-old has more than a 50 percent chance of needing long-term care.

Let's say it is 50 percent. Saving is a very inefficient way to deal with something that, yeah, there is

a 50 percent chance you will need it, but there is only a 5 percent chance that you are going to need it for 9 years.

And, yet, if you really want to rely only on savings, if you do not have any kind of catastrophic coverage in place and you want to really only on savings--people are in nursing homes that have been there for 8 or 10 years if they are there because of cognitive impairment. Not many.

But if you really want to fully be protected against it, then you have got to have, you know, a million dollars that you are not going to tap unless you--I mean, that is an extreme example, but that is the idea. It is a very inefficient way to deal with it.

Commissioner Guillard. Yeah, it is a very, very, very limited subset of people that stay in a nursing home more than a year.

Mr. Jeffrey Brown. Yeah, but you do not know if you are going to be one of them. That is the problem.

I do not mean you.

Commissioner Guillard. No, no, I understand.

Mr. Jeffrey Brown. But any individual does not know if they are going to be the person that does not enter or ends up in that tail.

And, if you do not have--now if you have some sort of catastrophic coverage program in place--and this gets back to your question--then if you cover the catastrophic risk,

then I do think there is a bigger role for savings, just like we have high-deductible health plans. So, there, I am open to that.

Commissioner Guillard. Yeah, I just believe your probability that you need nursing home care are reasonable. I do not know exactly what they are.

But the need that you would have is for a very limited amount of time, not for a year or two years or three years. The proportion of the population with the risk profile of anyone needing that is so de minimus that (a) it is unlikely they could ever afford long-term care insurance.

In my opinion, I somewhat disagree. I think you are better off to put the money in the bank.

Mr. Jeffrey Brown. I would go exactly the opposite way, which is because you do not know if you are going to be that 5 percent that is in the long tail, but you cannot save enough to cover for that.

Commissioner Guillard. But your premiums are so extremely high. Who is going to pay all the money for that low probability?

Mr. Jeffrey Brown. Who is going to pay for your long-term care when you run out of money if you do not have catastrophic coverage in place? That is the question, right?

With Medicaid, you spend down, and you end up on

Medicaid, but that is exactly why you then have less incentive to buy insurance.

So, I mean, it is true it is a low probability. But it is also very unlikely that my house is going to burn down, but I am not going to go without homeowner's insurance.

Commissioner Guillard. No, and I agree with you. But, again, that is an expense that seems to me to be a manageable expense whereas we just have not seen long-term care insurance be a rationale, manageable expense. It is so high.

Well, look at the track record of it. It has been an abysmal failure. I mean, we have heard how much testimony about that today.

Mr. Jeffrey Brown. All I am saying--I am not talking about the state of the current long-term care market. I am simply saying that based on first principles, individuals are made better off when they can insure against uncertain events that have catastrophic outcome.

Commissioner Guillard. And on a theory, I agree.

Mr. Jeffrey Brown. That is a much better way to deal with it than to try to save for a low probability event. The fact that you think it is low probability you are going to have a long stay is exactly why it is inefficient.

Commissioner Guillard. And, if it were such a low probability, you would expect that the premium would be

relatively low and manageable because more people would access it.

Mr. Jeffrey Brown. So I have research showing that the loads on long-term care insurance are quite large.

So, I mean, I am not going to say that the existing market is perfectly efficient. That is not what I am saying.

I am saying that--

Commissioner Guillard. Yeah.

Mr. Jeffrey Brown. --this is a risk that in an ideal world you would like to insure against because private savings is not an efficient way to handle it.

Commissioner Guillard. Thank you.

Commissioner Vradenburg. Mr. Chairman, can I have one question if it is a follow-up?

Chairman Chernof. It is tough up here.

Commissioner Brachman. I am afraid to see George afterwards under these circumstances.

[Laughter.]

Commissioner Brachman. And I think that Mr. Brown has been pretty clear on what he would recommend, so I think this question is for the other three of you, whomever might want to address this.

There has been discussion about whether there is asset transfer or if there is not asset transfer, how much of it

there is, and again, questions about whether there is or is not crowd-out.

