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EXAMINING THE FINANCING AND DELIVERY OF

LONG-TERM CARE IN THE U.S.

TUESDAY, MARCH 1, 2016

House of Representatives,

Subcommittee on Health,

Committee on Energy and Commerce

Washington, D.C.

The subcommittee met, pursuant to call, at 10:15 a.m., in Room 2322 Rayburn House Office Building, Hon. Joe Pitts [chairman of the subcommittee] presiding.

Members present: Representatives Pitts, Barton, Guthrie, Shimkus, Murphy, Burgess, Lance, Bilirakis, Long, Ellmers, Bucshon, Brooks, Collins, Schakowsky, Butterfield, Castor, Sarbanes, Matsui, Schrader, Cardenas, and Pallone (ex officio).

Staff present: Rebecca Card, Assistant Press Secretary;

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Graham Pittman, Legislative Clerk, Health; Michelle Rosenberg, GAO Detailee, Health; Chris Sarley, Policy Coordinator, Environment and Economy; Jennifer Sherman, Press Secretary; Heidi Stirrup, Policy Coordinator, Health; Josh Trent, Deputy Chief Counsel, Health; Christine Brennan, Minority Press Secretary; Jeff Carroll, Minority Staff Director; Tiffany Guarascio, Minority Deputy Staff Director and Chief Health Advisor; Rachel Pryor, Minority Health Policy Advisor; Samantha Satchell, Minority Policy Analyst; Matt Schumacher, Minority Press Assistant; and Andrew Souvall, Minority Director of Communications, Outreach and Member Services.

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Mr. Pitts. The subcommittee will come to order. The chair will recognize himself for an opening statement.

Today the Health Subcommittee will examine the financing and delivery of long-term care in the U.S. Long-term care largely differs from health coverage or medical care. I know every member of this committee wants to ensure that frail, elderly seniors or disabled individuals across the country receive high quality care.

We want to see each person treated with the dignity and respect that they deserve, and we want a long-term care system that empowers each person and respects individual preferences. Unfortunately, as we will hear from our witnesses today, many experts warn that we are facing a coming crisis in the provision of long-term care. Most notably, we face a demographic headwind with 10,000 baby boomers turning 65 every day.

Additionally, as life expectancy increases so too does the need to provide care for aging individuals, yet our private market is not as robust as needed. Our public payers are strained and many individual Americans face high out-of-pocket costs for providing a long-term care for themselves or a loved one. Unfortunately, too few Americans are currently prepared to pay

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for even a modest amount of long-term care whether through insurance or savings.

As we engage in today's hearing, I think it is important to remember our long-term care crisis affects all Americans. If the long-term care challenge is left unaddressed it will impact the elderly who require services, the middle-aged who are often responsible for caring for their aging parents, and the children who could be left responsible footing the bill for public programs.

As we embark on examining how we can confront the long-term care challenge, it is important we learn from failed ideas of the past. For example, in 2010, the ACA created a new federal entitlement program called the CLASS Act. The statute required that the CLASS Act be solvent over a 75-year period, and the program failed to meet tests for actuarial solvency. CLASS Act was found to be fiscally unsound; was ultimately repealed in subsequent legislation.

This committee knows all too well what financially unsound programs look like. Medicaid and Medicare are both facing growing financial strains as costs soar and demand increases. Medicaid is consuming increasing portions of state budgets, Medicare's long-term unfunded obligations are estimated over \$35 trillion in today's dollars. So it is understandable that many

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members of this committee are wary of proposals that resemble a new entitlement, but caution against new entitlements does not equal close-mindedness to new approaches.

There are many ideas about ways to improve the outlook for financing and delivering of long-term care in the country. For example, just in February, three bipartisan proposals have been offered. So today's hearing provides members an opportunity to learn more about the state of long-term care in our country and to examine the types of policy choices facing Congress if it wants to reform the current system to provide high quality care without bankrupting future generations.

Clearly, we need to find better ways to encourage private market solutions. We need to understand what the research tells us about what is working in the private and public sectors. We need to know barriers to efficient high quality care exist in our public programs, and we need to better understand how to encourage individuals and their families to plan for the future.

I appreciate our witnesses being here. We look forward to your testimony. Is anyone seeking time on our side? If not, I yield back, and at this point recognize Ms. Matsui of California filling in for Ranking Member Green as ranking member.

[The prepared statement of Mr. Pitts follows:]

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Ms. Matsui. Thank you, Mr. Chairman. And thank you very much for having this important hearing on a critical issue that affects millions of Americans -- the financing and delivery of long-term care. And I want to thank our witnesses for being here today.

Long-term services and supports are medical and personal care assistance services for people who have difficulty completing daily living activities over a prolonged period of time, from feeding or bathing to meal preparation or management of medications. Approximately 12 million Americans of all ages require long-term care for medical needs associated with developmental disabilities, traumatic injuries, behavioral health or chronic conditions. Elderly individuals in particular are at increased risk requiring long-term care.

So who is providing and paying for this care in our country? Unfortunately, we don't have a robust system in place that works for families. In fact, much of both the care and financing often falls on the family. Unpaid caregiving service as a front line across the country, 70 percent of working adults provide unpaid care for family members or friends. This is an estimated \$470 billion annually in labor costs. This lost productivity is estimated to the economy \$34 billion a year.

Oftentimes, women are the ones who disproportionately bear

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the burden of providing unpaid long-term care. Women often are called on to care for their family members at a time when they may not be able to reenter the workforce. Women also live longer. They find themselves unable to save for retirement when supporting family members. Our daughters, granddaughters or mothers should not have to carry the weight of this broken system any longer.

Despite the growing need for long-term care due to our aging population, there is no viable financing system in this country to support it. It is a common misconception that Medicare covers the long-term care in this country. However, it only covers limited circumstances such as care immediately following a hospital stay.

In fact, Medicaid is the single largest payer of long-term care in the United States. However, most middle class families do not qualify for Medicaid and must pay out of pocket to spend down their assets before receiving benefits. And for Americans with disabilities, successful employment can lead to a loss of Medicaid coverage and thus create a disincentive to participate in the workforce. We need to create a system that allows recipients to receive services and support while remaining employed.

Without Medicaid or private insurance, on average families are spending about \$140,000 on long-term care for their loved

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ones. For working families who are trying to pay their mortgage, send their children to college and take care of the long-term medical needs of their loved ones these costs are devastatingly high. The reality is clear. Long-term care financing is in a crisis state in this country and is one of the greatest threats to retirement security for seniors and the adult family members who care for them. It is time for us to act to protect our seniors, people with disabilities and those who care for them.

Today we will hear about major bipartisan reports which have independently agreed on three major actions Congress must take. First, we must strengthen and simplify Medicaid long-term care. Second, we need to build a more consumer-friendly long-term care private insurance market. Finally, we must create a program that will be there for those with catastrophic long-term care costs. Together we must commit to finding a sustainable means for financing and delivering quality long-term care to our loved ones because our families deserve more.

Mr. Chairman, we received many statements for the record for this hearing. I ask unanimous consent to submit statements from our good friend and colleague Representative Debbie Dingell who has certainly worked on these issues for a long time, the Christopher and Dana Reeve Foundation, and the National Academy of Elder Law Attorneys. And I ask that these be submitted for

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the record.

Mr. Pitts. And I will add to those statements from the American Health Care Association, the National Center for Assisted Living, and America's Health Insurance Plans.

Without objection, so ordered.

[The information follows:]

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Ms. Matsui. Thank you, and I yield back.

[The prepared statement of Ms. Matsui follows:]

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Mr. Pitts. The chair thanks the gentlelady. Now in the place of Chairman Upton, the chair recognizes Dr. Burgess five minutes for an opening statement.

Mr. Burgess. Thank you, Mr. Chairman. I appreciate the recognition. I actually had not prepared or planned on delivering an opening statement, but it does occur to me that we have had similar hearings multiple times in the past. Ms. Matsui just asked the question who is paying for long-term care. Mr. Chairman, you wondered aloud if there was a private sector solution, and indeed there are private sector solutions.

The private insurance market in long-term care was hurt by the introduction of the CLASS Act and then the abandonment of the CLASS Act. I think it was very disruptive in the market. Look, long before I ran for Congress, my mother -- my father was disabled and my mother told me that I needed to get long-term care insurance. She said if you don't buy it now before you are 50, you won't be able to afford it when you really need it. And it turns out that was good advice that she gave. Long-term private long-term care policy is expensive. Premiums run between 1,500 and \$2,500 a month. Yes, they are after-tax dollars.

But I can really think of no more loving gift that a parent can give their child than to prepare for what may happen in the future. For me, it just seems like responsible financial

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planning and I do wonder why it is not more of the financial planning that people do in their lives.

Look, 11 years ago, this committee, this subcommittee and this full committee passed language in the Deficit Reduction Act for what was known as the Partnership Program. This allowed for the protection of some assets in an estate. If a person had a private long-term care insurance policy, then the amount of the spend-down was protected to the extent of the private policy that they had. It was not as robust as perhaps providing full deductibility of a long-term care insurance premium, but it at least provided some incentive for people to consider a private long-term care insurance policy.

Again the CLASS Act was very disruptive. It was disruptive to the marketplace. We have seen our premiums go up over the last 10 or 15 years. That is unfortunate. But I do think this subcommittee and this committee should do what it can to get people my age to understand that this is important for you to do for your family.

Yes, there need to be safety net programs. No argument there. There need to be valuable programs for people who don't have other resources or other places to go. But I just remember my mother who was the primary caregiver for my father who was disabled by a stroke in 1989 and lived until 2005. You need to

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be prepared for these sorts of things. They can happen to you.

So Mr. Chairman, I appreciate the time that you have given me today. I will be happy to yield back and I am anxious to hear the testimony of our witnesses and what has happened over the last ten years in this space. I yield back.

Mr. Pitts. The chair thanks the gentleman, and now recognizes the ranking member of the full committee, Mr. Pallone, five minutes for an opening statement.

Mr. Pallone. Thank you, Mr. Chairman, and thank you for holding this hearing today to discuss long-term care, an issue that is very important to me.

Today we face a long-term care crisis that is forcing millions of Americans to drain all of their resources before they get any support from the federal government. This crisis is not only affecting those that need long-term care but also their families, sons and daughters who have no other choice than to spend hours every week caring for their parents.

This simply cannot continue and I hope that today's hearing is the beginning of an ongoing conversation that leads to real action to address this crisis. After all, the crisis is not new. Congress has been discussing a solution for decades. I worked with the late Senator Kennedy and Mr. Dingell on the inclusion of a public benefit for long-term care in the community setting

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as part of the Affordable Care Act. While this provision known as the CLASS Act was not a perfect piece of legislation, the ideas behind it were worth fighting for, namely, the idea that there is a desperate need for a strong federal program to help with long-term care costs.

This hearing is timely in that it falls just weeks after three separate and independent reports authored by those across the political spectrum have agreed on just that point. The three reports have all independently agreed on three actions Congress must take. The first is to strengthen and simplify Medicaid long-term care; the second, to build a more consumer-friendly long-term care private market; and third, to create a strong federal program that will be there for those with catastrophic long-term care costs when they need it.

And I could not agree more and that is why I plan to introduce legislation some time this year to provide a federal role in long-term care financing. Seventy percent of Medicare seniors will someday need long-term care services and support and they deserve a better option when faced with catastrophic out-of-pocket costs rising into the hundreds of thousands of dollars. Congress must do more to improve the quality and the affordability of these services, and I believe that we can achieve some of these goals by establishing a Part E option in the Medicare

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program to provide for this care. Now this can be done in many different ways, but whatever form this effort takes we must act with a sense of urgency.

