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BROKEN AND UNSUSTAINABLE: THE COST CRISIS OF LONG-TERM CARE FOR BABY BOOMERS

HEARING

BEFORE THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

ONE HUNDRED SEVENTH CONGRESS

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BROKEN AND UNSUSTAINABLE: THE COST CRISIS OF LONG-TERM CARE FOR BABY BOOMERS

THURSDAY, MARCH 21, 2002

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, DC.

The committee met, pursuant to notice, at 9:35 a.m., in room SD–628, Dirksen Senate Office Building, Hon. John Breaux (chairman of the committee) presiding.

Present: Senators Breaux, Carper, and Carnahan.

OPENING STATEMENT OF SENATOR JOHN BREAUX, CHAIRMAN

The CHAIRMAN. The Committee on Aging will please come to order. Our ranking member, Senator Craig, is on his way, so we will go ahead and begin. Our Committee on Aging, as most of you know who are here as guests and also our witnesses, has a responsibility to really look ahead and see that we as a nation are prepared to address the long-term health needs of the pending age wave of 77 million baby boomers that are part of our country who are right on the brink of becoming eligible for entitlement programs such as Social Security and Medicare.

Over the past few years, we have had many hearings on the question of Social Security reform and Medicare reform, and we have tried to find some solutions to these very, very difficult problems.

Now, of equal importance, we are focusing in on the problems that we as a nation are experiencing along with our states on the question of Medicaid, a combination Federal-state program, in trying to find out what the problems are and what we as a nation might do now to prepare for this problem that is awaiting us all.

Medicaid was originally designed, as most people know, as a health program to provide health care for our nation's people who are on the edges and, in fact, are in poverty themselves. It was basically a program for poor people to provide them adequate health care.

It is really tearing into our nation's de facto long-term health program, and it was never intended to do that. But most people in this country now get long-term health care through the Medicaid program, which was originally designed only to provide health care for people in poverty-type conditions.

The unfortunate thing is that you see people having to spend down their life savings in order to be able to qualify. That is degrading and it is not how it should work. So I think it is clear that we as a nation can do much better as we focus in on solutions to long-term health care.

Clearly trying to make the Medicaid program a long-term health care program without significant changes is simply not going to work. It was never intended to do that. We have sort of forced it to try and meet that need. It is interesting to note that the Federal Employees Health Benefit Plan, which I and folks behind me are probably all in and nine million other Federal employees as well, is beginning to offer a program for long-term health care insurance for Federal workers.

I think that that sets a good example as to what are the possible solutions to this very serious problem. But it is an issue that just cannot continue to be ignored and swept under the rug. We have two distinguished witnesses this morning to present testimony.

We are delighted to have Governor Paul Patton of Kentucky who is a distinguished Governor back in Kentucky. It is interesting that they tell me that, Paul, you were the first Governor of Kentucky in 200 years to be reelected to a second consecutive term. That is an outstanding achievement. In my State of Louisiana, you get in once, you are almost guaranteed a second term.

You serve now as vice chairman of the National Governors' Association, and in July will become the chairman of the NGA, and you have been a real leader in this whole effort in determining what we do as a nation in long-term health care and health care problems, and we are very, very pleased to have you give us your thoughts on this issue today.

We also are delighted to have once again David Walker who is Comptroller General of the General Accounting Office and has been there since 1998. I want to thank him for appearing once again. You have been with us, I think, for eight hearings on long-term care and the problems of Medicare and Social Security.

GAO has just done an outstanding job for this committee and for many other committees in the Congress in doing special work on some very significant issues. Mr. Walker himself has a long history on these entitlement reform issues and has served as a public trustee for both Social Security and Medicare, and we have worked with him on these issues and have been very pleased with the work that he has personally done, as well as the work that the General Accounting Office has done, particularly for this committee.

Gentlemen, we thank you both. Governor you may go first. If you would like to start, we would be pleased to have your testimony.

[The prepared statement of Senator Breaux follows along with prepared statements of Senator Craig and Senator Stabenow:]

PREPARED STATEMENT OF SENATOR JOHN BREAUX

This committee has the responsibility to look ahead and see that as a nation we are prepared to handle the long-term care needs of the pending "age wave" of 77 million baby boomers. Over the past few years we have had many hearings on Social Security and Medicare reform and tried to move closer to solutions. Now, of equal importance, we are tackling Medicaid reform and examining Medicaid's growing role in financing long-term care.

Although Medicaid was originally designed to provide health care to low-income women and children, it has become our country's "de facto" payor of long-term care

for elderly and disabled. Most people do not know that Medicaid expenditures are now outpacing Medicare nor do they realize that Medicaid is the second largest expenditure for state budgets. The unsettling notion here is that we have no real, comprehensive long-term care system in this country and yet we are spending billions of dollars for a system that was not designed—it just evolved. Unfortunately, the system we have is inefficient, outdated, incomplete and unable to meet the needs of current or future recipients.

Simply stated, this is an issue that just can't wait.

PREPARED STATEMENT OF SENATOR LARRY CRAIG

Thanks to Chairman Breaux's leadership, this committee has held many hearings on the issue of long-term care. Today we are holding what may prove to be one of the most important hearings on the subject. This hearing will be a hard look at the finances that will be required to care for the 77 million aging baby-boomers as they start retiring within the next ten years.

This committee is very aware that the long-term care system that we have in place now most likely will not be able to accommodate the needs of the soon-to-be-retiring. Not only does our current system lack a coherent system of care that seniors can turn to for help, but as this hearing will demonstrate, a solid financial foundation for the future may not be in place either.

Last week this committee heard from LT. Governor of Idaho, Jack Riggs, and Karl Kurtz, the Director of Idaho Health and Welfare regarding the tight fiscal constraints they have to consider when developing Medicaid and long-term care policies. States like Idaho are having to make substantial changes right now in their policies to provide care to current beneficiaries, and this says nothing of the changes they will need to make to prepare for the future. As I am sure we will hear from Governor Patton, these fiscal strains are felt in all states.

If long-term care financing changes are not made to our current system, both state and federal governments may be unable to meet the needs of the many seniors who depend on these programs. This country has focused many debates on the important need to keep Social Security and Medicare solvent, yet little attention has been given to the need to shore up long-term care finances. For this reason, I am happy the committee is looking at this topic and I welcome the opportunity to discuss this issue further.

I am delighted that Governor Patton is here to share some of the issues that he is facing in Kentucky and I look forward to Mr. Walker's testimony and his analysis on projected spending of long-term care.

PREPARED STATEMENT OF SENATOR DEBBIE STABENOW

Chairman Breaux and Senator Craig, I thank you both for holding this important hearing. Long-term care services are becoming increasingly important. As our population ages and lives longer, the amount of care we need increases. I am glad you are bringing attention to the fact that the way we pay for these health care costs today is increasingly problematic and will need to change as the baby boomers begin to require these services. Today's hearing will provide a basis from which we can create effective and efficient changes for covering these costs.

Today, Medicaid pays a significant amount of long-term care costs. If patients do not meet the strict qualifications for Medicaid, often their only other option is to pay for these critical services out of pocket. Due to the increasing costs of health care and prescription drugs, this option is not available to many of our seniors. We all know that this problem will only get worse as the baby boomers get older. Medicaid funds are already stretched in many states, as we discussed last week. As more and more seniors enter the Medicaid roles, those funds, as they are structured now, will not be adequate to help provide our seniors with quality long-term care.

It is vital that we review how long-term care is funded. we must also review ways in which we can educate and encourage baby boomers and young people alike to invest in long-term care insurance. I am very excited about the new initiative offered to federal government employees and their families for purchasing long-term care insurance. We must consider programs like this and other innovative methods in order to ensure that we provide our seniors with the quality care that they deserve.

I am very interested in hearing from our witnesses today on this important issue.

STATEMENT OF HON. PAUL PATTON, GOVERNOR OF KENTUCKY, FRANKFORT, KY

Governor PATTON. Thank you, Chairman Breaux, for the opportunity to appear before this Special Committee on Aging and discuss some serious problems with long-term care and the Medicaid program. I do appear both as Governor of Kentucky and on behalf of the National Governors' Association, and quite simply we have at present a crisis in Medicaid that is heading toward catastrophe, and so we need to have some short-term relief, and we need long-term solutions.

During the years when revenue was increasing, states were able to keep up more or less with the growing Medicaid expenditure. It was not easy given the pressure to find money for education, public protection, and other vital state services, and it also was not easy given the rapid growth of the cost of Medicaid.

The return of medical inflation and the new dynamic of pharmacy spending, growth of 20 to 25 percent a year, have made it a real challenge. The demands have been such that Medicaid now takes on average 20 percent of state budgets across the country.

Let me illustrate the problem by relating our experiences in Kentucky since I became Governor 6 years ago. During that period, Kentucky state government revenue has increased about 26 percent. The consumer price index has increased 16 percent, so we have had real growth, but we have experienced increases in our expenditure for elementary and secondary education of only 20 percent. That is it did not get its proportional part of the real growth.

Our social programs only grew by 18 percent, barely kept up with inflation. Our Medicaid program has increased 47 percent, almost double the growth in actual state revenue.

When revenue was growing, we really could not say no to the real medical needs of our needy citizens. Now that revenue growth is stagnant, we have no other choice. While my legislature was willing to give Medicaid more than its share of our growth revenue over the past 6 years, it is unwilling to take money away from other needed programs or to raise taxes to pay for double digit annual increases in the cost of providing the services that our Medicaid program has promised to our people.

Because of the downturn in the national economy, the Kentucky general fund revenue in the second year of the next biennium, and we are just right in that budget right now, is estimated to be less than the originally budgeted expenditures for the current fiscal year. Our challenge is to find ways to not cut services when we have less money than we had the year before.

There is absolutely no way that we can absorb a 10-percent increase in Medicaid with a zero percent increase in revenue. Our only choices are to increase taxes, and that is not going to happen, or decrease services, unless the Federal Government steps to the plate and helps us.

We will be forced, and I think this will be true of all the states, to cut optional services and/or optional eligibles by the end of the next biennial budget cycle. This is not what government is supposed to be. So while I am here today to discuss the burden of long-term care costs in the Medicaid program, I want to make an urgent

plea for some short-term relief, specifically, a temporary increase in the Federal match rate to states.

I know, Mr. Chairman, that you and perhaps other members of the committee serve on the Finance Committee, so I would like to ask you to carry this request for us. It is a very important issue to the states. We are having a hard time keeping our heads above water.

But there is another reason that Medicaid programs are in trouble. Demand for long-term care service under the Medicaid program is growing so rapidly that it will bankrupt state budgets unless another form of financing is found, and because of this, Mr. Chairman, I am here to tell you that the Medicaid program is indeed broken and unsustainable.

Traditionally, states took care, as you say, of the poor and the Federal Government took care of the needs of the elderly. Medicaid was created to provide health care to those on welfare, mostly moms and kids and folks that we really expected to eventually get back into the workplace.

But it is fast becoming the program to fund long-term care services in our country, and because the cost of caring for this group is so great, it is crowding out our ability to care for our traditional state mandates. Today, older and disabled beneficiaries account for only one-third of Medicaid beneficiaries, but account for more than two-thirds of Medicare expenditures.

A good bit of the financial burden of caring for the elderly through Medicaid comes to the states through our own decisions to provide coverage for optional programs. In fact, 83 percent of optional Medicaid spending is devoted to the elderly and disabled.

Pharmacy is an optional program, although all 50 states provide pharmacy services. Various spend-down programs for the poor elderly are also optional, but ending these programs is not a realistic option. What we need is flexibility in Federal law to tailor the resources that we have to stretch them as far as possible. Right now it is all or nothing. If you run a program by Medicaid, you cannot limit benefits or require adequate cost sharing, for example.