Looking at the data in terms of what you all were saying, that such a large proportion of people who are using long-term care public resources are low-income, I guess my question for you is, what are you recommending that we do?

We know that there is this large Baby Boomer population that is going to be needing long-term services and supports, that there is a growing number of people--younger people--with disabilities that are going to be relying on it, or are now and will be increasing.

And so I guess what I am not hearing is from you all, what you would suggest.

The dialogue that just went on was savings versus long-term care insurance. Are there other options out there? Do you recommend either of those?

Or, are we simply going to increase Medicaid by taxing the people who are already lower-income further?

What would you suggest?

Mr. French. As an employee of the Fed, I should probably be quiet on that one.

Participant. You can speak in Fed speak.

[Laughter.]

Chairman Chernof. You can speak on your own behalf. How is that?

[Laughter.]

Chairman Chernof. Seriously, we would love to hear your ideas on this.

I mean, this is literally what we are wrestling with. So, to the degree you have personal opinions separate and apart from your organizations, we would love to hear them.

Commissioner Stein. Poor Eric. He is about to speak, I see.

Mr. French. I thought some of the proposals made in the previous session were very good ones.

I think, as Jeff has pointed out, these are probably only going to have very small impacts in terms of the share of people who are actually insured, but perhaps getting from 10 to 15 percent of the population being insured; maybe that is of some value.

Mr. Johnson. I would just echo what Jeff said earlier, which is that there are not a lot of good options.

To me, what seems most--what is most appealing is probably not politically feasible, which is trying to add some of these services to Medicare and extending them to younger populations as well.

It just seems that it is very hard to have a voluntary insurance system that is going to work. The reason why, I guess, this Commission exists is because we tried a voluntary public system and realized before it was

implemented that it could not work, and it seems that the only way something like this is going to work would be to have a mandatory system.

Commissioner Brachman. And I guess as part of that--Ms. O'Brien, please jump in--the age at which you were focusing on people being low-income was at older ages. So, at younger ages, they may indeed have had larger incomes.

So, whether they put money aside in long-term care insurance or by savings, are there other ways to capture private money to put into the long-term care system other than depending on public dollars?

Mr. Johnson. So what I--Ellen referred to some of the research I had done earlier. That was looking at lifetime earnings, and what we found there--so not looking at how much you were able to save. It was looking at how much you earned, both you and your spouse, over your lifetimes.

And, there, what we found was that most people who were going onto Medicaid were in the bottom 40 percent of that lifetime distribution, unlikely to be able to devote much to long-term care savings.

And I think if you look at the history of 401(k) plans, where participation rates are not particularly high and where very few people are maxing out as it is, and given that the concerns about general retirement security, the idea of siphoning off some of those funds to long-term care

is a little discouraging, I think.

Ms. O'Brien. And I might just relate that to a Medicaid finance as well. We have seen states under tremendous fiscal pressure in the current environment, and we have seen cuts in Medicaid, including Medicaid long-term care. And so I just raise the issue that that continuing pressure, with the demographic change that Rich talks about, raises a real issue about the sustainability of the current Medicaid approach to Medicaid finance.

We have seen that the states with the largest projected growth in the elderly populations are the states that invest the least in Medicaid today, and so that is going to create, potentially, some pressure.

You will see more and more inequity across the Nation in the generosity of Medicaid's long-term care benefits, and that would tend to push you in the direction of needing to consider an alternative financing option, perhaps a social insurance option.

Chairman Chernof. Commissioner Jacobs.

Commissioner Jacobs. Thank you, Mr. Chairman.

I, actually, kind of want to follow up on that a little bit.

Mr. Brown, I am getting the impression from some of the earlier questioners at our earlier panel on terms of ways to reform the long-term care insurance market that your

research has led you to conclude that those reforms, if not necessarily a fool's errand, would certainly improve things at the margins because the catastrophic benefit provided by Medicaid is the 800-pound elephant in the room that kind of dominates that, if that is correct.

And then somewhat related to that, is it possible to quantify the fiscal effects of that on the Medicaid program and on states?

I know you have looked at it more from the individual perspective in terms of the crowd-out effects and all that sort of stuff.