The current system forces people to sell off all their assets in order to become eligible for Medicaid. While Medicaid was put in place to help our most vulnerable, it is currently funding 51 percent of long-term care expenditures, a full third of the program's total spending. And because many people never purchase one of the available albeit expensive plans on the market, private insurers only pay for about eight percent of care.

The fact that both public and private insurance plans provide so little in terms of long-term care benefits means that these costs are left to be shouldered by the elderly, the disabled and their families. These direct out-of-pocket costs account for \$53 billion of long-term care spending and this is too great a burden for many who do their best to manage without care, who often depend on family caregivers to provide health assistance free of charge.

An estimated 52 million unpaid caregivers make it possible for their loved ones to stay out of nursing homes and hospitals. As anyone who has ever cared for a loved one knows, this is often an arduous task and often means missing work. These costs to society add up and not fully tracked, but conservative estimates have found that 17 percent of working adults provide unpaid care

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for family members or friends providing an estimated \$470 billion annually in labor costs.

The federal government must be part of the solution and I stand ready to work with anyone on any of these options to start addressing this crisis because I think I simply can't, I just don't think we can afford to wait any longer. I thank you, Mr. Chairman. I yield back.

[The prepared statement of Mr. Pallone follows:]

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Mr. Pitts. The chair thanks the gentleman. As usual, all members written opening statements will be made a part of the record.

That concludes the opening statements and now we will go to our panel. And I would like to thank our panel for coming today. I will introduce them in the order of their presentation. First, Dr. Alice Rivlin, PhD, co-chair, Long-Term Initiative, Bipartisan Policy Center, Senior Fellow, Economic Studies Program, The Brookings Institution. And then Dr. William J. Scanlon, PhD, consultant, West Health Institute and National Health Policy Forum. And finally, Ms. Anne Tumlinson, CEO, Anne Tumlinson Innovations, Founder of Daughterhood.org.

Welcome. Your written testimony will be made a part of the record. You will each be given five minutes to summarize. So at this point, the chair recognizes Dr. Rivlin five minutes for your summary.

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STATEMENTS OF ALICE RIVLIN, PHD, CO-CHAIR, LONG-TERM CARE INITIATIVE, BIPARTISAN POLICY CENTER, SENIOR FELLOW, ECONOMICS STUDIES PROGRAM, THE BROOKINGS INSTITUTION; WILLIAM J. SCANLON, PHD, CONSULTANT, WEST HEALTH INSTITUTE AND NATIONAL HEALTH POLICY FORUM; AND, ANNE TUMLINSON, CEO, ANNE TUMLINSON INNOVATIONS LLC AND FOUNDER OF DAUGHTERHOOD.ORG

STATEMENT OF ALICE RIVLIN

Ms. Rivlin. Thank you very much, Chairman Pitts. And glad to see my old friend, Congresswoman Matsui, and especially to have Mr. Pallone here because he has been such a champion for long-term care for such a long time. I am happy to be back before this subcommittee which is never afraid to take on complex issues and to work in a bipartisan manner. The last time I was here we were talking about the SGR, so you are not afraid of the tough stuff.

I have worked on long-term care services and supports for a long time and I have recently had the privilege of co-chairing the Long-Term Care Initiative at the Bipartisan Policy Center along with several distinguished former elected officials. Nobody ever elected me to anything. But we produced in just last month, a report entitled "Initial Recommendations to Improve Financing of Long-Term Care,@ which is appended to my testimony and which is one of the three reports that have been referred to

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already.

I don't need to remind this committee that the need is increasing and that the burden on families, on seniors themselves and on the public programs, especially Medicaid, is increasing very, very rapidly and will of certainty increase more as the baby boomers age.

Many efforts have been made to find a comprehensive solution to long-term care financing. The chairman and several of you have referred to the CLASS Act. Recently, a growing consensus has formed among a number of groups that steps, incremental steps, could be taken to improve the availability and affordability of long-term services and supports to America's most vulnerable populations. And so we have addressed ourselves to that problem.

One thing that is important and this committee knows very well is that over the last few years the whole emphasis has shifted from institutional care and nursing homes to ways of keeping people in the community where they are happier and where they often can be served cheaper.

So the group that I worked with addressed ourselves to the question, is there a set of practical policies that could command bipartisan support and improve care for older Americans with disabilities, take significant pressure off families and Medicaid and not break the bank? We came up with four proposals. One is

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a major effort to make private long-term care insurance more affordable and more available. Long-term care should be an insurable risk and if more people bought long-term care insurance during their working years there would be less pressure on their savings, their family resources and Medicaid when they became disabled.

Our report recommends developing a new type of private insurance product, which we call retirement long-term care insurance, which would cover long-term care for a limited period after a substantial deductible or waiting period and would have co-insurance. This is not Cadillac long-term care insurance. This is bare bones but we believe it would help. It would have inflation protection and a nonforfeiture benefit. Employers would be encouraged to offer such policies as the default option as part of a retirement package. These policies if offered through employers and public-private insurance exchanges could, we estimate, cut premiums in half. We also suggest that penalty-free withdrawals be allowed from retirement plans such as 401(k)s beginning at age 45 for the purchase of such insurance.

We will also recommend designing a long-term care option, a federal long-term care option, for those with catastrophic costs. We would recommend streamlining the Medicaid home and community-based care options to encourage more effective care in

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lower cost settings. The Congress has already moved in this direction, but the waiver process is unbelievably complicated and we think it could be simplified. And finally, we recommend ensuring that working people with disabilities in need of long-term care services and support do not lose their access to those services under Medicaid as their earnings increase, a cheaper buy-in for just those services. Thank you, Mr. Chairman and members of the committee, and we will be happy to work with you over the longer run and to answer any questions.

[The prepared statement of Ms. Rivlin follows:]

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Mr. Pitts. The chair thanks the gentlelady and now recognizes Dr. Scanlon five minutes for your summary.

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STATEMENT OF WILLIAM SCANLON

Mr. Scanlon. Thank you very much, Mr. Chairman and members of the subcommittee. I am very pleased to be here as you discuss the issue of financing and delivery of long-term care services. Long-term care services and financing have been an area of concern during my entire career on health policy which is now about a 40-year period. Much of what you are going to hear from me also will be in agreement of what you heard from Dr. Rivlin, because I think we have recognized the nature of the problem for the long term and that the issue is finding the right set of options in terms of trying sort of to address it. The need to address it has become more acute as the aging of the baby boomer generation sort of adds sort of to the numbers of people needing long-term care so that it is a critical issue today.

In my view, long-term care is quite distinct from other health care services both in the nature and the provision of those services and its financing. Unlike medical care, which aims at treating or managing diseases or conditions, long-term care as you have heard involves assistance that determines how one lives one's life in the presence of a disability. It is the assistance with activities to daily living like bathing, dressing, eating and toileting that we all would do ourselves but those with

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disabilities cannot. Long-term care is not provided solely by health professionals, as you have heard family members are probably the principal suppliers of sort of long-term care services. Long-term care is also quite distinct in its financing. There is very little sort of insurance. The predominant payer is state Medicaid programs which constitute about two-thirds of all spending, with out-of-pocket spending comprising another one-fifth of total spending.

Medicaid as the primary source of payment is problematic for both individuals and the programs. Only individuals with limited resources are eligible for Medicaid. Some people outlive their savings and become Medicaid-eligible when a long-term care need arises, others exhaust their savings paying for long-term care needs that they have incurred. What services a Medicaid beneficiary receives depends greatly on where one resides. The options for home versus nursing home care differ by state. Medicaid offered in-home services supplement what families provide, do not replace them. An individual's preferences or relief of the burden on family caregivers may not be significant enough factors determining what services are offered.

For Medicaid programs long-term care is the largest share of their spending and generally has been the fastest growing part of the program. States have had some success in moderating

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spending growth as there has been a substantial shift from nursing homes to home and community care following the enactment of the Medicaid waivers. States have also restricted the number of nursing home beds through moratoria on new construction of new beds and sort of a stricter certificate of need. As a result, today we have one million fewer beds than we would have expected given the size of the elderly population.

The challenge for the future magnified by the Baby Boom generation involves reforming long-term care financing in ways that improve the well being of people with disabilities and their caregivers and that are affordable and sustainable. Unlike medical care, a solution is unlikely to be found in finding efficiencies that reduce spending. Medicaid programs efforts and individuals paying out of pocket sensitivity to costs have likely prevented considerable inefficiency already.

The need to find another way to finance long-term care is not a new idea. Serious discussions about alternatives to the current system began in the early '80s and with the primary focuses on expanding private long-term insurance. This seemed and is a reasonable approach as needing long-term care is an insurable event, a risk not a certainty, and insuring for that risk rather than saving for it makes more sense.

Despite multiple efforts, the private long-term care

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insurance market remains limited. Only three percent of adults and 11 percent of elderly currently have any coverage at all, and recently the number of policies sold sort of annually has declined. While the limited growth in long-term care insurance has generally been seen as a demand problem, today there is a need to consider the potential for a supply side problem as well. In 2002, 102 companies were selling long-term care insurance. The number declined to 20 by 2014 and additional companies have since left the market.

Long-term care insurance has always been a difficult product for insurers. There was and is uncertainty about the likely benefit use with the presence of insurance. There is an additional problem now though and that is the limited returns on the investment of premiums that have been associated with the low interest rates we have experienced over the last eight to nine years. The ability to invest premiums is key for insurers in setting premium rates and having a sustainable product.

I would like to conclude with some considerations that might be taken into account as you are examining sort of long-term care financing options. Encouraging personal preparedness should be a priority. While that might be perceived by some as limiting public expenditures, I see it as essential to providing individuals with more choice in how they live their lives when

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they have a disability and how their families will be impacted.

Insurance as I mentioned is preferable to savings as the primary means of preparation, yet we now have concerns about insurer participation. What actions can be taken to assure that insurers will be interested and able to market long-term care policies with reasonable benefits and premiums? The proposals that you are going to hear today sort of offer some sharing of risk which may be sort of key to the participation of insurers. It may also be key to giving a clear message to individuals that preparation sort of is an important personal responsibility.

Finally, what the Baby Boom generation means for state Medicaid programs deserves attention. States already differ significantly in the shares of their population needing long-term care and the cost of providing services. As the numbers needing long-term care increases and as economic activity may shift geographically, some states may be disproportionately affected. What assistance they may need should be considered. Thank you very much, Mr. Chairman.

[The prepared statement of Mr. Scanlon follows:]

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Mr. Pitts. The chair thanks the gentleman and now recognizes Ms. Tumlinson five minutes for her summary.

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STATEMENT OF ANNE TUMLINSON

Ms. Tumlinson. Thank you. Chairman Pitts and members of the committee, thank you very much for the opportunity to testify today. I really appreciate your focus on this issue.

The perspective that I am about to share comes from a variety of experiences over the past 25 years. I work at the Office of Management and Budget on the Medicaid program as a researcher and a consultant to long-term care providers and most recently serving as a facilitator between the economic modeling work done at the Urban Institute and Milliman and several of the very brave groups working on long-term care financing reform. I also write a blog for family caregivers. We have a very serious and significant financing gap between the services and supports that people need and the funds available to pay for them. I am going to make just three points that I hope will frame today's discussion and shape the work of this committee.