So I strongly urge that for those optional programs and services, the states should be given broad latitude to design an affordable program. The states have tried to deal with long-term care services in as responsive a way as possible. Through the creation of home and community based waiver programs and services such as adult day care, states have sought to give the elderly choices other than institutional placement, options which the states hope would cost less than inpatient nursing care, but we found in Kentucky—and I do not think it is unique among the states—that the demand for these services is so great that the alternatives ended up being program expansions with no commensurate reduction in facility spending.

Why? For every individual in a nursing home, it is estimated that there are as many as four people in the community who need care. There is a sense of urgency in my remarks today, Mr. Chairman, because at the time when state and Medicaid budgets are rising annually at double digit inflation rates and most states are facing budget deficits, we must find long-range solutions or we will be

ill-prepared to meet the long-care needs of those 77 million baby boomers that you referred to.

This is not an issue that can be put on the back-burner until Social Security and Medicare are reformed. It is an issue that will not wait. Again, I congratulate you for your leadership, Mr. Chairman, and that of the members of the committee for having the foresight to begin resolving this crisis before the real flood of elderly persons comes into the system.

No doubt hard questions about services, funding, expectations, patient responsibility, shared program administration and Federal/state responsibility will need to be asked and answered. When all the Governors met late last month here in Washington under the leadership of NGA Chairman Michigan Governor John Engler, there was absolute agreement that a crisis is at hand, that it must be confronted, and that the program must be changed if we are to serve the needs of our families.

There was also consensus in calling for a national Medicaid commission to recommend fundamental long-term reform of the program. The scope of this commission would include a look at the current and future capability of state government to finance health care for populations and services that Medicaid currently covers, to more clearly delineate between Federal and state roles and responsibilities and to make recommendations on how health care coverage should be provided to those who are dually eligible for both Medicaid and Medicare.

It was recommended that this commission be formed as separate from the NGA and should include bipartisan representatives from the administration, members of the House and Senate, Governors, and nationally recognized experts in the field.

So I urge you to join us in supporting the creation of a Medicaid commission to ensure that the very best minds in our country can elevate this issue to the top of the national agenda. The commission can sort through the complex issues, make recommendations for changes essential to the future of Medicaid program, and I hope enjoy substantial bipartisan support at both levels of government.

We look forward to working with you as our partners because we know that we need to tackle this problem together if we are to succeed. Again, thank you for the opportunity to be with you and we would answer questions at the appropriate time.

[The prepared statement of Governor Patton follows:]

Testimony of
GOVERNOR PAUL E. PATTON
COMMONWEALTH OF KENTUCKY

On Behalf of the
COMMONWEALTH OF KENTUCKY AND
THE NATIONAL GOVERNORS ASSOCIATION

Thursday, March 21, 2002

Chairman Breaux, Senator Craig, and members of the Special Committee on Aging, I thank you for inviting me to testify before your committee on the fiscal status of Medicaid and long-term health care financing. We are grateful that you are providing leadership on this critical health care issue.

Let me first introduce myself. I am Paul Patton, Governor of the Commonwealth of Kentucky and Vice-Chair of the National Governors Association (NGA).

As I think you know – the states have a Medicaid crisis on our hands. It's a very serious situation – in all 50 states – and it calls for short-term relief and long-term solutions.

During years when revenue was increasing, states were able to keep up – more or less – with growing Medicaid expenditures. It wasn't easy, given the pressure to fund education, public protection, and so on. It also wasn't easy given the rapid growth of Medicaid costs. The return of medical inflation and the new dynamic of pharmacy spending growth of 20 to 25 percent per year have made it a real challenge.

The demands have been such that Medicaid now takes, on average, 20 percent of state budgets across this country. Let me illustrate the problem by relating our experience in Kentucky since I was elected Governor six years ago.

Kentucky state revenue has increased 26 percent in those six years while the Consumer Price Index has increased 16 percent. We have increased expenditures for elementary and secondary education by 20 percent; social programs 18 percent; and Medicaid by 47 percent!

When revenue was growing, we couldn't say no to the real medical needs of our needy citizens. Now that revenue growth is stagnant, we have no other choice. While my legislature was willing to give Medicaid more than its share of its growth revenue over the past six years, it is unwilling to take money away from other needed programs or to raise taxes to pay for double digit annual increases in the cost of providing services our Medicaid program has promised to our people.

Because of the downturn in the national economy, Kentucky General Fund revenue in the second year of the next biennium is estimated to be <u>less</u> than the budgeted expenditures for the current fiscal year!!!

Our challenge is to find a way to not cut services when we have less money than we had the year before. There is absolutely no way we can absorb a 10 percent increase in Medicaid with

a zero increase in revenue. Our only choices are to increase taxes – which isn't going to happen – or decrease services....unless the federal government steps up to the plate and helps us. We will be forced – and I think this is true of all states – to cut optional services and/or optional eligibles by the end of the next biennial budget cycle. This is not what government is supposed to be!

So while I am here today to discuss the burden of long-term care costs to the Medicaid program, I want to make an urgent plea for some short-term relief. Specifically, a temporary increase in the federal match rate to states – known as FMAP. I know, Mr. Chairman, that you, and perhaps other members of the Committee, serve on the Finance Committee. So I ask you to carry this request for us. It is very important to states that are having a hard time keeping their heads above water.

But there's another reason that Medicaid programs are in trouble – and this one doesn't always find its way onto the list of likely suspects. The demand for long-term care services under Medicaid will bankrupt state budgets unless another form of financing is found. And because of this, Mr. Chairman, I am here to tell you that this program is indeed broken and unsustainable.

Traditionally, states took care of the poor and the federal government took care of the needs of the elderly. Medicaid was created to provide health care to those on welfare – mostly moms and kids and mostly folks we expected to return to the workplace – but it is fast becoming the program to fund long-term care services in this country. And because the cost of caring for this group is so great, it is crowding out our ability to care for our traditional state mandates. Today older and disabled beneficiaries account for roughly one-third of Medicaid beneficiaries...and more than two-thirds of Medicaid expenditures.

And it didn't happened by design, Mr. Chairman. It has happened by default.

- It happened first when Title XIX (19) or Medicaid was created in the mid-sixties. A financing strategy was needed to pay for folks in nursing facilities who had exhausted their resources. That responsibility was given to Medicaid, but little did anyone guess that nearly Medicaid would today fund 60 percent of the nursing facility beds in this country.

- It happened again in the late eighties, when we realized we couldn't exhaust a **couple's** resources so that the husband or wife in a nursing facility would be eligible for Medicaid. What would the remaining spouse in the community do with no resources? So spousal impoverishment policies were developed and many more individuals became eligible for long-term care via Medicaid.

- Again in the eighties, the Medicare Catastrophic Act gave states significant new responsibility for those on Medicare but with low incomes. While the needs of these individuals -- known as "dual eligibles" -- are great and need to be addressed, it has added significantly to state responsibility. While these dually eligibles represent only 17 percent of total Medicaid beneficiaries, they account for approximately 35 percent of Medicaid expenditures.

- It can also happen when Medicare trims its service coverage. The Balanced

Budget Act of 1997 reduced spending for Medicare, which resulted in cuts to home health services. As a result, a number of services and supplies for homebound elderly were no longer covered by Medicare. Those services were picked up by the states for all the dually eligibles.

- And finally, Mr. Chairman, recent proposals for a Medicare drug benefit for seniors have set off alarms in state capitols. Some of the plans call for a shared federal-state program, administered by the states. I don't think I need to tell you that the Governors believe that a Medicare drug benefit should be covered by and administered by Medicare. It seems to me that Medicare is an incomplete program if it doesn't provide assistance to elderly persons for the three most important components of their health care: physician services, hospital services **and** pharmacy services.

A good bit of the financial burden of caring for the elderly through Medicaid comes to the states through their own decisions to provide coverage of optional programs. In fact, 83 percent of optional Medicaid spending is devoted to the elderly and disabled. Pharmacy is an optional program – though all fifty states provide pharmacy services. Various spenddown programs for the poor elderly are also optional programs. But ending these programs is not a realistic or at least an attractive option for governors and state legislatures. What we need is flexibility in federal law to tailor the resources we have to stretch them as far as possible. Right now, it's all or nothing – if you run a program via Medicaid, you cannot limit benefits or require adequate cost sharing, for example. I strongly urge that for those optional programs and services, the states should be given broad latitude to design an affordable program.

Because so much of the Medicaid program has been enacted piecemeal, it has created a patchwork of eligibility categories and rules and regulations that are only good for the consultants that we need to hire to explain it to us. It is certainly not good for elderly Americans trying to negotiate their way through programs they badly need.

It makes little sense to me that services for the same group of people should be so divided. How can we manage the care of individuals when one branch of government is handling physician, hospital, lab services and so on, and another is trying to manage pharmacy and long-term care? Home health services are provided through both Medicaid and Medicare. Can you imagine if health plans tried to divide care in this way? Drug use can reduce hospitalizations. Physicians can reduce the number of prescriptions written. Home health can reduce or delay inpatient nursing care. But there is no way any of these savings will be achieved with the current fractured system. There is no unified incentive and that is basic to managed care.

The states have, by the way, tried to deal with long-term care services in as responsive a way possible. Through the creation of Home and Community Based Waiver Programs, and services such as Adult Day Care, states have sought to give the elderly choices other than institutional placement; options which the states hoped would cost less than inpatient nursing care. We found in Kentucky, however, – and I don't think it's unique among the states – that the demand for these services is so great, that the alternatives end up being program expansions with no commensurate reduction in facility spending. Why? For every individual in a nursing home, it is estimated that there are four people in the community who need care.

There is a sense of urgency in my remarks today, Mr. Chairman. At a time when state Medicaid budgets are rising annually at double digit inflation rates and most states face budget

deficits, we must find long range solutions or we will be ill-prepared to meet the long-term care needs of 77 million baby boomers when they retire.

This is not an issue that can be put on the back burner until Social Security and Medicare are reformed. It is an issue that will not wait. Again, I congratulate your leadership, Mr. Chairman, and that of the members of this Committee, for having the foresight to begin resolving this crisis before the real flood of elderly persons comes into the system. No doubt, hard questions about services, funding, expectations, patient responsibility, shared program administration and federal-state responsibility will need to be asked and answered.

When all the Governors met late last month in this city, under the leadership of NGA Chairman and Michigan Governor John Engler, there was absolute agreement that a crisis is at hand, that it must be confronted, and that the program must be changed if we are to serve the needs of our families. There was also consensus in calling for a national Medicaid Commission to recommend fundamental long-term reform of the program.

The scope of this Commission would include a look at the current and future capability of state government to finance health care for populations and services that Medicaid currently covers; to more clearly delineate between federal and state roles and responsibilities; and to make recommendations on how health care coverage should be provided to those who are dually eligible for both Medicaid and Medicare.

It was recommended that this Commission be formed separate from the NGA and should include bipartisan representatives from the Administration, members of the House and Senate, Governors and nationally recognized experts in the field.

I urge you to join us in supporting the creation of a Medicaid Commission to ensure that the very best minds in our country can elevate this issue to the top of the national agenda. The Commission can sort through the complex issues, make recommendations for changes essential to the future of the Medicaid program, and – I hope -- enjoy substantial bipartisan support at both our levels of government. We would look forward to working with you as partners because we know we need to tackle this together if we are to succeed. I would be glad to respond to questions.

Medicare and Medicaid

When the federal and state shares of Medicaid are considered together, Medicaid enrollees and expenditures currently exceed Medicare's enrollees and expenditures.

- For FY 2002, Medicaid beneficiaries will total 44 million, while Medicare beneficiaries will total 40 million.
- For FY 2002, total Medicaid expenditures (state and federal) will total $250.4 billion, while Medicare expenditures will total 227.2 billion.

Medicaid Expenditures for the Elderly and Disabled

Older and disabled beneficiaries account for roughly 1/3 of beneficiaries but more than 2/3rds of expenditures.