Quantify the effect on spending because, obviously--and we have talked about this in a variety of settings at our hearings. The fiscal impacts both to the Federal and the states are very constrained, and states have to deal with balanced budget requirements, as we heard in our first panel this morning.

Mr. Jeffrey Brown. So, yeah, I think your initial characterization is correct.

It is not that other things will not matter. It is just that they are going to be small relative to the underinsurance population.

So, as I have stated before, when you have a really small fraction of people insured, you might be able to enlarge that market in a substantial way, but you are still

going to leave the vast majority of the population uncovered.

That does not mean that some of these things are not worth doing. I do not mean to imply that. It is just that it is not--as you said, it is not the 800-pound gorilla.

As far as putting dollar estimates on these effects, is it possible? Yes.

Have I done it? No.

Am I in a position to share those results with you on the very tight time table in which this Commission is operating? Probably not, but I would be happy to talk about at least how to think about that.

Commissioner Jacobs. I mean, I think that would be interesting, and that would certainly be something I think a lot of states would be interested, and policymakers here in Washington as well.

Mr. French, I kind of wanted to follow up, and actually, Mr. Johnson mentioned some of this in his testimony, in terms of future income projections which, of course, are always hazy going out in the future.

But I recall seeing a Kaiser Family Foundation from a year or two ago, talking about--and this is off the top of my head. So I hope I am characterizing it correctly.

Basically, that the projection of individuals with incomes of over 500 percent of poverty is projected to

something like double over the next 20 or 25 years or thereabout.

Certainly, 500 percent of poverty is not rich by any stretch of the imagination, particularly for the senior population. By the same token, it is not destitute either.

So kind of my question is whether you have studied some of these effects on upper income quintiles and percentages, drawing on the Medicaid benefit and utilizing that benefit, over any kind of longitudinal study over time.

And then if those are in fact the demographic projections going out 20, 30 years, is it possible that the data might get skewed upwards a little bit more because of where things are going on income projections?

Mr. Jeffrey Brown. Right. America is becoming a more unequal society in terms of income. So this naturally implies that more and more people are going to be making many, many times the poverty line.

Just in terms of specifics relating to the Medicaid utilization of people who would be at least 500 percent of the poverty line, not exactly, but that would roughly correspond to those in the top income quintile in my group. And, for that group, they have a 5 percent Medicaid recipiency rate.

I have broken this down by age. Of course, amongst those who at the top of the income distribution, when they

are "young"--70--the Medicaid recipiency rate is, of course, much lower. The Medicaid recipiency rate of those in the top of the income distribution, the top quintile, it will rise to about 20 percent once individuals reach their 90s.

Commissioner Jacobs. So then it is it also related not just to where income projections are but then longevity projections?

And, if the two of them are linked, for instance--because those with incomes in the top quintile live longer. Therefore, they are also more likely to go on Medicaid at some point because of their longevity. So, if that trend skews along with the income trend, then you would see further skewing of that? Am I--

Mr. Jeffrey Brown. Yeah, that is potentially the case.

Commissioner Jacobs. Okay. Thank you, Mr. Chairman.

Chairman Chernof. Excellent. Thank you.

Commissioner Claypool.

Commissioner Claypool. Thank you and thank you again for being here and wrapping us up.

This is, I think, the last round of questions, but I wanted to go to you, Mr. Brown, and just again kind of come back to the question--the last exchange you had about whether or not Medicaid was really kind of crowding out long-term care insurance.

You made a statement of people look around and they see

that others are being taken care of. Is that the best way to characterize it--because I am--you know, if that is really the threshold for the support of your argument, aren't there a variety of other factors that might really pull at this individual for their attention?

By way of example, they may be paying down debt from their own education. They may be saving for their children's education. They may be preparing for their own retirement.

So it seems not entirely logical that there would be--you would be able to draw a strong correlation between the existence of Medicaid, which not many people really quite understand how it works or whether or not it pays for long-term care insurance--I give you your point that, generally, people may be taken care of. But, to believe that that fact is crowding out the purchase of long-term care insurance, really, I am still struggling with it.

And I know you have made the point a number of times.