First, as we have heard already, having a need, a high need for long-term care in old age is not an inevitable part of old age. And what I need by high level of long-term care need is when you get to the point that you need help with two or more activities, basic activities of daily living like bathing, eating or dressing, or if you are living with a severe cognitive impairment.

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And what we are learning from the recent work done by the Urban Institute and Milliman is that there is a huge variation in whether and the degree to which individuals will actually experience this high level of long-term care need in old age. The researchers project that over the older adult population there is roughly a 50 percent chance that if you live to age 65 that at some point over the rest of your old age you will experience that high level of need for long-term care.

Now there is also a smaller, a 15 percent chance that a person will live with that level of need for five or more years. Just imagine living with two or more activities of daily living limitations for five or more years. These situations are incredibly expensive. If you are among the top 15 percent of spenders, the Urban Institute projects that your care will cost at least, at least \$250,000 over your lifetime. The bottom line is that the risk here is large and it is uncertain.

So the second point I want to make is the way we finance these costs as we have all heard is inadequate to the need. Individuals and families face huge financial risks. Generally what the Urban Institute research is telling us is that on average over half of lifetime costs are actually financed through individuals' income and savings through out-of-pocket spending. But when and if these resources run out, Medicaid plays a very important role.

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It finances about a third of lifetime costs on average and makes the biggest contribution for people who need care for very long periods of time.

The reliance on individual resources and Medicaid has created huge gaps in the system. We have already talked about this, but we rely very heavily on unpaid family caregiving and this is in part because this is often the only option that families feel like they have.

But I want to talk about another gap that we see, which is that we often simply just fail to meet needs. In a recent survey, about a third of individuals with long-term care needs reported serious consequences from going without needed services. For example, individuals who have difficulty preparing their own food or difficulty eating and can't get help with that often go without eating, and this unmet need gets addressed in the emergency room and the hospital which is of course where Medicare pays.

So my third point is that the risk of needing long-term care is one that is well suited for insurance, but shifting all or even a part of our financing to insurance will be very challenging, so I am the Debi Donner here. So even when we estimate a twofold increase, a twofold increase, in voluntary participation in long-term care insurance we still don't see it moving the needle that much on how much we spend on Medicaid and how much

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out-of-pocket contributions are made. So I want to be careful here and say that this doesn't mean it wouldn't be helpful to increase insurance participation under a voluntary approach, it would. It just wouldn't dramatically change the role of Medicaid or out-of-pocket spending. To do that we need everyone to participate. But even when we assume that everyone is covered it is still hard because that new coverage soaks up so much of the unmet need that it increases overall spending almost as much as it offsets other sources of payment.

So in grappling with these tough issues, where the groups I have worked with have landed as you have heard is that some sort of private market and public insurance partnership solution is needed and that the appropriate role of public insurance is to cover that catastrophic risk; that five years or four years or three years, but the part that is the most expensive for individuals. But that is only going to work, that catastrophic risk coverage will only work as long as we can stimulate the private market and reform Medicaid to better cover the earlier risk.

But everyone has more work to do. We have to develop details. We still have to work on financing strategies. But we have to move forward no matter how challenging it might be, because our stopgap patchwork system has serious implications for future

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economic productivity, public program spending and for the functioning of the American family. Thank you.

[The prepared statement of Ms. Tumlinson follows:]

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Mr. Pitts. The chair thanks the gentlelady. That concludes the opening statements. We will now go to questioning and I will recognize myself five minutes for that purpose.

Dr. Rivlin, you have suggested Congress create a state plan amendment for home and community-based services in Medicaid. If home and community-based services are more cost effective and offer preferred settings, why aren't states making full use of existing authorities to provide such services under Medicaid?

Ms. Rivlin. I don't know the answer to that for all states. Many states would like to and get caught in the complicated waiver process, and we are simply saying let us make it easier. Let us make it simpler for states to do this and hope that they do and that therein can be encouraged broadly to get with it and use the authorities that are there.

Mr. Pitts. And why does the Bipartisan Policy Center feel the federal government needs to create incentives for states to increase the adoption of home and community-based options?

Ms. Rivlin. Because it is not happening and we think that some incentives might help.

Mr. Pitts. Okay.

Ms. Rivlin. And the simplification is really very important. The Congress has wanted to do this and has done it, but as so often happens in policy as you know we end up with a

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complexity that could be simplified.

Mr. Pitts. Ms. Tumlinson, I was particularly struck by the sentence in your written statement, quote, it is important to remember that because the system is currently underfinanced, any change that ensures a significant portion of the population with need will result in more overall spending rather than less, end quote. Would you explain more about what you are suggesting? Is it that there is cost shifting currently going on, or we just buckle up and spend more nationally, or are you suggesting we need to approve large new expenditures now for promised savings tomorrow?

Ms. Tumlinson. Oh, there we go. No. The way that our system works right now, we have a lot of care that is being financed so to speak without paying for it, so we are financing care through unpaid family caregiving. We are financing care through unmet need, so to speak, and we are financing care kind of back door through the health care system.

So when we put an insurance program in place, what the modelers estimate is that we have something called induced demand. In other words that people do actually, who have been essentially kind of holding back will actually come in and use their insurance benefits as we would expect them to. And as a result of that we will see, absolutely, we will see a replacement of some Medicaid

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dollars. It does reduce Medicaid dollars. It reduces out-of-pocket dollars.

But the insurance itself is, there is also kind of a place in the spending where the insurance brings in new dollars so we will have new dollars in the system. It is actually, it is good news. It is just that I think that this idea that our system somehow is, is we have out of control spending is a fallacy. We actually have a very tight, very efficient long-term care system right now.

Mr. Pitts. All right. Dr. Scanlon or Dr. Rivlin, do you want to comment on that?

Mr. Scanlon. I would agree with Ms. Tumlinson. I mean, it is very clear that sort of that there have been pressures to control costs that are present for both Medicaid programs as well as individuals sort of buying out of pocket. And the reason that we will have an expansion of spending sort of if we were to get insurance is the fact that at this point families are probably doing more than they really can bear in terms of the burden of sort of caregiving and if given sort of an option they will seek to provide some additional sort of outside resources. We don't want to supplant family caregiving, but we want to make sure that we do not have it sort of create sort of too much of a cost or burden sort of on those family members.

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Mr. Pitts. Dr. Rivlin, do you have any thoughts on this?

Ms. Rivlin. No, I agree with that.

Mr. Pitts. Dr. Scanlon, in your written testimony you state that Medicaid as a primary source of payment is problematic for both individuals and the programs. Can you explain why you believe it is problematic for Medicaid to be the primary payer for long-term care?

Mr. Scanlon. I feel it is problematic for the Medicaid program because of the sort of the enormity sort of, of its obligation in terms of trying to deal with sort of long-term care as the only financier. Secondly, sort of there is the difficulty of defining sort of what services should be provided sort of by Medicaid programs.

Historically, we have relied exclusively sort of on nursing home care and we recognize sort of the shortcomings of that but as we move sort of to having more care sort of in home, we also have to face the difficulty of deciding sort of how much care is appropriate to both sort of benefit the individual as well as sort of protect the program. And the reality there is we do again sort of we do not want to supplant sort of family care, we want to support it in a very positive way.

Mr. Pitts. The chair thanks the gentleman. My time has expired. The chair recognizes Ms. Matsui five minutes for

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questions.

Ms. Matsui. Thank you, Mr. Chairman. Our long-term services and support system are challenges that threaten our seniors' retirement security, young people with disabilities the ability to both work and afford needed services, and our nation's families who are attempting to either pay for their loved ones' services or to provide the care themselves. Unpaid caregiving particularly impacts women, as daughters most likely step out of the workforce to take care of their aging parents and mothers are most likely to take care of their disabled children. This leaves women with less retirement savings and Social Security accrual, and women need more as we also live longer. As we know, approximately 12 million Americans require long-term care and that number is expected to grow as the baby boomer population ages.

Given that the need for long-term care is driven by increased functional limitation whether it be from the aging process or untoward circumstances in life, isn't it fair to assume we need to approach this issue from a point of universality so that all Americans have a safety net without being required to become poor and significantly disabled in order to access the services and supports that they need? And I would like each of you to comment on that. Dr. Rivlin?

Ms. Rivlin. In an ideal world I think I would say yes, let

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us cover this in a universal way. But right now the idea of and to creating a new entitlement program primarily for older people seems to me both unlikely to happen and probably not desirable. I worry that we are spending so much on older people for good reasons that we are squeezing out investments in the young and in education both at the federal level and at the state level and for which reason I think it was important to take some of the burden off Medicaid.

Ms. Matsui. Right. Mr. Scanlon?

Mr. Scanlon. Yes. I agree that in an ideal world we would have a system where there is all needs that are going to be met, but I think that we need to also look at long-term care as something that is not just another health care service; that long-term care is about how you live your life in the presence of a disability. So it is not just the question of need, it is the question of sort of your preference and your satisfaction.

And while we can have sort of insurance that is aimed at sort of making, and public programs aimed at making needs sort of being met, there is this question of what additional sort of services one might want. That is where I think personal preparation comes into play, where individuals can sort of be able to exercise their preferences and the preferences of their family.

Ms. Matsui. Ms. Tumlinson?

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Ms. Tumlinson. Yes, thank you. Well, I can't figure out how to change the current system unless everybody is in it. Mathematically, can't figure it out. So universality is the -- and I think that it absolutely, we sort of have three different populations that need that universality -- children born with developmental disabilities, adults who develop disabilities or individuals who develop disabilities as adults and older adults.

And I think that as somebody who has worked on the budget side of Medicare and Medicaid for many years, I share Dr. Rivlin's concern about spending on older adults. At the same time, I think that we cannot back door finance this off of women who are giving up huge amounts of work time and their own financial resources in order to take care of their parents.

I certainly know from my work with caregivers that not only do they spend a lot of time, they also spend a lot of their own money. And that is not even in our model right now. We don't model that.

Ms. Matsui. I want to address long-term care insurance. The vast majority of employers as we know do not offer long-term care insurance to their employees. The federal government does offer long-term care insurance. However, over 80 percent in the general workforce does not have access through employers. Some have recommended requiring or incentivizing employers to offer

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long-term care insurance as an opt-out basis. What roles do you recommend employers play in education and enrollment in long-term care insurance? Dr. Rivlin?

Ms. Rivlin. I think employers could play a major role, especially if it were not so expensive and if they thought of it as part -- the selling point as protect your retirement resources, your savings, by buying this relatively inexpensive long-term care insurance which we are offering you, and not only that we are enrolling you unless you opt out.

Mr. Scanlon. I agree that the employers would be a trusted source of information, and I think education is the key to sort of having consumers understand sort of the value of insurance.

Ms. Tumlinson. I agree with Dr. Scanlon and Dr. Rivlin.

Ms. Matsui. Okay. Thank you, and I yield back.

Mr. Pitts. The chair thanks the gentlelady. I now recognize the vice chair of the subcommittee, Mr. Guthrie, five minutes for questions.

Mr. Guthrie. Thank you. Thank you for all being here for this important issue that we need to figure out a way to address. And I have a question for the panel, a couple questions for the panel. Generally, the home represents the individual's largest asset. Medicaid payments prevent certain individuals with substantial home equity from receiving coverage for long-term

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care. After adjustments for inflation, states' current home equity limits range from 552,000 of home equity to \$828,000.