- While the elderly and disabled account for about **30 percent** *or about one-third* of all Medicaid beneficiaries — expenditures for older and disabled beneficiaries account for about *two-thirds* (70 percent) of total program expenditures.

- In 1998, 57 percent of Mandatory Medicaid spending was devoted to the Elderly and Disabled, while 30 percent was devoted to children and 13 percent to parents.

- In terms of optional Medicaid spending, (which includes coverage for prescription drugs)—83 percent of spending was devoted to the elderly and disabled, while 8 percent was devoted to children and 9 percent to parents.

- Medicaid is now the nation's primary public financier of long-term care. The program should no longer be considered a welfare related program.

- A national survey, conducted in December of 2000, indicated that 37 percent of Medicaid enrollees were receiving cash welfare assistance—while 63 percent were not.

Medicaid and the Dually Eligible

While a small proportion Medicaid beneficiaries, the dually eligible account for approximately 35 percent of Medicaid expenditures.

- Of all Medicaid beneficiaries, approximately 17 percent are dually eligible for both the Medicare and Medicaid programs. While a small proportion of Medicaid beneficiaries, the dually eligible account for approximately 35 percent of Medicaid expenditures.

- Medicaid pays Medicare premiums and co-pays for dually eligible persons. Dually eligible persons are also eligible to receive Medicaid's long-term care and prescription drug benefits.

- Dually eligible persons are often in poor health and use a high proportion of long-term care and prescription drug services—neither of which is available under the Medicare program.

Long-Term Care Expenditures

The primary sources of funding for long-term care are Medicaid and out-of-pocket spending.

o A March 2002 article published in *Health Affairs,* indicated that 1998 total long-term care expenditures for elderly and disabled persons (nursing home care and home care) totaled $150 billion.

o The primary sources of financing for long-term care were Medicaid (40percent) and out-of-pocket spending (26 percent)—accounting for two-thirds of all national long-term care spending (66 percent).

- Medicare expenditures for skilled nursing care—which is limited to 100 days and usually related to a hospital stay or outpatientprocedure—
accounted for only 20 percent of overall expenditures.

- Private insurance covered 8 percent of expenditures.
- Other sources accounted for 7 percent of expenditures.

Medicaid Expenditures for Long-Term Care

The vast majority of Medicaid long-term care spending goes to nursing homes.

o Of the $150 billion spent in 1998 on long-term care—$100 billion went to nursing home care.

o Of the $100 billion spent on nursing home care, Medicaid expenditures totaled 44 percent and out of pocket spending totaled 31 percent—accounting for three – quarters of all nursing home expenditures.

- Medicare expenditures totaled 14 percent
- Private insurance expenditures totaled 7 percent
- Other sources accounted for 5 percent of expenditures.

o At present, the national average annual cost of nursing home care is nearly $56,000.

Prescription Drug Coverage: The Other Long-Term Care

Most older persons have at least one chronic condition and many have multiple conditions. Many of these conditions are treatable with prescription drugs.

o Beginning in 1998, and continuing into the present, prescription drug coverage—which is not available under the Medicare program—exceeded physician

services as the most utilized Medicaid Service.

- The most frequently occurring chronic conditions among the elderly are arthritis, hypertension, heart disease, cancer, diabetes and stroke. Most of these conditions are treatable with prescription drugs.

- Older Americans now buy about 29 prescriptions annually.

- In 2000, Medicaid expenditures for prescription drugs totaled approximately $21 billion, representing about 10percent of Medicaid expenditures in 2000.

- CBO indicates that Medicaid program growth over the next ten years is expected to grow by 8.5 percent.

- At the same time, for FY 2002, CMS estimates that spending for prescription drugs is estimated to increase by 16 percent or about double the increase in the overall Medicaid program.

- In a recent survey, Medicaid officials in 36 states listed pharmacy costs as the top cost driver in the Medicaid program in 2001. In an additional 12 states, the rising cost of prescription drugs was considered to be among the top two or three cost drivers in Medicaid.

- Increases in the cost of prescription drug prices are attributable to:

  - Increases in the number of prescriptions per enrollee.
  - Inflation in the cost of each prescription.
  - According to the National Institute of Health Care Management, escalating sales from 23 relatively new medications accounted for about 50 percent of the spending increase in prescription drugs nationally.

Recent Increases in Medicaid Costs for the Elderly and Disabled

Between 2001 and 2002, the increased cost of caring for elderly and disabled Medicaid beneficiaries was the single largest factor behind the $12.4 billion dollar increase in Medicaid growth.

- Of the $12.4 billion increase, $7 billion or 56 percent of the increase was attributable to the elderly and disabled.

- Among the elderly and disabled, 83 percent of this increase is attributable to inflation – including inflation in the cost of prescription drugs.

Steps States are Taking to Control Medicaid Costs Today

In order to balance their FY 2003 Budgets, states are taking a number of strategies steps to control Medicaid spending.

According to the Kaiser Family Foundation:

- *Imposing restrictions on prescription drugs.* As the cost of prescription drugs has increased faster than any other component of Medicaid, strategies include:

  - Contracting with Pharmacy Benefit Managers (PBMs).
  - Imposing prior authorization requirements on selected brand-name drugs.
  - Limiting the number of prescriptions that beneficiaries are allowed per month.
  - Reducing the amounts paid to pharmacists for filling prescriptions.
  - Reducing the amount Medicaid pays for pharmaceuticals.

- *Limiting payments to nursing homes and other providers.* In addition to the rising cost of prescription drugs, the largest areas of Medicaid spending are payments to hospitals and nursing homes—where services are overwhelmingly provided to seniors. For 2002, states have postponed or reduced provider payments and for 2003, many are considering provider payment freezes.

- *Limiting Access to Home and Community Based Services.* Although very popular, states are deferring expansions in their Home and Community Based Services Waiver programs as one means of controlling costs.

- *Reducing Eligibility.* Strategies include lowering the income standard for the dually eligible, and delaying implementation of Buy-In programs for the working disabled.

- *Increasing Co-Payments*. For pharmaceuticals and for other medical services including dental services and vision services.

Medicaid and Long-Term Care Growth Tomorrow

Spending for long-term care is expected to rise rapidly over the next decade.

- According to a March 2002 analysis of National Health Expenditures conducted by staff of the Office of the Actuary at the Centers for Medicare and Medicaid Services (CMS) -- spending for nursing home and home health care is expected to rise by nearly $100 billion, from $135.1 billion in 2001, to 237.2 billion in 2011.

- The same analysis also indicates that during the same period, prescription drug prices are expected to nearly triple, rising from $141.8 billion in 2001 to $413.9 billion in 2011.

- This recent National Health Expenditure survey indicates that Medicare costs are

expected to rise from $245.6 billion in 2001 to $450.1 billion in 2011.

o At the same time, the federal and state Medicaid expenditures are expect to rise from $226.1 billion in 2001 to $521.8 billion in 2011 -- exceeding costs in the Medicare program.

- This means that by 2011, the state share of the Medicaid program alone ($220.3 billion) will be close to total state and federal funding for the Medicaid program in 2001 ($226.1. billion).

o Moreover, the January 2002 Budget and Economic Outlook issued by the Congressional Budget Office (CBO) indicates that within the Medicaid program -- the federal share of long-term care expenses alone -- is expected to rise from $42 billion in 2002 to $98 billion in 2012. This rise would account for about one-third of all federal Medicaid spending over the period.

Long-term Care Expenditures: Looking Ahead

Demand for long-term care these services will increase when the baby-boom generation begins to grow old.

o Issues pertaining to long-term care financing will impact not only publicly financed programs -- but individual Americans their families as well – after Medicaid, most long-term care expenditures are paid for out-of-pocket.

o For every individual in a nursing home, it is estimated that there are approximately 4 people in the community who require care.

o Caregivers to individuals aged 65 and over, are most often daughters who devote 20 hours a week to caring for a loved one. Caregivers spend on average 4.5 years providing care. Researchers estimate that the annual cost of caregiving in terms of lost productively to U.S. businesses totals $11.9 billion annually.

o Over our lifetimes, and as we age, we can all be expected to need a mix of services including hospital care, short-term skilled nursing care, long- term care in or homes or in assisted living facilities or in institutional care. Long-term care is not an either or proposition – nor is it a Medicare vs. Medicaid issue – it is most of all – an issue about the health care needs of our mothers and fathers and eventually ourselves.

o Long-term care expenditures have to be viewed through a wider lens – one that will adequately reflect the current and future needs of our society.

o This is among the many reasons NGA has endorsed the notion of a Medicaid Commission.

Unfortunately, this is all coming to pass as states face an ongoing erosion of their revenue base. Even when states begin to recover from this recession—a time which, based on our

experiences in previous recoveries, is likely to lag national economic recovery by as much as 18 months—that recovery will not replace the elimination of nearly $90 billion in estate tax revenues, much less the growing erosion of the single most important source of state revenues, sales taxes, to electronic commerce.

The CHAIRMAN. Thank you very much, Governor Patton, for a very precise and concise statement. We appreciate your being with us and for your leadership. We would like to recognize now Mr. David Walker, David, for any comment that you might have.

STATEMENT OF HON. DAVID WALKER, COMPTROLLER GENERAL, U.S. GENERAL ACCOUNTING OFFICE, WASHINGTON, DC

Mr. WALKER. Thank you, Mr. Chairman.

The CHAIRMAN. Plus charts.

Mr. WALKER. There we go. We have got some big charts for you. These are big numbers. You need big charts.

The CHAIRMAN. Those may get the award for the largest charts, I will tell you that.

Mr. WALKER. You will need a bigger room next time.

The CHAIRMAN. Wow.

Mr. WALKER. Mr. Chairman, it is always a pleasure to appear before you in your various capacities and here as chairman of the Special Committee on Aging to talk about a very important topic, and that is long-term care. I would ask, Mr. Chairman, that my entire statement be entered into the record if that is all right, and I will move to summarize it now.

The CHAIRMAN. Without objection.

Mr. WALKER. Thank you. I think it is important to be able to put the issue of long-term care in context. On the right, Mr. Chairman, I know this is a graphic that you have seen previously in various capacities including your capacity as a member of the Senate Finance Committee.

I think we have to put this in the broader context. Because of known demographic trends including the aging baby boom generation and rising health care costs, primarily because of those two reasons, the Federal Government faces severe long-range fiscal challenges of unprecedented proportions.

The chart on the right shows that if we assume that tax levels as a percentage of the economy—these are Federal tax levels, percentage of GDP, which is the black line—if they stay constant, and if we assume that discretionary spending grows at the rate of GDP, which is historically what it has done over the last 10 to 20 years, and if we assume that the Medicare and Social Security trustees' best estimate assumptions are reasonable, then this is what our future looks like at the Federal level, that by the year 2030, we will be faced with a choice of either cutting discretionary spending by two-thirds or raising taxes at the Federal level alone by 30 percent or some combination thereof.

The CHAIRMAN. The green is discretionary.

Mr. WALKER. The green is discretionary. That is correct, Mr. Chairman. As you know, discretionary includes certain things like national defense, it includes our judicial system, infrastructure investments, the Federal portion of education, and a variety of other items that are deemed to be discretionary spending.

If we look out to 2050, the Federal Government faces a choice of either doubling Federal taxes or cutting Federal spending in its entirety by 50 percent. Now, again, these are based on CBO's projections of economic growth. It is based upon the Social Security and

Medicare trustees' best estimate assumptions, and I think a reasonable assumption of what discretionary spending is likely to grow in the future.

The CHAIRMAN. Could I interrupt?

Mr. WALKER. Yes, Mr. Chairman.

The CHAIRMAN. If you had another block in there between 2000 and 2030, you know, split the difference, and maybe 2015, where would that line likely to be?