Mr. Jeffrey Brown. No, it is okay. But let me go back to the very first point that I hoped, or at least intended to make, which is we are not and never have claimed that the Medicaid implicit tax, or the Medicaid crowd-out, is the explanation of the small size of the market and that if only we would eliminate this, suddenly, everything would be fine. We have never claimed that.

What we have said is even in a world where people were behaving rationally and where there were no problems in the market, this would be sufficient to prevent the private market from ever being very large.

I am very sympathetic to the views--and some of my own research supports--that people have decision-making biases, that they are not always forward-looking in their planning and that there are a whole host of other reasons that might prevent them from buying insurance even if we did not have a Medicaid program. Nothing I have said is inconsistent with that.

But most of those biases go in the direction of people not buying insurance, not in the direction of buying insurance. That is why I have also said that even if you somehow eliminated the implicit tax on Medicaid you might not solve the problem because there are all these other factors at play that might still constrain the market.

Commissioner Claypool. It would be fair to characterize your statement then as Medicaid is a factor, among others, and you really cannot weigh them.

Mr. Jeffrey Brown. What I would say is that Medicaid, by itself, is sufficient to explain the small size of the market.

Commissioner Claypool. Okay.

Mr. Jeffrey Brown. That is about as strong of a

statement as I can make. It is sufficient to explain it, and even if you solve everything else, then you are still going to have a problem to solve.

Commissioner Claypool. And then in your exchange around insurance, in which I appreciated the back-and-forth, I look to the challenges that the private long-term care products have faced and then start to think about what are other options.

We could have a public insurance program that would be available. And, if we look at how they fare in comparison, we see the general population fairly satisfied with a public health insurance program like Medicare, and it stands up fairly well against a private health insurance. People are fairly well satisfied with Medicare compared to Medicaid, right? Excuse me, compared to their private health insurance.

And I am just, I guess, putting something out there for our consideration--that perhaps building a public insurance option might stand up as well over time as Medicare has, and people would rally around it and not have to go through what, unfortunately, many Americans are dealing with right now. When they purchase long-term care insurance, they have found themselves left without the type of protection that they thought they were making an investment in.

So a general statement and then a final question for

Rich--going forward, is there anything your crystal ball tells you about what is going to happen as we move the tail end of this Baby Boom population, which I actually represent, that is not attached in many cases to a real defined benefit retirement program?

And we are really looking at people that are participating in defined contributions. And what does that mean for their ability to accumulate any wealth or be prepared for retirement?

Mr. Johnson. So that is a big uncertainty, I think, about exactly how that is going to play out.

One of the real challenges with the defined contribution plan is that most people do not annuitize those assets, and so how they end up spending that money can have a big impact on their retirement security. We know that people are not saving as much in those plans as we would like, and so that has created some challenges going forward.

But we also know that the traditional defined benefit plan system did not always work that well either, and there are a lot of people, particularly those who changed jobs and, frequently, never accumulated much. A lot of people never had coverage to begin with.

So, in our crystal ball, which is based on a lot of assumptions, we find that the average pension wealth is declining a bit, will decline a bit over time, but it is not

falling off the cliff or anything, and overall, things are not so bad.

But the biggest challenge is medical expenses that are rising but, most importantly, long-term care expenses. And that is really what is--from what we are seeing, the income seems okay. It is the long-term care expenses that are the major challenges for the Boomers and later generations.

Commissioner Claypool. Thank you.

Chairman Chernof. Great. On behalf of the entire Commission, I want to thank all of you for being here.

Again, this is one of the most prickly areas, and we appreciate your kind of walking with us through this issue.

With that, I want to thank everybody for being here today. The Commission's open session is done for the day.

I know that there are people who are watching this live. And for those of you who are in the room, I will say it one last time. We are completely open and want public testimony. So you can go in through the web site--www.LTCCommission.Senate.gov--and there are instructions for how an organization or individual can do that. We encourage that.

We all got our memory sticks today. So we have plenty of reading for our plane trips home, for those of us who are planing home.

The next Commission meeting will be August 19th. There

will be information forthcoming about the structure of that meeting shortly.

Thank you all for being here.

[Applause.]

[Whereupon, at 4:40 p.m., the Commission was adjourned.]