I have introduced H.R. 1361, legislation to encourage the use of home equity to finance long-term care by eliminating the option for states to increase the home equity allowance above 500,000 adjusted for inflation. Are there other policies that could be implemented to encourage -- this is a question. Are there are policies that could be implemented to encourage individuals, especially elderly individuals, to tap the equity interest in their home to help finance long-term care needs?

Ms. Tumlinson. Okay. So first of all, thank you for that question. We also know that individuals that-one of the ways, the main ways that individuals access assisted living is by selling their homes and getting access to the home equity and then spending that down. That is what we hear from assisted living providers. So it is a really important sort of set of assets that we would like to be able to tap better. I think we have kind of been around the, kind of around and around about reverse mortgages, and I think that that is definitely an area where we could definitely do some more work in understanding how to make those financial instruments that basically allow people access to that equity without having to move out of their house.

Mr. Guthrie. Okay. Thank you. Okay, the second question

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then, use of personal care in home health services in Medicaid has been growing rapidly. For example, in 2011, Medicaid costs for personal care services totaled 12.7 billion, a 35 percent increase since 2005. At the same time, the Office of Inspector General found that fraud in personal care services is on the rise, representing more cases investigated by state Medicaid fraud control units than any other type of Medicaid fraud.

Another bill I have introduced is H.R. 2446, which would reduce the level of fraud and improper payments in personal care services by requiring the adoption of electronic visit verification systems for personal care and home health services under Medicaid. We can protect some of the most vulnerable Medicaid beneficiaries and ensure they receive the care they need.

Given most people's preference to remain at their home and growing demand for long-term care services, do you each think it is important to use technology such as electronic visit verification systems to ensure that the vulnerable beneficiaries receive the services they need and for which Medicaid is paying?

Mr. Scanlon. I definitely do. I mean, I think that in the statistic that you have cited in terms of the growth of expenditures there is actually sort of a positive side of that which is those expenditures have been growing because we have been reducing reliance sort of on nursing homes. I saw some data

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recently that in 2013, while the numbers of dollars spent by Medicaid programs on home care increased significantly, the numbers of dollars spent on nursing homes had actually declined which is rather surprising.

Monitoring sort of the integrity sort of, of home care is one of the most difficult things to contemplate if you are running a program when you think about it, this care being delivered sort of in homes across sort of one's jurisdiction. Using any technology that would aid in that is a plus, but I also think we need to think for the future in terms of this, if we are talking about service delivery for long-term care, what other roles can technology play?

To be quite honest, as the Baby Boom generation grows and needs more long-term care, the idea of sort of withdrawing people from the labor force to provide that care has very serious implications for our economy.

Mr. Guthrie. Yes. Thank you very much. And the third question for Dr. Rivlin, I understand the recommendations the Bipartisan Center released last month are just an initial recommendations in that the Center continues to work on additional recommendations regarding the financing of long-term care. Can you share with us some of the additional areas that will be the focus of the Center's continued efforts?

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Ms. Rivlin. The primary one is to work out some details for the catastrophic insurance. That we believe has to be a federal program and universal, but it is complicated to work out and we wanted to put some more effort into that. We also want to work on how long-term supports and services could be integrated with Medicare Advantage.

Mr. Guthrie. Thank you very much and I yield back the balance of my time.

Mr. Pitts. The chair thanks the gentleman. I now recognize the ranking member of the full committee, Mr. Pallone, five minutes for questions.

Mr. Pallone. Thank you, Mr. Chairman. I wanted to ask Ms. Tumlinson, I mean, we will see how much time there is. Maybe the others could respond as well. Two things about the spend-down provision and just about affordability of long-term care. I don't want to put words into Dr. Burgess' mouth because he is not here right now, but I think he said between 1,500 and \$2,500 a month for long-term care insurance. Was that accurate? I mean, let us assume it is 2,000, which is halfway between, right.

Mr. Shimkus. For over 50.

Mr. Pallone. For over 50. So you think about that that is what, \$24,000 a year, right. Will we say nursing home care now is about maybe 100,000, a little less than that? So I mean, it

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doesn't even seem worth it, I mean in the sense that you could, say you are 50, or of course even if you were younger and you put away that 25,000 for ten years or so that would be -- I don't know. That would pay for at least two years of nursing home care.

So it seems to me that -- and then a lot of times those policies don't even cover more than six months or a year of care. So I think a lot of people just look at this and say it is not worth it. In other words -- and that is what I wanted you to comment. I think a lot of people just look at it and say, look, it is so expensive I could just as easily put the money in the bank or in some kind of a mutual fund and have enough to cover it.

The real issue really is catastrophic, if you had to be in a nursing home for five years or so which I know is unusual but not totally unheard of. So I just wanted you to comment on that. I mean, I don't see, practically speaking it doesn't even seem like the long-term care insurance is even worth it given its cost and limitations. And is that why you talk, all of you were talking primarily about catastrophic and what would that catastrophic entail?

Ms. Tumlinson. All right. So I think it is the case that today it is very hard to buy private long-term care insurance for catastrophic risk. Most of the insurers are not interested in

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lifetime policies, selling lifetime policies anymore, so policies that would cover the care that you might need after a certain period of time. And so that is one of the reasons why we have all, all of these groups have been interested in a public program to cover the catastrophic risk.

Mr. Pallone. And the catastrophic would be covering like what, after a couple years?

Ms. Tumlinson. So, right. I think -- right. So after, well, defining that is part of the work that we have to, still left to do, but in the modeling that we did we started it after two years. So you have two years of high need and that at year two that is when the catastrophic piece of the insurance would kick in.

Mr. Pallone. Well, see that seems to me to make the most sense if we are talking about a public program, extension of Medicare or something else after that two years, because otherwise from what I see on the market it is just not worth it.

Well, let me ask you the second question. We haven't really talked much about it, but to me the biggest scandal, if you will, in this whole system is the spend-down provision. I don't like to talk about values, but I mean, from a value, we say that we are trying to instill certain values in what we do here, and it seems to me that that is like the most valueless, if that is the

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right word, thing that we ever created is the spend-down provision. And all I hear from my constituents is how do I get around it. What can I do to transfer my assets before the deadline so that I don't have to spend my savings or whatever, and then I can go on Medicaid.

I mean, I have to go be honest with you, practically speaking is one thing, but just from a value point of view I think it is outrageous because this is what people do. And I just -- yes, would you comment on that? I mean, in your experience this whole spend-down and people's efforts to get around it and what does that do to the family and the fabric of things from a moral point of view, I guess, is what I am asking.

Ms. Tumlinson. Sure. Well, so what I observe actually in what we are seeing, I think, in the data, is actually that in part because of Medicaid, because access to, even though access to home and community-based services is much better than it used to be through Medicaid, but because it is not guaranteed, in many cases, still, families only -- the only way you can use Medicaid is if you are in a nursing home.

And many, many, many families, most of the families that I talk to or that I deal with would much prefer to spend their own money in assisted living, senior housing, they would prefer to provide unpaid caregiving, max out their -- one of the home care

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providers in California told me they had folks maxxing out their credit cards to pay for home care themselves. So I don't really see people really working to sort of get rid of their assets in order to qualify for Medicaid because in many cases that just simply means a nursing home for their family member and they would prefer to avoid that.

Having said that there is a huge amount of diversity out there, and absolutely, once you have made that decision that a nursing home is where it is going to have to be there is, maybe the incentives are in place to try to figure out how to make that work in a way that is financially best for your family. But generally speaking, I don't really see people gaming it given how much out-of-pocket spending is happening.

Mr. Pallone. I appreciate what you are saying, but I hear it so often and it just galls me to think that we have set up a system where people are encouraged to basically get around it. And I know we cantalk about it another day, but it is one of my biggest concerns. Thank you.

Mr. Pitts. The gentleman yields back. The chair recognizes the gentleman from Illinois, Mr. Shimkus, five minutes for questions.

Mr. Shimkus. Thank you, Mr. Chairman. Welcome. This is a great hearing and something that we have been struggling with

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forever since I have been on the subcommittee. And I really appreciate Ranking Member Pallone's comments, because I do have frustrations with that and elder law attorneys who try to find these ways to protect assets when those assets should be used. I mean, we can't take it with us when we die, right. So I think maybe we will continue to talk about that because there has got to be a way to incent and keep and encourage, and I think a lot of different ideas are being thrown out here.

And I have always been, I have spent a lot of time talking about the budget as a whole, Dr. Rivlin, and whatever 2014 numbers, the 3.4 trillion and really the 1.900 billion or the 1.1 trillion discretionary budget that we always seem to fight about when the real challenge is our entitlements. People are entitled to these services and then the mandatory money then follows because you are entitled for these programs. So those are the right words and I think are rightly used.

But in the Bipartisan Policy Center when we talked about the failure of the CLASS Act, because you all talk about the new programs, how would we fund something like a CLASS Act to help people coverage? I mean, what would be a possible funding mechanism? Or is that to be answered in -- it is kind of a follow-up from the other discussions.

Ms. Rivlin. The CLASS Act was very expensive and that was

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one of the problems. If you are funding something less expensive like catastrophic care, then I think you still have the usual options. It could be a small payroll tax. It could be some other kind of tax. And I don't know exactly what the cost would be because we haven't done that work yet, but I think we need -- it has to be funded, in my opinion, and the less pressure you put on the federal budget, the easier it is to fund it obviously.

Mr. Shimkus. Because we are going to continue to fight budget debt, deficits and the like and just we will have to make sure that we have a funded program so it doesn't add to the deficit because then we are just continuing in the spiral down. Let me also go, we know the benefits of employing our disabled community and keeping them, but long-term services and long-term support and services help them stay in the workforce.

But there is that balance, right, of how you continue to provide Medicaid support so that they can then be active citizens and in employment without getting into the other -- oh, now, you are making money or you are not making money and we are going to kick you off services or we are going to add you to services. So do you have any comments on that?

Ms. Rivlin. Yes. We suggest a limited buy-in to Medicaid just for the long-term supports and services not for the whole Medicaid package because they may not need that. They may, if

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they are employed have insurance.

Mr. Shimkus. Ms. Tumlinson, you are smiling, so do you want to add?

Ms. Tumlinson. Well, I just, I agree with the Dr. Rivlin side. The BPC has got a really interesting solution that they have put forward, but I go back to if we had, the other option of course is to create an insurance system that if you, so that if you sort of unexpectedly face a disability as a working age adult that you have access to those long-term support and services through that insurance program. That is what the CLASS Act was designed to do, but it was a voluntary program.

Mr. Shimkus. Right. Thank you. And I want to finish up. There has also been debate, we are talking Medicaid, but recently we are also following the Puerto Rican debt crisis, health care dilemma, et cetera, et cetera, et cetera. But there is some confusion. I want to go to Dr. Scanlon. I don't think all Americans understand that the Puerto Ricans do not pay federal income tax as a protectorate, but the question is does Puerto Rico even provide long-term care which is mandatory Medicaid service?

Mr. Scanlon. My understanding of that and this is based on some GAO work that was done in 2000 and sort of in '05, is that Puerto Rico does not cover either nursing facilities, or at that point it was identified as home health. The home health portion

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sort of is not really long-term care. I think one of the things in educating the public is to stop confusing them about sort of what home health is. In terms of the nursing facilities there is the question of whether they, outside of Medicaid, support any other types of residential care.