Mr. WALKER. Well, as you know, Mr. Chairman, it gets progressively worse between 2000 and 2030. These are just point in time estimates, and I think one key date, Mr. Chairman, would be in 2016 based upon the last Social Security and Medicare trustees' report. That is when Social Security and Medicare start turning negative cash-flow which has real fiscal implications for the government. Even though the trust funds still have assets, we start running negative cash-flow at that point in time.

The CHAIRMAN. In Social Security?

Mr. WALKER. Social Security and Medicare.

The CHAIRMAN. And Medicare both.

Mr. WALKER. We would be more than happy to provide that information for you if you want.

The CHAIRMAN. I think that would be helpful to show that a lot of Members of Congress—I do not mean to interrupt your testimony.

Mr. WALKER. No, that is fine.

The CHAIRMAN. But since it is just you and I, we can do that. The question is a lot of members will think I am not going to be here in 2030, you know, somebody else will solve that problem then. I am looking in the short term. The short term really is 2015. I mean that is not that far in the distance as far as making changes now that will be available in 2015.

So I think to bring it closer to a sense of immediacy, you know, I think it would be helpful to concentrate on that 2016 timeframe and let us see something on that. 2050, I mean, you know, nobody in this room will probably be here, I guess. Well, maybe.

Mr. WALKER. Well, I hope some of the people against the back wall will be. I am sure they do, too.

The CHAIRMAN. As chairman of the Aging Committee, I stand corrected. You are right. [Laughter.]

But I mean if you give us something on that 2015, I think it would be very helpful.

Mr. WALKER. I think your point is an excellent one, Mr. Chairman. We will do that.

But I think while it is important to be able to help members understand this, and I think that clearly would be a help, I think members also have children and grandchildren, in some cases great-grandchildren. I think one of the things that I find that you have to do is to be able to put a face on these issues, and sometimes by thinking of close family members and loved ones, that helps to do it.

So that is our future. It is clearly unacceptable. It is clearly one that we have to face some difficult choices. As you see the red, the red represents Medicare and Medicaid. By far, the fastest growing portion until we end up getting to a period of time where debt

starts amassing and therefore interest ends up becoming a major portion.

If we look on the left here, Mr. Chairman, you will see the projected burdens of Social Security and Medicare and Medicaid as a percentage of GDP, as a percentage of our economy, and you will see how they are projected to grow dramatically.

Interestingly, while Medicaid clearly represents a major challenge for the state governments, as Governor Patton has noted, and while their challenge is a more immediate challenge, and one that obviously they believe cries out for action, at the Federal level, Medicaid is actually our smallest challenge, although a considerable one, as it relates to these three major entitlement programs.

The bottom line is that we are going to have to make some tough choices because we now have a situation where we have made promises that are unsustainable, and we are going to have to go about reconciling the differences between what people want versus what they need versus what can be afforded and what can be sustained over the longer term.

There is a huge expectation gap among individuals, and I think at the Federal and state level that ultimately we have to move to try to reconcile.

The next board, I think, is helpful to be able to demonstrate what is happening in the long-term care area, because the next board will demonstrate that long-term care, and these are in constant 1999 dollars, is projected to increase significantly, as the Governor mentioned, in the years ahead, and the red represents the Medicaid portion of spending as it relates to total long-term care.

Bottom line, Mr. Chairman, I think one of the things we have to keep in mind is that long-term care is not just a health care issue. It also comprises a variety of services for the aged and disabled persons that deal with maintaining quality of life, including housing, transportation, nutrition and social support, to help maintain independent living.

Given the challenges of providing and for paying for these different types of services and the growing population and the growing needs, we think it is important to be able to look at this from a variety of dimensions which I lay out on page two of my testimony. You need to look at what is the appropriate division of responsibilities, not only between the Federal and state levels of government but also between individuals, family members and government and other parties, to look at the potential role of social insurance and financing, to do more with regard to education to encourage people to prepare more for what is likely to be a significant need in future years, to recognize the fact that much of this care is provided by family members or other friends and loved ones, and that that does impose certain burdens and costs on those parties, to recognize that we are not going to be able to fiscally sustain the current system. We are going to have to make some tough choices.

In addition, I think it is also important to note that if you are going to look at Medicaid, that we need to consider changes in Medicaid or long-term care or long-term care as it relates to Medicaid and changes there as it relates to our broader health care challenges, Medicare and other challenges, because they do have domino effects.

One of the things that the Congress is considering right now is whether or not to add a prescription drug benefit. Clearly, when Medicare was created in 1965, prescription drugs were not as important or prevalent. They now are. However, we already know that we have got an unsustainable program, and so we are going to have to start making some tough choices as to how should this program be designed, administered, how should the burdens be shared, and there are things that could be done in the short term that quite frankly we may not be able to fiscally sustain in the longer term. Trying to be able to recognize that and have that as an important part of current debates, we believe is imperative for our children, grandchildren and those that will go after them.

So Mr. Chairman, I hope this is helpful to you, and I am more than happy to be able to answer any questions that you may have and Senator Carnahan.

[The prepared statement of Mr. Walker follows:]

United States General Accounting Office

GAO

Testimony

Before the Special Committee on Aging, U.S. Senate

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LONG-TERM CARE

Aging Baby Boom Generation Will Increase Demand and Burden on Federal and State Budgets

Statement of David M. Walker
Comptroller General of the United States

GAO-02-544T

Mr. Chairman and Members of the Committee:

I am pleased to be here today as you discuss the effects of the aging baby boom generation on the demand for long-term care services and the challenges that increased demand will bring for federal and state budgets. In general, the aging of the baby boom generation will lead to a sharp growth in federal entitlement spending that, absent meaningful reforms, will represent an unsustainable burden on future generations. As the estimated 76 million baby boomers born between 1946 and 1964 become elderly, Medicare, Medicaid, and Social Security will nearly double as a share of the economy by 2035. We have been able to sustain these entitlements in the past with low depression-era birth rates and a large postwar workforce. However, absent substantive reform of entitlement programs, a rapid escalation of federal spending for Social Security, Medicare, and Medicaid beginning in less than 10 years from now is virtually certain to overwhelm the rest of the federal budget.

Most attention has been focused on the need for Social Security and Medicare reform in order to maintain their viability and ability to meet programmatic commitments. As I have testified before various committees, Social Security and Medicare's Hospital Insurance trust funds will face cash deficits not long after the first baby boomers are eligible to retire. While these are important issues, a broader focus should also include Medicaid, particularly as it involves financing long-term care. Long-term care includes an array of health, personal care, and supportive services provided to persons with physical or mental disabilities. It relies heavily on financing by public payers, especially Medicaid, and has significant implications for state budgets as well as the federal budget.

My remarks today will focus on (1) the pressure that entitlement spending for Medicare, Medicaid, and Social Security is expected to exert on the federal budget in coming decades; (2) how the aging of the baby boom population will increase the demand for long-term care services; and (3) how these trends will affect the current and future financing of long-term care services, particularly in federal and state budgets. I will also highlight several considerations for any possible reforms of long-term care financing.

In summary, as more and more of the baby boom generation enters retirement over the coming decades, entitlement spending for Medicare, Medicaid, and Social Security is expected to absorb correspondingly larger shares of federal revenue and threatens to crowd out other spending. The aging of the baby boomers will also increase the demand for long-term

care and contribute further to federal and state budget burdens. Estimates suggest the future number of disabled elderly who cannot perform basic activities of daily living without assistance may be double today's level. Current problems with the provision and financing of long-term care could be exacerbated by the swelling numbers of the baby-boom generation needing care. These problems include whether individuals with disabilities receive adequate services, the potential for families to face financially catastrophic long-term care costs, and the burdens and social costs that heavy reliance on unpaid care from family members and other informal caregivers create coupled with possibly fewer caregivers available in coming generations. Long-term care spending from all public and private sources, which was about $137 billion for persons of all ages in 2000, will increase dramatically in the coming decades as the baby boom generation ages. Spending on long-term care services just for the elderly is projected to increase at least two-and-a-half times and could nearly quadruple in constant dollars to $379 billion by 2050, according to some estimates. Without fundamental financing changes, Medicaid—which pays over one-third of long-term care expenditures for the elderly—can be expected to remain one of the largest funding sources, straining both federal and state governments.

In considering any long-term care financing reforms in light of these anticipated demands for assistance and budgeting stresses, it is important to keep in mind that long-term care is not just about health care. It also comprises a variety of services an aged and/or disabled person requires to maintain quality of life—including housing, transportation, nutrition, and social support to help maintain independent living. Given the challenges in providing and paying for these myriad and growing needs, several considerations for shaping reform proposals include:

- determining societal responsibilities;
- considering the potential role of social insurance in financing;
- encouraging personal preparedness;
- recognizing the benefits, burdens, and costs of informal caregiving;
- assessing the balance of state and federal responsibilities to ensure adequate and equitable satisfaction of needs;
- adopting effective and efficient implementation and administration of reforms; and
- developing financially sustainable public commitments.

Background

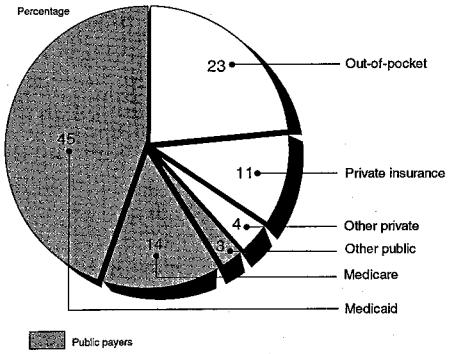
Long-term care includes many types of services needed when a person has a physical or mental disability. Individuals needing long-term care have varying degrees of difficulty in performing some activities of daily living without assistance, such as bathing, dressing, toileting, eating, and moving from one location to another. They may also have trouble with instrumental activities of daily living, which include such tasks as preparing food, housekeeping, and handling finances. They may have a mental impairment, such as Alzheimer's disease, that necessitates supervision to avoid harming themselves or others or assistance with tasks such as taking medications. Although a chronic physical or mental disability may occur at any age, the older an individual becomes, the more likely a disability will develop or worsen.

According to the 1999 National Long-Term Care Survey, approximately 7 million elderly had some sort of disability in 1999, including about 1 million needing assistance with at least five activities of daily living. Assistance takes place in many forms and settings, including institutional care in nursing homes or assisted living facilities, home care services, and unpaid care from family members or other informal caregivers. In 1994, approximately 64 percent of all elderly with a disability relied exclusively on unpaid care from family or other informal caregivers; even among elderly with difficulty with five activities of daily living, about 41 percent relied entirely on unpaid care.

Nationally, spending from all public and private sources for long-term care for all ages totaled about $137 billion in 2000, accounting for nearly 12 percent of all health care expenditures.[1] Over 60 percent of expenditures for long-term care services are paid for by public programs, primarily Medicaid and Medicare. Individuals finance almost one-fourth of these expenditures out-of-pocket and, less often, private insurers pay for long-term care. Moreover, these expenditures do not include the extensive reliance on unpaid long-term care provided by family members and other informal caregivers. Figure 1 shows the major sources financing these expenditures.

[1]Based on our analysis of data from the Office of the Actuary of the Centers for Medicare and Medicaid Services and The MEDSTAT Group. These figures include long-term care for all people, regardless of age. Amounts do not include expenditures for nursing home and home health services provided by hospital-based entities, which are counted generally with other hospital services.

Figure 1: Medicaid Is the Largest Funding Source for Long-Term Care



Note: Amounts do not include unpaid care provided by family member or other informal caregivers or expenditures for nursing home and home health services provided by hospital-based entities.

Source: GAO analysis of 2000 data from the Centers for Medicare and Medicaid Services and The MEDSTAT Group.