Mr. Shimkus. Yes. So the only way -- if Mr. Chairman, I will just in my summary -- is, it is a debate between block grants and per capita grants and there is a confusion, then to lump what states are doing with what is going on in Puerto Rico is not appropriate. So with that I will yield back.

Mr. Pitts. The chair thanks the gentleman and now recognizes the gentlelady from Florida, Ms. Castor, five minutes for questions.

Ms. Castor. Thank you, Mr. Chairman, and thank you to the panel for sharing your expertise with the committee.

It is very important as you know to families across America and it is in our national interest to strengthen long-term care across the spectrum from home and community-based care to skilled nursing. And Dr. Rivlin, you suggested working on practical bipartisan solutions and I wanted to recommend one to my colleagues.

Congressman Gregg Harper, my Republican colleague, and I are cosponsoring H.R. 3009. That is the RAISE Family Caregivers Act.

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RAISE means Recognize, Assist, Include, Support and Engage Family Caregivers Act. It would create a national caregiving strategy based upon the input from advocates and experts and families across the country. And the reason I really recommend it to you is it passed the Senate. The Senate version has passed, and we the House should take action. So I would ask my colleagues to take a look at that and help us move forward on some of these practical solutions.

And Ms. Tumlinson, thank you very much for bringing up the fact that long-term care right now is often funded in a back door way by women and families who take time off their job, who cut into their salaries and overtime, and there must be a solution for that. And all of the witnesses have mentioned this as well. So thank you.

Another concern I have is that American families do not fully understand the availability or more accurately the lack of availability of financed long-term care services. Specifically, many Americans mistakenly believe that Medicare provides for long-term care services. Ms. Tumlinson, in your testimony you described Medicaid's role in long-term services and supports. Can you briefly talk about Medicaid's current role, and if no Medicaid reforms are taken here in the near future what do you believe is the outlook for financing long-term care through

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Medicaid?

Ms. Tumlinson. So in other words what happens under status quo.

Ms. Castor. Yes.

Ms. Tumlinson. We do nothing for Medicaid. So the modelers did what we call a baseline estimate of Medicaid, so what happens to Medicaid spending in the absence of current law, and it certainly starts to decline fairly rapidly. Just the long-term service and supports portion for older adults is the piece that they did, and it starts to decline very rapidly hitting 500 billion fairly soon, and so we are going to see rapid growth. But that is just kind of a modeler's view of the world, not that there is anything wrong with that.

But asking of myself sort of practically, what does that mean because can states and the federal government actually really absorb that? And I think that what I worry about is that when you have all of these people coming through the system who are entitled to these services and you can't change that entitlement, your only other choice is to use all of the leverage at your disposal to reduce spending on a per person basis.

So that what we will start to see is just sort of this kind of like this compression around what is available through Medicaid, further putting pressure on families and personal

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finances at exactly the same time when we are going to see this rapid decrease in the availability of family caregivers relative to the number of older adults. So this is kind of a perfect storm of unsustainability.

Ms. Castor. So could you expand on some of the most promising Medicaid reforms going on at the state level? It would seem that to your point a moratorium on skilled nursing beds is a false reform. And that is what you are talking about is the compression and the -- if we don't have the ability to make these reforms it is simply going to shift costs to families.

Ms. Tumlinson. Right. That is a good example of ways in which it is -- states can reduce spending on a per person basis for home and community-based services, they can increase waiting lists, they can put moratoriums on beds, they can reduce payments to nursing homes to the point where their margins are negative for Medicaid.

But in the states that are very innovative, what we see, for example, in Minnesota is a combination of efforts to use sort of central information systems called aging and disability resource centers to help people who are starting to have a need for a long-term services supports and have potentially financial eligibility to actually get tracked into the right level of appropriate care for them so that they don't end up in an

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institution unnecessarily, and so that for example, if all you really need is a wheelchair ramp then you get a wheelchair ramp. You don't get 12 hours of personal care a week if that is not what you need. So developing personalized care plans that are specific to the individual needs of the people.

I mean, the thing about long-term care is that it is a universal. Universally it is an issue that we all in our families and our lives may face, but each situation is in fact fairly personalized. And so what I like about what Minnesota is doing is that it is allowing those individuals to get the right level of care.

Ms. Castor. Thank you very much.

Mr. Pitts. The chair thanks the gentlelady and now recognizes the gentleman from Texas, Dr. Burgess, five minutes for questions.

Mr. Burgess. Thank you, Mr. Chairman. And first off, let me apologize to Mr. Pallone if I misspoke, or if he misheard let me correct him. The premium that I pay for a long-term care insurance policy right now is 1,500 to \$2,500 per month. Now I am used to talking about the exorbitant premiums I pay in healthcare.gov -- did I say it is per month again? I meant per year. The healthcare.gov premiums are per month.

And so I am used to the exorbitant premiums per month, but

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that is for the ACA coverage. The long-term care coverage is 1,500-\$2,500 per year. Still a significant amount of money out of a household budget, 100 or \$200 a month amortized over the course of a year, but an amount of money that perhaps is achievable for middle-class families. And what worries me about what we are doing or what we have done with the discussions we have on long-term care insurance is we pretty much have taken the middle class out of it. Sure, we are going to provide benefits, we are going to provide the safety net for the most vulnerable populations -- the blind and disabled, disabled children -- that continues unabated. But what we are talking about are people my age, people in the 55 to 75-year age group who are aging into a situation where their families now may be called upon to provide long-term care.

So wouldn't it be great if people would at least consider whether or not that makes sense for them and their families? And again I am not even talking about the tax consequences. I am talking about the actual consequences for your family. Again, I referenced the loving gift that a father, mother, father can give their children which is to provide for that care and not be a burden to their offspring at a time when, correctly, under the normal circumstances of living their offspring are actually raising their offspring and life goes on.

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But back to practicalities. Now Ms. Castor just talked about bipartisan solutions, so Dr. Scanlon, let me just ask you. Independence at home was something that was worked on in this subcommittee and this committee. Actually, the demonstration project was then, I believe, extended and that was just signed into law during this Congress, so that is one of the achievements in health care that can be correctly attributed to this Congress. But can you perhaps fill us in a little bit more on the Independence at Home program and ongoing what it actually means for families?

Mr. Scanlon. Certainly. The Independence at Home program also could be called the Home Based Primary Care program in which sort of individuals are enrolled in primary care practices that will deliver their medical care services in their homes. It is aimed at sort of individuals that have sort of very serious chronic conditions that make it very difficult to be receiving sort of their medical care sort of in physicians' offices and other settings.

The idea behind it is that it will sort of generate sort of savings by preventing these individuals from having their conditions be exacerbated where they will have to visit emergency departments or end up sort of being hospitalized. As you mentioned, sort of the demonstration sort of is underway. I think we are now sort of in the third year sort of, of that demonstration

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and the early results have been positive in a number of the practices.

And so there is this question sort of, of how can we make this sort of potentially sort of practical sort of on a widespread basis, sort of what are the types of patients that are best served, what kind of practices should be serving them.

Mr. Burgess. And would you suggest that the results are positive? Not just positive from a family care-patient care standpoint, also positive from a standpoint that it was self-sustaining and in fact did result in a negative score by the Congressional Budget Office; is that not correct?

Mr. Scanlon. In the first year results. We do not yet have the second and third year results. But I would say again, I mean, in terms of this hearing, this is about sort of your medical care needs. This is not about sort of your long-term care or long-term service and support needs.

Mr. Burgess. Well, let me just ask of the panel for anyone who wants to answer. I mean, I referenced the Partnership Program that we did, now, I guess, 10, 11, 12 years ago under the Deficit Reduction Act of 2005. Those hearings that led up to that inclusion in the Deficit Reduction Act, the inclusion of the Partnership Program, I mean, there were people are -- there are lawyers who make a business of impoverishing families so that they

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can then be Medicaid eligible.

And the idea of the Partnership Program was there are a certain number of assets that you can then protect as a family and you don't have to do this to yourself. And one of the unfortunate things about people who enter into long-term care is most will not actually overspend or outlive, if you will, the ability of premiums to cover their term in long-term care. There are limits on the policies, but most people don't exhaust those. Unfortunately, whatever the problem is that brought them to long-term care is going to claim them before the amount is exhausted.

But for families to have that option to fall back on, to give an incentive for families to actually participate in this program, do any of you have any thoughts on that?

Mr. Scanlon. Well, I think it is a positive to allow families to have this option. And in my discussions sort of with people in the insurance industry, they have said that it has had a positive impact in terms of the number of people buying policies with there is maybe a 15 to 20 percent increase sort of in sales of policies.

The problem, overall, for what we are discussing today though is we are talking about a 15 to 20 percent increase on an incredibly small base. If you raise five percent by 15 or 20 percent, as

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you know we only are increasing it by one or two sort of percentage points.

Protecting your assets in order to pass them on to heirs is potentially sort of one very positive thing that families may value in terms of partnership policies, but I also think that they shouldn't overlook the fact that the policy is going to increase your purchasing power. It is going to be able to allow you to sort of get more services that are potentially going to relieve families of some of the excessive burdens that they may be sort of incurring. That is a second aspect of insurance that I think we really have to focus on.

Mr. Burgess. Okay. Thank you, Mr. Chairman, I will yield back.

Mr. Pitts. The chair thanks the gentleman and now recognizes the gentleman from Oregon, Dr. Schrader, five minutes for questions.

Mr. Schrader. Thank you very much, Mr. Chairman. I appreciate it. I appreciate the hearing. This is a good area of bipartisanship. We can all agree that the rising cost of the baby boomers coming into long-term care need situation is going to be untenable and unacceptable.

My state has been a pioneer, I guess, in the community-based services. We don't emphasize nursing homes at all. We are

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primarily an assisted living, foster care or in-home-based long-term care state. We have great success. It is wildly popular. People prefer to be in these settings than a nursing home, at least in my area. It is also a lot cheaper for the taxpayer and I think for the individuals that are at risk here. So I urge the rest of my colleagues to look at the Oregon program and maybe try and create some similar situations in their own home state.

We have talked a lot about Medicaid. The ranking member and others have talked about the spending down provisions that seem relatively unconscionable. You can't get good care until you are poor, until you spend yourself into poverty. And that is certainly not a great pattern for success, I don't think. It is something that the greatest nation on earth should not be striving for as a way to provide long-term care services.

And Medicaid is expensive for the taxpayer. Now as was alluded to by several of my colleagues, it is one of the fastest growing parts of our budget. The safety net programs are the long-term debt deficit conundrums that we face. And I think it has also been said here today that it is a little untenable to have another program added into these otherwise already slightly untenable programs at high cost to the taxpayer.

So there has got to be some other alternatives out there.

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Dr. Rivlin, you mentioned very briefly about before we get into the higher cost Medicaid programs that maybe there is something that could be done in the Medicare Advantage arena for seniors seeking home and community-based services. Could you elaborate on that please?

Ms. Rivlin. I mentioned that in the context of a question of what else do we need to work on, and I think that is certainly one. A Medicare Advantage plan, which is a comprehensive approach to health care anyway or should be, could, if we figure out how to do it, offer long-term supports and services as part of a package and that would help with integrating the health care with the LTSS.

Mr. Schrader. And I appreciate that. And to that end, there is a bill that Congressman Lance, Congressman Meehan, and Congresswoman Linda Sanchez and I are putting forward, H.R. 4212. It is a bill based for Community-Based Independence for Seniors Act, and basically it is a demonstration project picking five MA plans across the country. It is budget neutral.