Medicaid, the joint federal-state health-financing program for low-income individuals, continues to be the largest funding source for long-term care. Medicaid provides coverage for poor persons and to many individuals who have become nearly impoverished by "spending down" their assets to cover the high costs of their long-term care. For example, many elderly persons become eligible for Medicaid as a result of depleting their assets to pay for nursing home care that Medicare does not cover. In 2000, Medicaid paid 45 percent (about $62 billion) of total long-term care expenditures. States share responsibility with the federal government for Medicaid, paying on average approximately 43 percent of total Medicaid costs. Eligibility for Medicaid-covered long-term care services varies widely among states. Spending also varies across states—for example, in fiscal year 2000, Medicaid per capita long-term care expenditures ranged from $73 per year in Nevada to $680 per year in New York. For the national average in recent years, about 53 to 60 percent of Medicaid long-

term care spending has gone toward the elderly. In 2000, nursing home expenditures dominated Medicaid long-term care expenditures, accounting for 57 percent of its long-term care spending. Home care expenditures make up a growing share of Medicaid long-term care spending as many states use the flexibility available within the Medicaid program to provide long-term care services in home- and community-based settings.[2] Expenditures for Medicaid home- and community-based services grew ten-fold from 1990 to 2000—from $1.2 billion to $12.0 billion.

Other significant long-term care financing sources include:

- Individuals' out-of-pocket payments, the second largest payer of long-term care services, accounted for 23 percent (about $31 billion) of total expenditures in 2000. The vast majority (80 percent) of these payments were used for nursing home care.
- Medicare spending accounted for 14 percent (about $19 billion) of total long-term care expenditures in 2000. While Medicare primarily covers acute care, it also pays for limited stays in post-acute skilled nursing care facilities and home health care.
- Private insurance, which includes both traditional health insurance and long-term care insurance,[3] accounted for 11 percent (about $15 billion) of long-term care expenditures in 2000. Less than 10 percent of the elderly and an even lower percentage of the near elderly (those aged 55 to 64) have purchased long-term care insurance, although the number of individuals purchasing long-term care insurance increased during the 1990s.

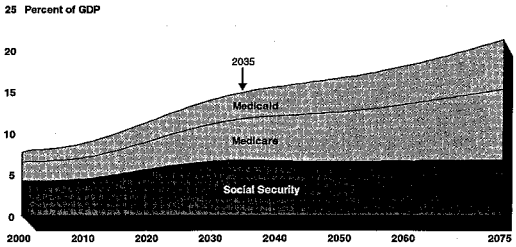
[2]Through Medicaid home-and community-based services, states cover a wide variety of nonmedical and social services and supports that allow people to remain in the community. These services include personal care, personal call devices, homemakers' assistance, chore assistance, adult day health care and other services that are demonstrated as cost-effective and necessary to avoid institutionalization. In their home- and community-based services programs, however, states often limit eligibility or the scope of services in order to control costs.

[3]Private long-term care insurance commonly includes policies that provide coverage for at least 12 months of necessary services—as demonstrated by an inability to perform a certain number of personal functions or activities of daily living—provided in settings other than acute-care hospital units.

Absent Reform, Spending for Medicaid, Medicare, and Social Security Will Put Unsustainable Pressure on the Federal Budget

Before focusing on the increased burden that long-term care will place on federal and state budgets, it is important to look at the broader budgetary context. As we look ahead we face an unprecedented demographic challenge with the aging of the baby boom generation. As the share of the population 65 and over climbs, federal spending on the elderly will absorb a larger and ultimately unsustainable share of the federal budget and economic resources. Federal spending for Medicare, Medicaid, and Social Security are expected to surge—nearly doubling by 2035—as people live longer and spend more time in retirement. In addition, advances in medical technology are likely to keep pushing up the cost of health care. Moreover, the baby boomers will be followed by relatively fewer workers to support them in retirement, prompting a relatively smaller employment base from which to finance these higher costs. Under the 2001 Medicare trustees' intermediate estimates, Medicare will double as a share of gross domestic product (GDP) between 2000 and 2035 (from 2.2 percent to 5.0 percent) and reach 8.5 percent of GDP in 2075. The federal share of Medicaid as a percent of GDP will grow from today's 1.3 percent to 3.2 percent in 2035 and reach 6.0 percent in 2075. Under the Social Security trustees' intermediate estimates, Social Security spending will grow as a share of GDP from 4.2 percent to 6.6 percent between 2000 and 2035, reaching 6.7 percent in 2075. (See fig. 2.) Combined, in 2075 a full one-fifth of GDP will be devoted to federal spending for these three programs alone.

Figure 2: Projected Federal Spending for Medicaid, Medicare, and Social Security Will Double as a Share of GDP by 2035



Note: These estimates do not include the state share of Medicaid.

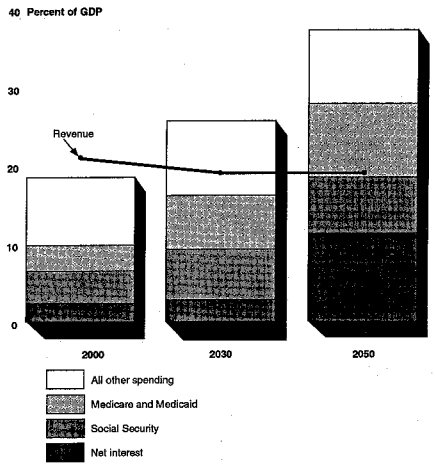
Projections based on intermediate assumptions of the 2001 Old-Age, Survivors, and Disability Insurance, Hospital Insurance, and Supplementary Medical Insurance Trustees' Reports and on the Congressional Budget Office's (CBO) January 2002 long-term Medicaid projections.

Source: Office of the Actuary, Centers for Medicare and Medicaid Services; the Office of the Chief Actuary, Social Security Administration; and CBO.

To move into the future with no changes in federal health and retirement programs is to envision a very different role for the federal government. Our long-term budget simulations serve to illustrate the increasing constraints on federal budgetary flexibility that will be driven by entitlement spending growth. Assume, for example, that last year's tax reductions are made permanent, revenue remains constant thereafter as a share of GDP, and discretionary spending keeps pace with the economy. Under these conditions, spending for net interest, Social Security, Medicare, and Medicaid would consume nearly three-quarters of federal revenue by 2030. This will leave little room for other federal priorities, including defense and education. By 2050, total federal revenue would be insufficient to fund entitlement spending and interest payments.[4] (See fig. 3.)

[4]For additional discussion of our long-term simulations, see U.S. General Accounting Office, *Budget Issues: Long-Term Fiscal Challenges*, GAO-02-467T (Washington, D.C.: February 27, 2002).

Figure 3: Medicare, Medicaid, Social Security, and Net Interest Will Put Unsustainable Pressure on the Federal Budget



Source: GAO's January 2002 analysis. See U.S. General Accounting Office, *Budget Issues: Long-Term Fiscal Challenges*, GAO-02-467T (Washington, D.C.: February 27, 2002).

Beginning about 2010, the share of the population that is age 65 or older will begin to climb, with profound implications for our society, our economy, and the financial condition of these entitlement programs. In particular, both Social Security and the Hospital Insurance portion of Medicare are largely financed as pay-as-you-go systems in which current workers' payroll taxes pay current retirees' benefits. Therefore, these programs are directly affected by the relative size of populations of covered workers and beneficiaries. Historically, this relationship has been favorable. In the near future, however, the overall worker-to-retiree ratio

will change in ways that threaten the financial solvency and sustainability of these entitlement programs. In 2000, there were 4.9 working-age persons (18 to 64 years) per elderly person, but by 2030, this ratio is projected to decline to 2.8.[5] This decline in the overall worker-to-retiree ratio will be due to both the surge in retirees brought about by the aging baby boom generation as well as falling fertility rates, which translate into relatively fewer workers in the near future.

Social Security's projected cost increases are due predominantly to the burgeoning retiree population. Even with the increase in the Social Security eligibility age to 67, these entitlement costs are anticipated to increase dramatically in the coming decades as a larger share of the population becomes eligible for Social Security, and if, as expected, average longevity increases.

As the baby boom generation retires and the Medicare-eligible population swells, the imbalance between outlays and revenues will increase dramatically. Medicare growth rates reflect not only a rapidly increasing beneficiary population, but also the escalation of health care costs at rates well exceeding general rates of inflation. While advances in science and technology have greatly expanded the capabilities of medical science, disproportionate increases in the use of health services have been fueled by the lack of effective means to channel patients into consuming, and providers into offering, only appropriate services. Although Medicare cost growth had slowed in recent years, in fiscal year 2001 Medicare spending grew by 10.3 percent and is up 7.8 percent for the first 5 months of fiscal year 2002.

To obtain a more complete picture of the future health care entitlement burden, especially as it relates to long-term care, we must also acknowledge and discuss the important role of Medicaid. Approximately 71 percent of all Medicaid dollars are dedicated to services for the aged, blind, and disabled individuals, and Medicaid spending is one of the largest components of most states' budgets. At the February 2002 National Governors Association meeting, governors reported that during a time of fiscal crisis for states, the growth in Medicaid is creating a situation in

[5]The specific ratios for the programs differ because of differences in the respective covered populations. Specifically, for Social Security, the ratio of covered workers to beneficiaries in 2000 was 3.4. Under the 2001 Trustees' intermediate estimates, this ratio is projected to decline to 2.1 by 2030. For Medicare Hospital Insurance, the ratio was 4.0 in 2001 and was projected to decline to 2.3 by 2030 under the 2001 Trustees' intermediate estimates.

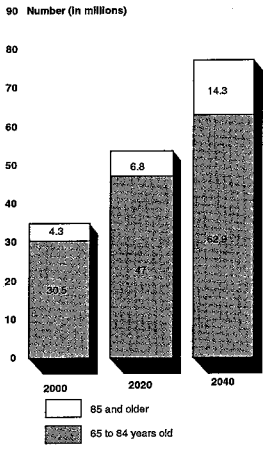
which states are faced with either making major cuts in programs or being forced to raise taxes significantly. Further, in a 2001 survey, 24 states cited increased costs for nursing homes and home- and community-based services as among the top factors in Medicaid cost growth.[6] Over the longer term, the increase in the number of elderly will add considerably to the strain on federal and state budgets as governments struggle to finance increased Medicaid spending. In addition, this strain on state Medicaid budgets may be exacerbated by fluctuations in the business cycle, such as the recent economic slowdown. State revenues decline during economic downturns, while the needs of the disabled for assistance remain constant.

Baby Boom Generation Will Greatly Expand Demand for Long-Term Care

In coming decades, the sheer number of aging baby boomers will swell the number of elderly with disabilities and the need for services. These overwhelming numbers offset the slight reductions in the prevalence of disability among the elderly reported in recent years. In 2000, individuals aged 65 or older numbered 34.8 million people—12.7 percent of our nation's total population. By 2020, that percentage will increase by nearly one-third to 16.5 percent—one in six Americans—and will represent nearly 20 million more elderly than there are today. By 2040, the number of elderly aged 85 years and older—the age group most likely to need long-term care services—is projected to more than triple from about 4 million to about 14 million (see fig. 4).

[6]Vernon Smith and Eileen Ellis, "Medicaid Budgets Under Stress: Survey Findings for State Fiscal Year 2000, 2001 and 2002," prepared for The Kaiser Commission on Medicaid and the Uninsured (Washington, D.C.: The Henry J. Kaiser Family Foundation, Oct. 2001).

Figure 4: Elderly Population Will More than Double by 2040



Source: Bureau of the Census, "Projections of the Total Resident Population by 5-Year Age Groups and Sex With Special Age Categories: Middle Series," selected years 2000 to 2040 (Jan. 2000).

It is difficult to precisely predict the future increase in the number of the elderly with disabilities, given the counterbalancing trends of an increase in the total number of elderly and a possible continued decrease in the prevalence of disability. For the past two decades, the number of elderly with disabilities has remained fairly constant while the percentage of those with disabilities has fallen between 1 and 2 percent a year. Possible factors contributing to this decreased prevalence of disability include improved health care, improved socioeconomic status, and better health behaviors. The positive benefits of the decreased prevalence of disability, however, will be overwhelmed by the sheer numbers of aged baby boomers. The total number of disabled elderly is projected to increase to between one-third and twice current levels, or as high as 12.1 million by 2040.

The increased number of disabled elderly will exacerbate current problems in the provision and financing of long-term care services. Approximately one in five adults with long-term care needs and living in the community reports an inability to receive needed care, such as assistance in toileting or eating, often with adverse consequences.[7] In addition, disabled elderly may lack family support or the financial means to purchase medical services. Long-term care costs can be financially catastrophic for families. Services, such as nursing home care, are very expensive; while costs can vary widely, a year in a nursing home typically costs $50,000 or more, and in some locations can be considerably more. Because of financial constraints, many elderly rely heavily on unpaid caregivers, usually family members and friends; overall, the majority of care received in the community is unpaid. However, in coming decades, fewer elderly may have the option of unpaid care because a smaller proportion may have a spouse, adult child, or sibling to provide it. By 2020, the number of elderly who will be living alone with no living children or siblings is estimated to reach 1.2 million, almost twice the number without family support in 1990.[8] In addition, geographic dispersion of families may further reduce the number of unpaid caregivers available to elderly baby boomers.

Spending for Long-Term Care for Elderly Could Nearly Quadruple by 2050

Currently, public and private spending on long-term care is about $137 billion for persons of all ages, and for the elderly alone is projected to increase two-and-a-half to four times in the next 40 to 50 years—reaching as much as $379 billion in constant dollars for the elderly alone, according to one source.[9] (See fig. 5.) Estimates of future spending are imprecise, however, due to the uncertain effect of several important factors, including how many elderly will need assistance, the types of care they will use, and the availability of public and private sources of payment for care. Absent significant changes in the availability of public and private payment sources, however, future spending is expected to continue to rely

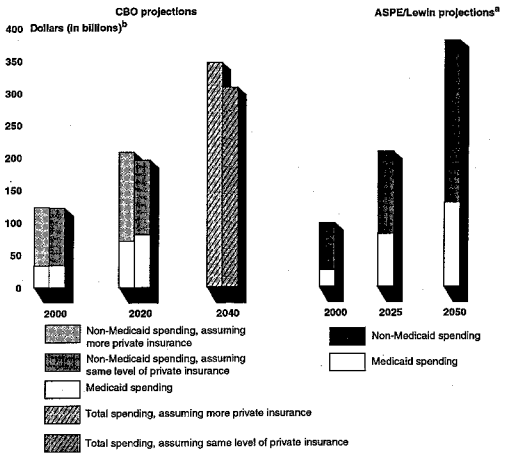
[7]Judith Feder et al., "Long-Term Care in the United States: An Overview," *Health Affairs*, May/June 2000, pp. 40 to 56.

[8]"Aging into the 21st Century," prepared by Jacob Siegel for the Administration on Aging, U.S. Department of Health and Human Services, May 1996.

[9]Assistant Secretary for Planning and Evaluation (ASPE) of the U.S. Department of Health and Human Services, who contracted with The Lewin Group, as published in Urban Institute, "Long-Term Care: Consumers, Providers, and Financing, A Chart Book," (Washington, D.C.: March 2001).

heavily on public payers, particularly Medicaid, which estimates indicate pays about 36 to 37 percent of long-term care expenditures for the elderly.

Figure 5: Projected Long-Term Care Expenditures for the Elderly Could Nearly Quadruple by 2050



[a]ASPE/Lewin did not report separate estimates for different assumptions about the role of private insurance.

[b]Projections are in constant dollars.

Sources: CBO, "Projections of Expenditures for Long-Term Care Services for the Elderly" (Washington, D.C.: March 1999) and ASPE/Lewin, published in Urban Institute, "Long-Term Care: Consumers, Providers, and Financing, A Chart Book," (Washington, D.C.: March 2001), with additional information provided by ASPE on projected Medicaid spending.

One factor that will affect spending is how many elderly will need assistance. As I have previously discussed, even with continued decreases in the prevalence of disability, aging baby boomers are expected to have a disproportionate effect on the demand for long-term care. Another factor

influencing projected long-term care spending is the type of care that the baby boom generation will use. Currently, expenditures for nursing home care greatly exceed those for care provided in other settings. Average expenditures per elderly person in a nursing home can be about four times greater than average expenditures for those receiving paid care at home.[10] The past decade has seen increases in paid home care as well as in assisted living facilities, a relatively newer and developing type of housing in which an estimated 400,000 elderly with disabilities resided in 1999.[11] It is unclear what effect continued growth in paid home care, assisted living facilities, or other care alternatives may have on future expenditures. Any increase in the availability of home care may reduce the average cost per disabled person, but the effect could be offset if there is an increase in the use of paid home care by persons currently not receiving these services.

Changes in the availability of public and private sources to pay for care will also affect expenditures. Private long-term care insurance has been viewed as a possible means of reducing catastrophic financial risk for the elderly needing long-term care and relieving some of the financial burden currently falling on public long-term care programs. Increases in private insurance may lower public expenditures but raise spending overall because insurance increases individuals' financial resources when they become disabled and allows the purchase of additional services. The number of policies in force remains relatively small despite improvements in policy offerings and the tax deductibility of premiums. However, as we have previously testified, questions about the affordability of long-term care policies and the value of the coverage relative to the premiums charged have posed barriers to more widespread purchase of these policies.[12] Further, many baby boomers continue to assume they will never need such coverage or mistakenly believe that Medicare or their own

[10]Data from the Medical Expenditure Panel Survey show that the average annual expenditures for home health care for all elderly individuals was $6,041 in 1996 compared to average annual expenditures for nursing home care of $20,116 for those 65 to 69 years and $25,765 for those 90 years and older.

[11]Kenneth Manton and XiLiang Gu, "Changes in the Prevalence of Chronic Disability in the United States Black and Nonblack Population Above Age 65 from 1982 to 1999," *Proceedings of the National Academy of Sciences of the United States of America*, May 22, 2001, pp. 6354 to 6359.

[12]U.S. General Accounting Office, *Long-Term Care: Baby Boom Generation Increases Challenge of Financing Needed Services*, GAO-01-563T (Washington, D.C.: Mar. 27, 2001) and *Long-Term Care Insurance: Better Information Critical to Prospective Purchasers*, GAO/T-HEHS-00-196 (Washington, D.C.: Sept. 13, 2000).

private health insurance will provide comprehensive coverage for the services they need. If private long-term care insurance is expected to play a larger role in financing future generations' long-term care needs, consumers need to be better informed about the costs of long-term care, the likelihood that they may need these services, and the limits of coverage through public programs and private health insurance.

With or without increases in the availability of private insurance, Medicaid and Medicare are expected to continue to pay for the majority of long-term care services for the elderly in the future. Without fundamental financing changes, Medicaid can be expected to remain one of the largest funding sources for long-term care services for aging baby boomers, with Medicaid expenditures for long-term care for the elderly reaching as high as $132 billion by 2050. As I noted previously, this increasing burden will strain both federal and state governments.

Considerations for Reforming Long-Term Care Financing

Given the anticipated increase in demand for long-term care services resulting from the aging of the baby boom generation, the concerns about the availability of services, and the expected further stress on federal and state budgets and individuals' financial resources, some policymakers and advocates have called for long-term care financing reforms. As further deliberation is given to any long-term care financing reforms, I would like to close by suggesting several considerations for policymakers to keep in mind.

At the outset, it is important to recognize that long-term care services are not just another set of traditional health care services. Meeting acute and chronic health care needs is an important element of caring for aging and disabled individuals. Long-term care, however, encompasses services related to maintaining quality of life, preserving individual dignity, and satisfying preferences in lifestyle for someone with a disability severe enough to require the assistance of others in everyday activities. Some long-term care services are akin to other health care services, such as personal assistance with activities of daily living or monitoring or supervision to cope with the effect of dementia. Other aspects of long-term care, such as housing, nutrition, and transportation, are services that all of us consume daily but become an integral part of long-term care for a person with a disability. Disabilities can affect housing needs, nutritional needs, or transportation needs. But, what is more important is that where one wants to live or what activities one wants to pursue also affects how needed services can be provided. Providing personal assistance in a congregate setting such as a nursing home or assisted living facility may

satisfy more of an individual's needs, be more efficient, and involve more direct supervision to ensure better quality than when caregivers travel to individuals' homes to serve them one on one. Yet, those options may conflict with a person's preference to live at home and maintain autonomy in determining his or her daily activities.

Keeping in mind that policies need to take account of the differences involved in long-term care, let me offer several considerations as you seek to shape effective long-term care financing reforms. These include:

- Determining societal responsibilities. A fundamental question is how much the choices of how long-term care needs are met should depend upon an individual's own resources or whether society should supplement those resources to broaden the range of choices. For a person without a disability requiring long-term care, where to live and what activities to pursue are lifestyle choices based on individual preferences and resources. However, for someone with a disability, those lifestyle choices affect the costs of long-term care services. The individual's own resources—including financial resources and the availability of family or other informal supports—may not be sufficient to preserve some of their choices and also obtain needed long-term care services.

  Societal responsibilities may include maintaining a safety net to satisfy individual needs for assistance. However, the safety net may not provide a full range of choices in how those needs are met. Persons who require assistance multiple times a day and lack family members to provide some share of this assistance may not be able to have their needs satisfied in their own homes. The costs of meeting such extensive needs may mean that sufficient public support is available only in settings such as assisted living facilities or nursing homes. More extensive public support may be extended, but decisions to do so should carefully consider affordability in the context of competing demands for our nation's resources.

- Considering the potential role of social insurance in financing. Government's role in many situations has extended beyond providing a safety net. Sometimes this extended government role has been a result of efficiencies in having government undertake a function, and in other cases this role has been a policy choice. Some proposals have recommended either voluntary or mandatory social insurance to provide long-term care assistance to broad groups of beneficiaries. In evaluating such proposals, careful attention needs to be paid to the limits and conditions under which services will be provided. In addition, who will be eligible and how such a program will be financed are critical choices. As in defining a safety net, it

is imperative that any option under consideration be thoroughly assessed for its affordability over the longer term.

- Encouraging personal preparedness. Becoming disabled is a risk. Not everyone will experience disability during his or her lifetime and even fewer persons will experience a severe disability requiring extensive assistance. This is the classic situation in which having insurance to provide additional resources to deal with a possible disability may be better than relying on personally saving for an event that may never occur. Insurance allows both persons who eventually will become disabled and those who will not to use more of their economic resources during their lifetime and to avoid having to put those resources aside for the possibility that they may become disabled.

  The public sector has two important potential roles in encouraging personal preparedness. The first is to adequately educate people about the boundaries between personal and societal responsibilities. Only if the limits of public support are clear will individuals be likely to take steps to prepare for a possible disability. Currently, one of the factors contributing to the lack of preparation for long-term care among the elderly is a widespread misunderstanding about what services Medicare will cover. The second public sector role may be to assure the availability of sound private long-term care insurance policies and possibly to create incentives for their purchase. Progress has been made in improving the value of insurance policies through state insurance regulation and strengthening the requirements for policies qualifying for favorable tax treatment through the Health Insurance Portability and Accountability Act of 1996. However, long-term care insurance is still an evolving product, and given the flux in how long-term care services are delivered, it is important to monitor whether long-term care insurance regulations need adjustments to ensure that consumers receive fair value for their premium dollars.