Please look at a way that these MA plans, which we have great success with in the state of Oregon, most of our seniors are frankly on MA plans not fee-for-service, and see if they can't integrate with a cap so you can't spend too much, but a cap on how much senior per month so that they can get this in-home care

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in their home care setting or at least in their community before they have to spend themselves down into the much more expensive Medicaid programs, which are much more expensive for the individual and their family as well as the taxpayer.

So I would urge the committee to please look favorably upon Mr. Lance and my proposal and see if we can't at least get something going, one part of this problem with long-term care our country faces. So I appreciate the opportunity and would yield back my time then.

Mr. Pitts. The chair thanks the gentleman and now recognizes the gentleman from New Jersey, Mr. Lance, five minutes for questions.

Mr. Lance. Thank you very much. And Congressman Schrader and I are working together and I hope the panel will look at the proposal we have. And our cosponsors are Linda Sanchez and Pat Meehan of Ways and Means, so we have Ways and Means and Energy and Commerce working together for precisely the reasons the distinguished congressman has suggested as a model moving forward.

Does anyone on the distinguished panel know how many Americans age 65 or older are currently in nursing homes?

Mr. Scanlon. It is probably about 1.75 million.

Mr. Lance. All right. And I know there are others who go

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to nursing homes, younger people, for other reasons, but the Medicare, Medicaid, the Medicare population 65 or older, about 1.75 million. How many in those nursing homes in that age category are funded by Medicaid?

Mr. Scanlon. About 60 percent of them are funded by Medicaid.

Mr. Lance. Sixty percent of those 65 years or older in nursing homes funded by Medicaid, so not private payment at all?

Mr. Scanlon. That is correct. But at the same time, one of the features of the Medicaid program is that if you become a nursing home resident that you pay your entire income less a personal needs allowance for your care, which in the personal needs allowance is around \$50 a month.

Mr. Lance. Yes. Yes. And Medicaid is a program funded partially by the federal government and partially by the states. And in the state of New Jersey, for example, we fund it mightily. Our contribution is significantly higher than many other states. Is that accurate?

Mr. Scanlon. That is correct.

Mr. Lance. And this may be a more difficult figure. Of the Medicaid population in nursing homes, 60 percent of almost two million so it is roughly a million people, I suppose, what percentage have had their assets spent down and have been

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impoverished?

Mr. Scanlon. That is a number I can't give you. I do not know it.

Mr. Lance. Yes. I come from a family law firm, and on occasion people come into the law firm saying we want to impoverish our parents. And I am vigorously opposed to that and we don't do it, so they just go next door to somebody else who helps them. Has there ever been a study as to this phenomenon in the United States?

Mr. Scanlon. There has been some GAO work sort of on this issue. It has been a number of years, I think, since it has been looked at.

Mr. Lance. And I want to work with others in the Congress on a program that helps senior citizens stay in their residences. I think it will be cheaper, vastly cheaper over the foreseeable future and that is why the congressman and I are working on a bill that we hope that you will examine.

Is there any discussion in the academic community or the fine work you do at Brookings as to this challenge regarding impoverishing one's parents? Dr. Rivlin?

Ms. Rivlin. I think we are all aware that we are not doing research on it.

Mr. Lance. Anyone else on the panel? Ms. Tumlinson?

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Ms. Tumlinson. Yes. Well, I think a lot of people have tried really hard to research this because it is has been this persistent question for years and years, as long as I have worked on long-term care for 25 years, and it is hard to get any real conclusive evidence. And the reason is because there is so much -- well, it is challenging to analyze what is really going on in people's financial lives, and there is some data sets that we have used.

But Josh Wiener and I did some work and we were not able to find evidence of a significant amount of asset transfer or improper use of assets in order to gain eligibility for Medicaid. And again I would just emphasize that even though that certainly does happen and it sounds like quite a bit in New Jersey from what I am hearing from you --

Mr. Lance. I don't think in New Jersey to any differently from any other state that might I respectfully place on the record.

Ms. Tumlinson. Certainly. Sorry. But that there is in fact quite a bit of --

Mr. Lance. New Jersey is a state if I might reclaim my time that sends funds to Washington. We are either number one or number two in the percentage we send as opposed to what we get back. I am sure that this is a state where we send a lot of money to Washington, Ms. Tumlinson.

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Ms. Tumlinson. So we know that at least a third of all spending on assisted living comes from adult children. So for as many children who are seeking to impoverish their parents there are probably just as many who are seeking to pay for them.

Mr. Lance. I am sure that is the case. That doesn't mean there isn't a problem with the former category. Thank you, Mr. Chairman.

Mr. Pitts. The chair thanks the gentleman and now recognizes the gentlelady from Illinois, Ms. Schakowsky, five minutes for questions.

Ms. Schakowsky. Let me just say I would hope that those who are interested in figuring out how many ordinary families are trying to figure out how to be able to pay for long-term care that we might look at how the wealthiest among us figure out how to pay lower taxes than many of their secretaries. So I would urge that.

I just came from, the National Institute on Retirement Security is having their national conference. I spoke to them. And they just issued a report today, "Shortchanged in Retirement: The Continuing Challenges to Women's Financial Future." And among the things that I pointed out in my speech was that the average yearly out-of-pocket costs for a patient living with dementia is \$61,522, and the average annual cost of a semi-private

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nursing home is over \$80,000 a year. And what we are talking about significant, ending up with significant out-of-pocket costs.

But it is also as Bankrate tells us, two-thirds of Americans don't have enough savings to handle a \$500 emergency car repair. A lot of people are not able to set money aside for the kinds of contingencies that we are talking about, or perhaps inevitabilities that we are talking about.

So I am really happy that we are having this conversation. I think it is just the beginning of how we can work together to truly improve or maybe even create a long-term care system in the United States. We have to improve the quality of our long-term care facilities. We need to increase access to community and home-based services. We need to drastically expand our caregiving workforce, and most importantly we need to have that serious conversation, in my view, about universal social insurance for long-term care.

I would like to just address quickly one of the most persistent issues in long-term care and that is nursing home quality. And I believe one of the best ways to find efficiencies in our long-term care system and better protect taxpayer dollars is to improve the quality of patient care offered at long-term facilities and especially nursing homes and skilled nursing facilities.

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So currently, federal law only requires a nurse to be present eight hours a day at nursing homes and skilled nursing facilities. I personally was shocked to find that out and I think most Americans, especially putting their parents in nursing homes, would be. This means that for 16 hours a day patients can be left without a nurse on staff at all, and as a result residents are experiencing avoidable injury, increased illness acuity and premature death due to the lack of direct care from an R.N. So I have legislation, H.R. 952, to put, it is called Put a Nurse in the Nursing Home Act that would require nursing homes and SNFs to have an R.N. on staff 24 hours a day.

But Mr. Scanlon, do you believe that efforts to improve the quality of care offered at nursing homes and SNFs would improve efficiencies in our long-term care system and help save federal tax dollars?

Mr. Scanlon. Those types of efforts to improve quality in nursing homes would certainly improve sort of our long-term care system. And in fact we actually have experience with what you are suggesting. If you go back into the 1980s, there was a demonstration program called the Teaching Nursing Home where the amount of nursing services in nursing homes was increased. What resulted was both an increase in the quality of care and a reduction in hospitalizations which are very expensive. Because

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the reality is that nurses in nursing homes can deal with many of the kinds of problems that lead today to hospitalizations such as pneumonia and other infections.

Ms. Schakowsky. Thank you so much for telling me that because I think that would be good evidence for this legislation.

The other thing, where was it that I wanted to ask you. So the National Association of Insurance Commissioners, again Mr. Scanlon, you mentioned, previously worked to develop model laws and regulations for long-term care insurance. Unfortunately, the regulations surrounding long-term care insurance have not been updated for over, well, a decade and a half. I previously introduced legislation with Congressman Lloyd Doggett to require HHS to ask the insurers to update their model laws and regulations for long-term care insurance every five years and to require their update to be incorporated into the model act and regulations used by HHS. Do you believe that Congress should work with NAIC to update the standards and regulations pertaining to long-term care insurance?

Mr. Scanlon. I think we need to assure ourselves that the standards are sort of up to date. I don't know what is on sort of NAIC's agenda sort of at this point. In the past it would appear that sometimes that they have updated sort of the standards, the model laws and regs, in response to some sort of

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crisis that has appeared. That has actually, might alleviate the problem for the future, but it has the negative effect of the crisis erodes consumer confidence and really sort of undermines sort of the ability to convince people that long-term care insurance may be sort of a positive idea.

Ms. Schakowsky. Thank you. I want to thank all the witnesses, but I want to say a special welcome to Dr. Rivlin. It is so good to see you once again.

Ms. Rivlin. Very good to see you.

Ms. Schakowsky. Just wanted to comment, if I could, Mr. Chairman.

Mr. Pitts. The chair thanks the gentlelady. I now recognize the gentleman from Florida, Mr. Bilirakis, five minutes for questions.

Mr. Bilirakis. Thank you so very much, Mr. Chairman. Thank you also for holding this hearing, and I thank the panel for their testimony.

This is a question for the entire panel. Back in the 1990s, Congress experimented with a demonstration program called the Cash and Counseling. This allowed Medicaid recipients with disabilities to pay for long-term services. The government provided funds to the beneficiary to establish a personal budget for personal assistance services that would best meet the personal

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needs and paid financial counseling services. This participant-directed personal assistance service allowed flexibility for caregivers and flexibility for beneficiaries to pay for nontraditional services such as respite services and hiring family members as the caregiver. Can you take lessons from this program and other programs to build a better system to promote greater flexibility within the long-term care program, and can we promote more home and community-based care so that seniors may tailor the program to best fit their needs? Who would like to begin?

Ms. Tumlinson. I will just go first. Yes, I think that that program, the Cash and Counseling programs have been kind of game changers in the way that we think about how we finance and pay for long-term service and supports. In the sense that as I was saying earlier the experience of having a long-term care need is very personal and the individual and the family caregiver is very integral to that. And so making the funds available based on that person's need as opposed to what the services that they buy is a way that we can actually incentivize, I think, a lot of innovation in the marketplace and give people control over their own personal care needs.

Mr. Bilirakis. Very good. Thank you.

Mr. Scanlon. I think this program illustrates sort of an

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important aspect of long-term care that long-term care is not like medical care, where you are willing to accept a prescription because you hope there is science behind that prescription which says this is going to deal with your condition or your disease. Long-term care is about how you live your life. And having personal direction and sort of affecting sort of that is a critical dimension of sort of the satisfaction you are going to get sort of in terms of living your life.

The counseling part of this, I think, is very important because it is not just a question of money. There really, it is very difficult to navigate the market for long-term care services even if you have money. It is not the kind of very visible market that we have for many other services. So being able to assist people to be able to exercise their choices is a very critical piece.

Mr. Bilirakis. Thank you.

Ms. Rivlin. I agree with all of that. Let me just pick up on one thing you mentioned and that was respite care. And I think that is in our list of things we would like to work more on because it is very important.

Mr. Bilirakis. I agree. Thank you.

Dr. Scanlon and Ms. Tumlinson, the Deficit Reduction Act of 2005 provides states the option to create a Long-Term Care

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Partnership Program which is a joint federal-state policy initiative to promote the purchase of private long-term care insurance. What can you tell me about the success of this program both in terms of the extent to which it increased use of private long-term care insurance and the extent to which it reduced Medicaid costs? Are there changes that we could make to improve the program? Again for -- yes, please.