- Recognizing the benefits, burdens, and costs of informal caregiving. Family and other informal caregivers play a critical role in supplying the bulk of long-term care to disabled persons. Effective policy must create incentives and supports for enabling informal caregivers to continue providing assistance. Further, care should be taken to avoid creating incentives that result in informal care being inappropriately supplanted by formal paid services. At the same time, it is important to recognize the physical, emotional, and social burdens that providing care impose on the caregiver and its economic costs to the caregiver and to society. Caregiving may create needs in caregivers themselves that require respite or other relief services. In addition, caregiving can conflict with caregivers' employment, creating economic losses for caregivers and society. Such

losses in productivity will become even more important in the coming decades as the proportion of the population that is working-age declines.

- Assessing the balance of federal and state responsibilities to ensure adequate and equitable satisfaction of needs. Reforms in long-term care financing may require reevaluating the traditional federal and state financing roles to better ensure an equitable distribution of public support for individuals with disabilities. The variation across states in Medicaid spending per capita on long-term care is in part reflective of differences among states in generosity of services as well as their fiscal capacity. Given these differences, having states assume primary responsibility for financing long-term care subjects individuals to different levels of support depending on where they live. In addition, because states' revenues are sensitive to the business cycle and states generally must have balanced budgets, their services become vulnerable during economic downturns.

- Adopting effective and efficient implementation and administration of reforms. Proposed reforms to better meet the increasing demand for long-term care within budget constraints will be successful only if they are administratively feasible, effectively reach targeted populations and unmet needs, and efficiently provide needed services at minimum cost while complementing already available services and financing sources.

- Developing financially sustainable public commitments. Finally, as I earlier noted, absent reform, existing federal entitlement commitments for Medicaid, Medicare, and Social Security will represent an increasing and potentially unsustainable share of the economy. States, too, are concerned about their budgetary commitments for long-term care through their share of the Medicaid program. Before committing to any additional public role in financing long-term care, it is imperative to provide reasonable assurance that revenues will be available to fund its future costs.

Mr. Chairman, this completes my prepared statement. I would be happy to respond to any questions you or other members of the committee may have at this time.

Contacts and Acknowledgments

For future contacts regarding this testimony, please call William J. Scanlon or Kathryn G. Allen at (202) 512-7114. Other individuals who made key contributions include JoAnne R. Bailey, Linda Baker, John E. Dicken, Karen Doran, Romy Gelb, Rick Krashevski, James McTigue, Jr., and Melissa Wolf.

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The CHAIRMAN. Thank you very much, Mr. Walker, for an excellent statement. Let me just ask you before I begin with the real questions a factual thing. The increases on the Medicare and Medicaid, the projections, would that include a Medicare program that would have prescription drugs in it or it does not?

Mr. WALKER. No. No, it does not.

The CHAIRMAN. Because it does not now. So that does not even include Medicare with prescription drugs?

Mr. WALKER. No, it does not, Mr. Chairman.

The CHAIRMAN. Obviously, if you added a $750 billion prescription drug ingredient to Medicare today, which some are advocating, that red box would be even substantially larger?

Mr. WALKER. Well, that is correct, and as you know, Mr. Chairman, the fastest growing cost in health care is prescription drugs, and while some prescription drugs serve to end up reducing the need for more acute care, many of them do not. So there is a net cost increase, because a lot of prescription drugs are not just with regard to extending life or saving life, but it is also something that people want in order to enhance their quality of life, but it may not necessarily be a need.

The CHAIRMAN. Well, thank you very much. Governor Patton, thank you again for your statement. We have been joined by our colleague, Senator Carnahan. Senator Carnahan, do you have a statement you would like to make?

STATEMENT OF SENATOR JEAN CARNAHAN

Senator CARNAHAN. Thank you, Mr. Chairman. I certainly applaud your leadership on this issue of long-term care. This committee is focusing on a serious problem that is right around the corner. The demographics in our country are changing rapidly. My home State of Missouri has the 14th largest senior citizen population in the country. The growth of Missouri's 60 and over population now outpaces all other age categories. Before we know it, the baby boomers will be retiring and needing long-term care services.

We will not be prepared without laying the groundwork now. Most Americans probably think little about this issue until someone in their family needs assistance. When this situation arises, one of the first questions that comes to mind is what are the options? That is what we are discussing today, making sure that seniors have options.

We need to explore and support options that allow citizens to live independently for as long as possible in their own homes and communities. That is why I have decided to cosponsor the Long Term Care and Retirement Security Act.

This legislation would establish a $3,000 tax credit to individuals with long-term care needs or their caregivers. Seniors are most likely to receive long-term care from family members, typically wives or daughters. Caregivers often lose wages and benefits, sometimes even jobs, to be able to care for family members.

These women provide care out of love, but to do so, they sometimes have to make a huge financial sacrifice. This tax credit would make a real difference to families struggling to care for an ailing loved one.

In addition, the legislation would create a tax deduction for the cost of long-term care insurance premiums. These tax benefits would help seniors pay for the high cost of long-term care insurance premiums and also provide incentives for younger people to begin investing in long-term care insurance.

This legislation is a step in the right direction. I would like to thank both the witnesses for being here today and I look forward to hearing your testimony.

The CHAIRMAN. Thank you, Senator Carnahan, and thank you for your cosponsorship of the legislation on the long-term care tax credit. I think that is very important. I have questions, and I know Senator Carnahan has questions, and we have a vote. So I think that what we will do is take a short recess if that is OK and come right back and get some discussion with you. The committee would be in recess. [Recess.]

The committee will come to order. If everybody can take their seats, we will continue. Governor, let me ask you questions. I know you have to depart, and thank you very much for your patience. I like your testimony up till the time when you start talking about another commission. [Laughter.]

I think from a congressional standpoint, commissions really reflect what Congress should be doing ourselves. I mean, commissions normally, you know, the concept is that they are going to make recommendations that Congress can accept. The experience with commissions, Social Security and Medicare, which I chaired, has really not been that good. I know we are looking for a way to solve this, and I appreciate that. You know, perhaps a commission is the right idea.

Let me ask you another question, in Kentucky, maybe from your experiences. We are trying to say to the states that, look, long-term care is not just nursing homes. Nursing homes are good for people who need 24 hours a day, 7 day a week care. But many people in nursing homes, at least a significant number in nursing homes, really do not need to be there. Assisted living facilities or home health care or something short of 24 hour a day, 7 day a week care would be sufficient to meet their needs.

Has Kentucky utilized Medicaid waivers in order to use those funds for assisted living facilities or other type of care short of 24 hour/7 day a week care facility?

Governor PATTON. Yes, but let me address briefly the commission. We are looking for a way to elevate this issue to its appropriate place, and we recognize that it is going to have to be a partnership with the Congress. So the National Governors' Association wants to work with you to try to figure out how can we bring attention to this issue.

Yes, Kentucky has a waiver on in-home care, but we find the need so great that, to be very frank, the only way we are able to contain the cost at all is just to limit the availability of service. Even with institutional care, through certificates of need, we do not allow nursing home beds to be built at a market demand because we know that they would be filled and Medicaid would be picking up a large part of that cost.

With our home care waiver, we have a fixed number of waivers or the slots that are available, and when the slots are filled, then

the next person does not get the service. That is the only way we can control the costs. If it were unlimited it is estimated that there are probably four times as many people that would meet a definition of real need than is what is being served.

The CHAIRMAN. Do you remember what the reimbursement rate for Medicaid Federal/state in Kentucky happens to be? 70/30? 65?

Governor PATTON. Kentucky's rate is 70/30, 30 percent state.

The CHAIRMAN. 70/30. So if your costs in Medicaid have gone up by 47 percent, what are you attempting to do with the legislature to try and curtail, reduce those costs? How are you doing that?

Governor PATTON. Flexibility is the greatest thing that could happen to us to reduce costs. Now there is a limit to how much we could do, but Medicaid, as I understand it, is sort of one-size-fits-all. If you are going to provide some benefit, then you have to provide that benefit to all people that are eligible, and you cannot have a different copay for different income levels. I am getting a little deeper into this than I really know, but I know that if we could tailor our optional benefits a little bit more closely to fit some populations, it would make a tremendous difference.

Over the last year, we have had some experts and we have done an awful lot of reducing the cost of our program. One of the things that we have done has been to become more efficient in transferring more of the cost to the Federal Government by finding more services than we have been providing that are, in fact, Medicaid eligible that we were paying 100 percent of the cost of.

The CHAIRMAN. Yes.

Governor PATTON. But we have gone as far down that road as we can go.

The CHAIRMAN. Well, you have done some great work in Kentucky, and we admire you for it. I appreciate your leadership in the National Governors' Association on this issue. I would really hope that what you said about elevating this issue to a level of national debate and national discussion really can be what we accomplish here.

I think the NGA can be a major player in that. Maybe it is another commission. I do not reject it out of hand, but I think, you know, if we can work together on this with the NGA and the Congress, I think perhaps we can get some serious discussion. When I left here, a reporter asked me outside of the Senate chamber what are you all going to do about increasing health costs?

I said, you know, we are not going to do anything this year; it is an election year. You know we are not going to make any real decisions of major importance on Medicaid or Medicare because no one wants to touch it, because it is such a volatile issue, and then we are going to say, well, we will do it next year. But next year never gets here, and that is the problem.

But we appreciate your leadership. I urge you to continue providing it when you become chairman of the NGA. We look forward to working with you, and I understand you have to depart. So we appreciate your being with us and let you go.

Governor PATTON. Thank you, Mr. Chairman. We appreciate the opportunity.

The CHAIRMAN. Thank you. Thank you very much, Governor Patton.

Governor PATTON. We do look forward to working with you in partnership.

The CHAIRMAN. Yes, absolutely.

Governor PATTON. Thank you.

The CHAIRMAN. With regard to some of the things that Governor Patton said, Mr. Walker, I become convinced that we operate health care in this country under the box theory. Senator Kerrey used to talk about this, that if you are a veteran, you are in the veteran's box at VA; if you are a poor American, you are in the Medicaid box; if you are a working American, you are in an employer-sponsored health insurance box; if you are an old American, you are in the Medicare box. Each one of those boxes has a complete bureaucracy that is set up to run it.

Medicaid program, the Medicare program, the VA program, the employer's sponsored health insurance, ERISA box. It just seems to me that we as a nation ought to just provide health care for Americans and get out of the box system. What I am thinking about and what I have been working on with other members is a concept that the Federal Government should mandate health care insurance for all Americans, not an employer mandated system, but federally mandated requirement that every American have health insurance.

Every state in the union requires every American before they drive a car or get a driver's license to have liability insurance. People have accepted that and they understand they have to do it, and there is no distinguishing difference between poor people or wealthy people. It is just a flat law. You have to have liability insurance or you cannot drive a car.

We are thinking of the approach which would say that every American has to have a health insurance policy, and we will help buy it for poor people. It will be a graduated contribution to their premium. For poor people, we will pay 100 percent of the premium. Then on a sliding scale up to the point where people can afford to pay for their own premium, perhaps with it being deductible on their income tax.

We spend $300 billion a year on Medicare, $200 billion on Medicaid, billions of dollars on the VA program, billions of dollars on a tax credit for employer sponsored health insurance because it is deductible. We could take all of that money and use it to have a program that we would be subsidizing and requiring everybody to have health insurance.

Do you have any thoughts about that type of concept? I know it is a long-term process, and it is not going to be done overnight, but if we do not start, we will never finish. Do you have any thoughts on that concept?

Mr. WALKER. Well, Senator, without specifically addressing the mandate per se, let me address some elements that I think that you touched on. I think what we have to recognize is we have a lot of silos right now. You talk about it in terms of boxes. I look at it in terms of silos. You know we have got, you know, Medicare. We have got VA. We have got DoD. We have got all these things, each with their own infrastructures, each with their own definitions of what is covered, and in many cases each with their own delivery mechanisms.

I think we need to step back, and we need to say that what we have right now is fundamentally broken, it is unsustainable. If there is one thing that could bankrupt this country, it is health care costs. All right. Now that is not going to happen. We will not allow that to happen, but it is that serious.