Mr. Scanlon. At this point I think it is too early to look for its impact on Medicaid costs, because the issue of the long-term insurance is one buys a policy and then hopefully over, say, a 20- or 30-year period, there is going to be a 20- or 30-year period before one sort of goes into benefit and starts to receive the benefits sort of under the policy.

My sort of conversations as I mentioned sort of with insurance industry sort of executives have indicated that the Partnership Program has a positive effect on the sale of insurance policies. It is a modest effect of maybe 15 to 20 percent on a base that is small of maybe five or six percent. One of the difficulties in the Partnership for while it has got positive aspects actually adds to this problem. If you talk to brokers or agents for long-term care insurance they will tell you this is a complicated product to explain to consumers; that is not fun to try and sort of sit down and convince somebody that they should

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buy a policy. The Partnership aspect of this creates additional value to that product, but is also another complexity to have to explain sort of how that is going to work.

Ms. Tumlinson. Yes. I will just add very quickly that part of the challenge is that brokers tell us is that they are both selling against Medicaid and then also for Medicaid at the same -- so you want long-term care insurance to avoid Medicaid, but then if it runs out you get Medicaid. So that is a hard sell, but the concept of the partnership is a really powerful one, and I think it is one that the groups have built on to try to, maybe if it is not Medicaid as the backstop it is something else. So the idea that the private insurance could sell against a public backstop is still a really good idea.

Mr. Bilirakis. All right. Well, thank you very much. I yield back, Mr. Chairman.

Mr. Pitts. The chair thanks the gentleman and now recognizes the gentleman from Maryland, Mr. Sarbanes, five minutes for questions.

Mr. Sarbanes. I want to thank the panel. This is a fascinating and sobering topic. Speak a little bit sort of to the actuarial dimension of needing to come up with some products, whether they be hybrid, sort of public-private products or whatever they may be, sooner rather than later, just because the

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way the trajectory is going you are going to get this huge influx of people hitting at a certain time in terms of their needs and at that point it will be prohibitively expensive to try to solve the problem. You want to have had the benefit of people paying in obviously earlier when they are healthier.

So against where we are headed with the demographic trends, I don't know if anyone has computed with each passing year what the extra cost is that we are talking about in terms of even the kind of bare bones solution that you are offering up. But I imagine that dynamic is something very present in all of these considerations, so maybe you could just speak to that.

Mr. Scanlon. I think that is a very sort of important point. One of the strong differences between medical insurance where actually premiums are covering the cost of services during a single year, what we are talking about with long-term care insurance is trying to build the reserves that are going to be able to pay sort of for benefits 25 or 30 years later. And as we talked about premiums for long-term care insurance here today, if you look at those premiums they rise dramatically with age, essentially telling everyone if you start too late this is going to become prohibitively expensive and that applies both at the individual level sort of and for sort of the population of the whole.

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Ms. Rivlin. That is clearly right, and that is why we were looking for ways to get people in their earning years to more likely buy long-term care insurance, even if it is a limited long-term care insurance, and to establish a catastrophic program which will take some of the pressure off both the carriers and the beneficiaries.

Ms. Tumlinson. This is definitely one of the most challenging parts of thinking about the financing of anything that we are contemplating, because we have a lot of cross, what we call cross-cohort challenges with asking very young people to pay as much as we ask older people to pay who are going to be in that level of need much more quickly. And so there are ways in which I think we need to continue to work on the financing so that we can arrange it so that we have kind of the ability to not shift the costs for that population that is nearly there onto the younger people entirely, so we are asking them to pay more, for example.

Mr. Sarbanes. I mean, there is a little bit of a moral hazard dimension here in that you can imagine people saying, well, I don't necessarily want to step in now and be the guinea pig if it doesn't look like structurally the system is actually going to get fixed. I will just assume that at some point when the whole thing crashes we are not going to let people just be without any kind of recourse, and then I will step in and benefit from whatever that fix is at

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that time. So you have that dynamic at work too.

It is not helped by the fact that people don't really understand this product. That many as was mentioned, I think, by Representative Castor have gotten confused and assume that it is somehow bound up in Medicare and Social Security and these other programs and benefits that are available to them. So I appreciate your testimony. Thanks very much.

Mr. Pitts. The chair thanks the gentleman and now recognizes the gentleman from Indiana, Dr. Bucshon, five minutes for questions.

Mr. Bucshon. Thank you, Mr. Chairman. I am going to take a little bit different approach. I am going to, well, our conversation today has mostly been addressing coverage and how to finance a system in a system that needs to be changed in another area and that is how much it costs on the front end, not just how to finance a system that has been growing in cost for decades much faster than the rest of our economy. The ACA addressed mostly coverage. That is one of the issues I have with it not really affecting cost.

And what I mean by cost is I am not talking about the cost to a program overall, what I am talking about is the cost to the government or private insurance companies on an individual care basis when services are rendered. So even if less services are

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rendered overall, yes, the cost to the Medicaid program is down, but on a case by case basis that is probably not the case. The cost to the system continues to go up.

And if we are going to reform many of these programs, one of the things we really are going to have to do is figure out on the front end how it costs us less, but rather than just talking about how we are going to figure out how to pay for what it currently costs or what the cost in the future will be. Does that make sense?

Mr. Scanlon. Yes.

Mr. Bucshon. And so I am going to get to the question in a second. So one of the things that I am really focused on is trying to work on that and in a number of areas. Price transparency for the consumers is extremely important. Quality transparency for consumers is extremely important. And we are really going to have to look at a number of things that are in place legally and otherwise that are impinging on our ability to address those issues.

Why can't consumers know exactly what something costs? I mean, and it starts all the way from the bottom at a hospital or at a long-term care facility, the cost of a gauze pad or the cost of a diaper or whatever in the health care system. It can be way up there compared -- a gauze pad is essentially a little square

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of cotton fabric, but it is sterile and it -- I mean, it costs almost nothing except if you have to buy it, if you are a hospital and you have to buy the product. I am a free market guy so we need to look at how to fix this in a free market way, in my opinion. Price fixing is not an answer to the question.

So my question is for all of you is, are any of you looking at what the actual cost of providing long-term care is on the front end and so that we can help decrease the actual outlay of payments on the back end, and what are the drivers, currently, drivers of the actual increasing costs to provide the care? Again not the cost of what the insurance company or the government has to pay, but buying the product. What are the drivers? Have you looked at it? Because we are going to have to address that.

Ms. Tumlinson. To one of the maybe sort of sad things about long-term care is that because so much of it is paid for out-of-pocket there is more natural transparency in the system. And so I would, I am sure Dr. Scanlon will want to say this too, but I just want to stress that there really are some -- medical care and what we are used to in terms of the lack of transparency in medical care that is so frustrating to everybody, especially consumers, is it is medical care and long-term care act very differently sometimes.

And one of the ways that they do is that much of the spending

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is out of pocket and the other way is that long-term care is primarily labor. It is not a high tech business, it is a hands-on business. So you really just have two things. There is a price for the hour of labor and then you have the amount that people are using per person. And so we know fairly well what it costs to hire a home care aide, for example, per hour.

Mr. Scanlon. I have spent a lot of my career sort of looking at the differences between Medicare and Medicaid and looking at exactly at this issue that you are talking about which I will call unit costs. And I will have to say that the Medicaid programs, in terms of nursing homes at least, have done sort of much more sort of effective job in terms of trying to keep those costs down. I wish that actually sometimes we could take some of the lessons from those Medicaid programs and apply them sort of within sort of Medicare.

There is actually, I mean, there is a concern that I think that should be raised that relates to your question for the future, which is that as we have sort of more what I will call purchasing power, more people sort of wanting to buy services, we have to worry about what is going to be the impact then sort of on unit costs, because we don't want to necessarily create a system that is so formalized that we build in a lot of overhead. That gauze pad is expensive in a hospital because you pay the overhead as

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well as the cost of the pad. And we want to avoid that when we are paying for more long-term care services.

Mr. Bucshon. Briefly, my time is running low.

Mr. Pitts. The chair thanks the gentleman and now recognizes the gentleman Mr. Cardenas for questions.

Mr. Cardenas. Thank you very much, and thank you, Mr. Chairman, for holding this hearing. But I just, for those of you who came here and had to change your schedule, I want to quote a very knowledgeable famous legislator in California, and I will clean up the phrase a little bit because it was made about 70 years ago. He says, hold on to your horses and your spouses, the legislature is in session. So let us just hope that we have some good constructive not only dialogue but outcomes from this hearing, this legislative hearing.

My first question is for you, Ms. Tumlinson. Until the new policy options are available, what is your thoughts on ensuring that Medicaid remains stable and adequately funded? I mean, in our current environment.

Ms. Tumlinson. So I think that what probably the most productive thing that we can do around Medicaid right now is just continue to work on ways in which we can ensure that individuals who are eligible and for the program are getting the supports and services that they need in the most appropriate setting and the

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most efficient way possible through the use of aging and disability resource centers, for example.

I think that from a budget perspective it is funded through general revenues and the challenge, really, is on the per person level for the states to manage those funds as efficiently as they can while at that same time ensuring access to high quality care.

Mr. Cardenas. Now when it comes to access to high quality care the dynamic is changing, because the demands on that care with the baby boomers seems to be shifting this whole environment. So that being the case, what should we not do right now before we have a more comprehensive solutions and changes? Yes, Ms. Rivlin. Dr. Rivlin.

Ms. Rivlin. Well, I think we should do some of the things that the three reports that have been mentioned are recommending. And one, to come back to the question of saving costs as well as improving quality, is to make it easier to use home and community-based care and make it easier for the states to do that because there is plenty of evidence that it is just better and cheaper if it is done well.

Mr. Cardenas. And also, when it comes to home care I think of the information that I have received, not speaking ill of hospitals or what have you, just because it is an environment where you have so many people with an array of illnesses and reasons

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why they are there, there is a higher likelihood that somebody is going to catch an infection in a hospital, correct, than they would maybe if they were in a different adequate environment, et cetera.

So there are other tertiary reasons why we should make sure that our panoply of solutions takes into account the whole range of reasons why it is a better solution, or better way in which we should deliver care.

Ms. Rivlin. Right. Hospitals are dangerous places to be. But I think working on hospital safety is another aspect.

Mr. Cardenas. And I just want to make sure that I am not casting aspersions on hospitals. One of the most unfair, dumbest statements I have ever heard is that more people die in hospitals than anywhere else. Well, for god's sakes that is where the people are in the worst condition, but more people, their lives are saved because that hospital is there and they have the facility and the professionals to actually put people back together and keep them alive for god's sakes. So I just want to make it clear that this is not a bashing point, it is just trying to remind everybody how involved this very important issue is especially with an aging population.

You were going to say, Doctor?

Mr. Scanlon. No, I mean, I am in total agreement, I think,

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and physicians and hospitals, I think, would also agree with you. I mean, we have seen this decline sort of in length of stay because they recognize sort of that it is in their patients' interests to have them out of there as quickly as possible.

Mr. Cardenas. And these are not funny issues. I mean, I will use a very personal example. My father used to say, why do I want to go to the doctor, so they can tell me I am sick? But little did he realize that when he finally went to the doctor he was 60-some years old, only God knows how long he was a diabetic and had he gone to a doctor and enlisted the help of professionals he would have had a better quality of life. He would have lived longer, et cetera.

And it is not just about my father, it is about the kids and grandkids, et cetera, who don't have him around because unfortunately he thought he was being funny and cute, but what he should have been is a little bit more responsible with all due respect. And so I just want to point out that this is incredibly serious. And again, seriously, Chairman, thank you for holding this hearing.

Mr. Pitts. The chair thanks the gentleman and now recognizes the gentlelady from Indiana, Mrs. Brooks, five minutes for questions.

Mrs. Brooks. Thank you, Mr. Chairman. The figures I have

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seen and that we hear repeated over and over are that we have about 10,000 Americans turning 65 every day and aging into the system, and so the numbers are off the charts. But what we also, I think, are realizing is that the retirees are astoundingly unprepared.

In my district, in 5th district of Indiana, CNO Financial, one of the nation's largest long-term care insurers is headquartered in my district, and I have talked with them on many occasions and they have studied this issue pretty significantly and some of the stats they have found are pretty astounding. What they have found is that half of middle income boomers report investable assets of less than 100,000, with a third reporting assets of less than 25,000. And so they have found at CNO two-thirds of the middle income boomers express doubts whether or not they will have money to live comfortably throughout retirement, eight in ten have not received any specialized training or education on retirement financial security, and six in ten don't receive any professional financial guidance at all.

And so my question to the panel is, I think there is a severe lack of education and of understanding for middle income America about what is coming at them and what they should expect with respect to retirement, and so I am really curious as to what your thoughts are about how we as a country do a far better job. And I would like each of you, what do we need to be doing to share

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with people what is happening because so many people actually, I think, believe that Medicare is going to take care of them in long-term care and that is not the case. And so how do we bridge this gap of a significant under education?

Dr. Rivlin, any ideas?

Ms. Rivlin. Well --

Mrs. Brooks. Because I don't know that -- the reports are great with a lot of ideas, but we just have so few Americans really understanding what is coming at them in retirement.

Ms. Rivlin. That is certainly true. And it is hard to know how to reach the people. It is the people in their middle earning years that you really need to reach. If you do education in school, nobody is going to pay attention because they are too young to worry about it. And so I don't know exactly how we do this, but I think employers are key. And one of the things that I think has come out of behavioral economics in recent years -- economists do some useful things -- is the notion that if you tell people you can opt-out of this, whether it is a savings plan or a long-term care plan, we are not forcing you to take it but the default option is you are in that really works. More people save and we think more people would buy long-term care insurance if it were the default option.

Mrs. Brooks. Thank you, Doctor.

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Mr. Scanlon. I think approaching this as a retirement sort of question is really the right way to go as opposed to thinking that this is only sort of a health care issue. This is a portion of sort of your thinking on planning sort of for retirement. Now the reality is that as some of the statistics that you indicated for us, it is a challenge to think about all your needs in retirement given sort of the resources that you are going to have available. But we need to think about sort of bringing this into the discussion so that people can recognize it and, if possible, sort of prepare for it.

On the issue of sort of being confused that Medicare is going to cover this service, I think we have to stop doing a disservice to Americans at the federal level by having sort of talking about Medicare covering some long-term care. It covers no long-term care. Skilled nursing facilities and home health agencies may provide long-term care services, others, but they are paid by another source when they are providing long-term care services. The services they provide to Medicare are not long-term care. We cannot expect sort of the public to read the footnotes to understand that Medicare is not covering long-term care.

Mrs. Brooks. Thank you. Ms. Tumlinson?

Ms. Tumlinson. Yes, I just agree very much with what Dr. Rivlin and Dr. Scanlon said. And the only thing I would add here

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is just that I think that this is an odd kind of silent crisis in every American family, and for whatever reason we are not having a national dialogue about the fact that our whole demographic structure is going to shift from now on and that retiring at age 65 is not maybe an reasonable expectation if you are going to live to be 95.

So we have to rethink how we think about work, how we think about our old age and that I guess my brilliant idea is I think we need to have much more of a public conversations in our districts, at national level with leadership and even among the private capital and investor community.

Mrs. Brooks. Experts -- oh, I am sorry. I guess my time is up.

Mr. Pitts. That is all right.

Mrs. Brooks. Thank you.

Mr. Pitts. That is all right.

Mrs. Brooks. I yield back.

Mr. Pitts. The chair thanks the gentlelady and now recognizes the gentleman from New York, Mr. Collins, five minutes.

Mr. Collins. Thank you, Mr. Chairman. I want to thank the witnesses from coming in. I am the last one, I think, to ask questions.

Just a little brief history in my case. My dad passed back

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in January of 2010, but prior to that he was through some levels of dementia unable to care for himself at all. So for three years we had a team of seven women who cared for him 24/7. It took seven full-time individuals to care for one person 24/7. Six hour shifts with four individuals with him every second of every day, and then you throw in the weekends. That is the staggering amount of individual time it takes. And the cost for seven full-time individuals was a significant burden, but we determined in our family's case my dad had earned money, it was the right thing to spend it for him to be safe, clean and well fed. But that was not an easy thing to do.

But when I come back again to what Mrs. Brooks was talking about and Dr. Scanlon, would you think it would make sense in the Medicare & You handbook in some bold print to point out Medicare pays no part of this? I mean, we have got a federal handbook that people get.

Mr. Scanlon. I think the no has to be sort of in bold print. I mean, I think that this issue of trying to kind of split hairs and tell them what it covers and what it doesn't cover is confusing people. Because years ago we were doing a survey and 80 percent of the people would say Medicare covers long-term care. It is now maybe around 50 percent would say that.

Mr. Collins. Big bold letters right, top, bottom, in the

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middle, Medicare does not cover any type of long-term care. I think we have got a vehicle in the Medicare & You handbook that we could do a better job at.

My other question, really, carrying it in the same vein is about advance directives, individuals making sure the family knows. I know in our case again with my dad we had a DNR on the refrigerator for emergency personnel just to make sure the wishes of the family were well known, my dad's wishes as well.

But in that regard, I think the federal government now is trying to address that problem of very few people having these advance directives for long-term care in talking about paying physicians to have a small conversation. And Representatives Diane Black, Peter Welch and myself introduced H.R. 4059 which would actually have a small incentive paid by Medicare to individuals to put together a plan. If you are putting together a plan you have to be thinking it through.

I mean, what we were just talking about with Representative -- and myself is the lack of education, people being in denial and so forth. So the bill we are promoting is a very small payment to get somebody attention just would ask if you have any opinions on something like that.

Ms. Tumlinson. Yes, sure. I think that is really creative, actually. And it is absolutely the case that you can even, once

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somebody is even educated about advance directives that they are still very reluctant to have that conversation. Having that conversation between the family member and the older adult is very hard to do. I have tried to do it and my mom said, she said, do you think I am dying? Like not yet.

So I think it is a really creative idea. I think we have to continue to come up with it those because ultimately having a good advance directive someplace can be cost saving.

Mr. Collins. Well, it lets the family be more at ease with what we are talking about. End of life decisions is what our country seems to be unwilling to have discussed.

Mr. Scanlon. I think our education efforts, some clearly is sort of not working, part of it is the message that we have been delivering, but also a part of it is getting the attention of the people that we want to deliver the message to. So your idea is very innovative.

Ms. Rivlin. And part of it is medical education in medical schools, getting young doctors to recognize this is part of your practice. You need to be talking about death and dying.

Mr. Collins. Well, I want to just thank all the witnesses for coming in. This is a discussion we need to be continuing to have as more and more old folks are -- since I was there last May I can joke about it. I have got my card. Mr. Chairman, I

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yield back.

Mr. Pitts. The chair thanks the gentleman and now recognizes the gentleman from Missouri, Mr. Long, five minutes for questions.

Mr. Long. Thank you for recognizing me, Mr. Chairman, even though Mr. Collins failed to do so, and when you are talking about elderly you would think that you would at least recognize me.

Dr. Rivlin, I am interested in the Bipartisan Policy Center's recommendation for creating lower cost, limited benefit, retirement long-term care insurance policy options. Can you provide more details on what a policy like that would look like and how it differs from existing options?

Ms. Rivlin. Yes. What we are suggesting, what we call retirement long-term care insurance, is a bare bones policy. It is not fancy. It would have a high deductible or waiting period and it would have co-insurance and a limited period for which it covered benefits. That doesn't make it sound very desirable. It has other desirable features, but it would cost much less than long-term care insurance typically costs now. And we think if it was marketed properly as part of a retirement plan by employers, and if it were the default option in your retirement plan and if you were allowed to pay the premiums out of your 401(k) beginning at age 45, those are all small changes that we think would make

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it more attractive and more people would buy it.

Mr. Long. Are there any current statutory or regulatory barriers to preventing companies from offering those policies today?

Ms. Rivlin. Yes.

Mr. Long. There are?

Ms. Rivlin. There are in that as you know this kind of regulation is at the state level, and so what we are suggesting is that the NAIC be asked to prepare model regulations that states could then adopt.

Mr. Long. So legislative action that would be something that you would recommend even with at the state level?

Ms. Rivlin. Right.

Mr. Long. Okay. And this is for any of you or all of you on the panel that want to respond. In recent years, state Medicaid programs have been shifting long-term care into a managed care environment. From 2004 to 2012, the number of states with managed long-term services and support programs doubled from eight to 16, and the number of beneficiaries receiving these services grew from 105,000 to 389,000. What have been the experiences of these new programs in terms of improving services for beneficiaries and controlling costs?

Ms. Tumlinson. So there is really a diverse set of

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experiences with managed long-term services and supports throughout the country, but certainly in certain states what we have seen is that the states have been able to use the managed care mechanism to enable a fairly dramatic shift out of nursing home setting and into home and community-based services settings, because the managed care plans are on the ground level with care managers helping to ensure appropriate, and with significant financial incentives to do so to ensure a persistent home care.

I think that it is not, from my perspective, a way that necessarily the state is going to save money over the long term and in many cases the managed care plans are actually able to get paid based on their costs and their experiences, and so I am not sure it is -- I think it is a great mechanism for shifting the services and maybe over time the state would realize some savings from that. But at the same time, I am not sure that I see it as an immediate cost saver.

Mr. Long. Dr. Scanlon, do you care to weigh in?

Mr. Scanlon. No, I would agree, because I think that states when they have not used managed care have been still managing the benefits sort of much more than for medical care services. In looking to the managed care organizations, I think they are working to sort of make sure that there is a capacity to continue to sort of manage that benefit as best as possible, but over time

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it is likely to be inflation in the numbers of people that need services is going to drive the cost.

Mr. Long. Dr. Rivlin, last 30 seconds, do you care to weigh in on that?

Ms. Rivlin. No, I think it is a work in progress.

Mr. Long. Okay. Thank you all and thanks for being here today. Mr. Chairman, I yield back.

Mr. Pitts. The chair thanks the gentleman, and I have a UC request. I would like to submit a statement from the National Association for Home Care & Hospice into the record, and without objection, so ordered.

[The information follows:]

*****COMMITTEE INSERT*****

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Mr. Pitts. That concludes our questions of members present. We will have some follow-up questions in writing. We will send those to you. We ask that you please respond. I remind members they have ten business days to submit questions for the record and that means they should submit their questions by the close of business on Tuesday, March 15.

Excellent, excellent hearing. Excellent testimony. Thank you very much for being here on this very important issue. This is a discussion that our society really needs to have today. Without objection, the subcommittee hearing is adjourned.

[Whereupon, at 12:22 p.m., the subcommittee was adjourned.]