So I think we need to step back and we need to say, OK, what are fundamental needs, and how best can those needs be met? I would argue for your consideration that access to health care at group rates or, stated differently, guaranteed insurability; second, protection against financial ruin due to an unexpected catastrophic illness.

All right. Now, financial ruin is different if you are a multi-millionaire than if you have very little; OK. Inoculations for children against infectious diseases. All right. So to try to define what are the basics, what are the basics that people need and it is in the national interest for them to have and how best to go about doing that.

To the extent that people want more than that, then choices, options, and to the extent that they have resources, then obviously they ought to put some of their resources on the table to be able to make a more conscious choice about how much risk they want to lay off versus resources that they are willing to put to do that.

I think you are right in saying you have got to put the tax preferences on the table. I think the tax preferences are part of the problem right now. I would suggest that it is appropriate right now for the employers to get a deduction, because if they do not get a deduction, then they will not offer health care coverage. They will just pay cash, and that could end up undercutting coverage.

On the other hand, right now all individuals get an income tax exclusion for the value of health care, which further desensitizes them to the cost of health care, and so there are different ways, I think, you could go about it. But I think the idea that you need to step back, you need to reassess, we need to focus on, you know, what are the real needs, what is the appropriate role from the standpoint of the individual versus the employer versus the government, tax side as well as the benefit, is the only way to go, because right now we are on an unsustainable path and we are headed for a train wreck of massive proportions. While the states are ahead of us, because Medicaid is their biggest problem, that is our smallest problem.

The CHAIRMAN. I mean you make a very good point. And most of the discussion in the Congress right now is not about reducing the amount we spend in this area. If anything, adding $750 billion prescription drug program to a Medicare program, we are going in exactly the opposite direction as far as not controlling costs. We are going to be adding to the government's responsibility unless we fix the program itself. Is that concern legitimate?

Mr. WALKER. Well, as you probably recall in your capacity as a member of the Senate Finance Committee, one of the things I testified a year ago was different levels of fiscal risk that we need to consider today: while there are things we can afford to do today, are we going to be able to sustain it tomorrow? The area I said represented the highest fiscal risk is increasing entitlement spending.

Increasing entitlement spending when we already have a huge delta, or huge gap, between what is promised and what funding we have available for it right now, and the degree of difficulty in changing entitlement promises represents the highest risk I believe from a fiscal perspective.

The CHAIRMAN. My final question is how much of a risk is it if we are going to have a $750 billion prescription drug program, and we just are going to pay for it out of Social Security surplus, which is what some have advocated? I mean what does that do to that system?

Mr. WALKER. Well, in the end, people will say, well, all we have to do is grow the economy more and we will solve our problem, but I think these charts, as you know, assume economic growth based on CBO assumptions which are not that far different than OMB. We are not going to grow ourselves out of this problem.

We are going to have to end up starting to make some of these tough choices because Social Security might have a surplus today, but it is not going to have one in the not too distant future—2016, based on the latest Social Security trustees' estimates. Frankly, the trustees said when I was a trustee in 1992 that that program is unsustainable in its present form, but, guess what, it is the easiest thing to solve.

Medicare and Medicaid are much tougher, and the reason being is in the case of Social Security I would respectfully suggest that you can restructure that program. You and I were on a commission together. There are different ways to do it. You can restructure that program in a way that you exceed the expectation of all generations of Americans, because current retirees can get what they are promised, near-term retirees can, and you can restructure it increasingly toward baby boomers, Xers, and Y. They are already discounting this program to a great extent, much greater than they should. So you can restructure it so you give everybody more than they think they are going to get, and also make it sustainable.

But the problem is the subject of this hearing, which is long-term care, which is really not just health care. The Medicare and Medicaid, the imbalances are so huge, the expectation gaps are so great, that we are going to have to start making some of these tough choices. I mean the states are starting to do it. They are starting to cut back. In certain areas where they were discretionary, they are not required to provide.

But it would be great if we could do it more comprehensively, which is what you are talking about, to step back and let us try to rationalize the whole system and try to make sense of it now rather than just incrementally just keep on chopping back to where we have got a worse situation years from now.

The CHAIRMAN. Well, I could not agree with you more. I thank you very much. We have been joined by Senator Carper. Tom.

Senator Carper. Mr. Chairman, as we listen to Mr. Walker talking about restructuring Social Security and all, this is, you know, the issue of notch babies. We have been dealing with that issue for as long as you and I have been here.

The CHAIRMAN. Yes.

Senator Carper. In a sense, we have a great opportunity to have a whole new generation of notch babies or those who perceive

themselves to be that. Thanks for joining us today and thank you for the work you do and for the leadership that you provide. I apologize for not being here to hear your testimony, and I had a chance to visit with Governor Patton, my old colleague, and chatted a little bit in the halls, so I have some sense for what he was here to say.

One of the things that would be helpful for me would just be to ask for you to take the next 5 minutes or so and lay out for me what you think our options are with respect to long-term care, and maybe some of the pluses and minuses of those options, and then if you have an option or a path forward that you think would be especially preferable, if you could share that with me.

Mr. WALKER. Well, let me give you an executive summary, Senator. First, I think we have to keep in mind that we face a very serious long-range fiscal challenge at the Federal level due primarily to known demographic trends and rising health care costs, Medicare, Medicaid being a subset of that, a major element of that.

Second, long-term care, as you know, is not just health related. It is quality of life related. There are certain services that really do not have that much to do with a person's health. It is more a matter of daily living, assisted daily living, and certain of those types of things.

Clearly one of the things that has to be recognized is we already have made more promises than we have funded, and the gaps are huge, and so we to have a division, try to come up with what is the appropriate division of responsibilities. How much should individuals personally be responsible? To what extent, through either tax preferences, through encouraging the insurance market, and through public education efforts, that you can get people to be doing things today that will help put them in a better position to be able to meet these needs in the future?

To the extent that there are portions of the population, whether it be the disabled or the poor that might need special assistance, for them to target assistance into those areas of greatest need, but recognizing that, you know, we do not want to make promises that we cannot deliver on 10 years from now or 15 years from now in doing that.

So I think what I would commend to you, and I am happy to provide more details, if you would like, Senator, is on page two of the testimony, which we have entered into the record. Those are some of the key questions that I think, and I think part of it is defining what is long-term care, and what kind of services represent needs versus wants, because right now there are differences, there are significant differences, there are about five or six basic services that are normally included in there, but there are others that are sometimes included.

I think the insurance market right now is not very strong, in part because the numbers are not there yet, but, you know, when baby boomers start retiring, I think the numbers will come, but I would say last that I think we have to recognize that long-term care is a subset of Medicaid. Medicaid is a subset of our health care challenge, and our health care challenge is a subset of the overall long-range challenge. So we have got to be careful not to try to

solve this piece without understanding how it fits with the rest of the puzzle.

That is why I think the idea of trying to look more comprehensively here is the way to go, because otherwise we are in danger of solving one problem but creating bigger problems in other areas, and I think that would be unfortunate if that is what happens.

Senator CARPER. All right. Good. Thank you very much.

Mr. WALKER. Thank you, Senator.

The CHAIRMAN. Thank you, Senator Carper. Then the next hearing we are going to have is going to be on the use of tax credits to buy long-term health care insurance in more specific detail. But as a concept, I mean rather than just adding an ingredient into Medicare or Medicaid, if the government is going to pay for it again, can you comment on the concept of using the tax code to provide a tax credit for people to purchase long-term health care insurance?

Mr. WALKER. I think clearly from an intellectual standpoint, that is preferred than adding an entitlement that would end up being broad-based, if you will. I do, however, believe that one of the things that has to be a part of your comprehensive review that you are talking about is that Congress places a lot of time and attention focusing on direct spending programs, Medicare, Medicaid, et cetera.

We do not spend enough time collectively in this country in looking at the revenue side, the tax preference side. Health care is either No. 1 or No. 2 on the tax preference. If it is not No. 1 yet, it will be very shortly, and I think that has to come under the microscope to figure out how that fits within this overall equation, because obviously if you give tax preferences, it helps on one hand, but it can end up hurting potentially with regard to the fiscal imbalance as well, and so that has got to be targeted as well I think.

The CHAIRMAN. Yes. I appreciate it. Thank you, Mr. Walker. Always a pleasure to have you before the committee and look forward to continuing with our work with GAO. That will conclude this hearing.

Mr. WALKER. Thank you.

[Whereupon, at 10:45 a.m., the committee was adjourned.]

APPENDIX

AAHSA

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Statement for the Record

American Association of Homes and Services For the Aging

"Broken and Unsustainable: The Cost Crisis of Long-Term Care for Baby Boomers?"

Senate Special Committee on Aging March 21, 2002

The American Association of Homes and Services for the Aging (AAHSA) appreciates the opportunity to submit this statement for the record of the Committee's hearing on March 21, 2002 on the potential impact of long-term care costs for the baby boom generation.

AAHSA is a national nonprofit organization representing almost 6,000 not-for-profit providers of health care, housing, long-term care, and community services to more than 1,000,000 individuals daily. AAHSA and its members have long been committed to providing quality care to the residents we serve and to meeting the needs of these individuals in a manner that enhances their sense of self-worth and dignity, and that allows them to function at their highest level of independence.

When it comes to caring for its older citizens, America faces a looming challenge. There are more than 77 million aging baby boomers, yet our current long-term care system is not sustainable. Regulatory inconsistencies and restrictions, a workforce crisis and fragmented and inadequate funding have created a system that is unable to meet the growing needs of seniors. While we applaud the committee's examination of the need for Medicaid reform, which will certainly be an essential part of the solution to long-term care financing in the coming decades, AAHSA urges Congress to act on other aspects of the issue as well.

Members of the American Association of Homes and Services for the Aging (AAHSA) believe our nation deserves a healthy, affordable, ethical long-term care system – one where seniors and younger persons with disabilities can get support and care in the least restrictive setting that is equipped to meet their needs. AAHSA believes this can be achieved through a coordinated continuum that includes housing with supportive services, community-sponsored programs, in-home care, adult-day care, assisted living and nursing homes. These options already exist, but there is a lot of work to do before they are accessible, coordinated and sustainable. Major overhauls in the programs that cover long-term care will be necessary in order to reduce fragmentation, inconsistent requirements, and jurisdictional disparities.

Advancing the Vision of Healthy, Affordable, Ethical Long-Term Care for America

RICHARD C. SCHUTT, CHAIR
WILLIAM L. MINNIX, JR, D.MIN., PRESIDENT AND CEO

Instead of a cohesive national policy to ensure access to long-term care, our citizens face a "patchwork" of programs that is inefficient, inequitable and often ineffective. Services vary from state to state and community to community. Each program has its own standards for eligibility, and each provides different services. People most often receive care in the setting in which it can be reimbursed, rather than according to their own needs and preferences.

Long-term care at its best is a community network of health and supportive services that helps chronically impaired persons and their caregivers manage their situations over time, place and provider in the least restrictive setting they call home. The various components in the long-term care continuum include nursing homes, skilled nursing facilities, adult day care, housing with supportive services, assisted living, intermediate care facilities for the mentally retarded and developmental disabilities (ICFs-MR) and home and community-based services.

There are severe challenges facing access to long-term care services due to a host of forces that directly impact care. Demographic changes—including the aging population, increased longevity due to medical advances and declining family size—not only call attention to the inefficiency and inequity of our current system, but also raise a serious concern for the future. The 77 million baby boomers now are reaching retirement age, and people over 85 years of age are the fastest growing segment of America's population. Half of those now aged 85 and over currently require some help with personal care and activities of daily living, and these numbers will continue to grow as our population ages. Our nation faces a crisis that requires a complete overhaul of the ways in which we care for our frail, elderly and disabled populations.

The cost of long-term care, which is already financially devastating to most Americans, will only become more expensive as our population ages and people live longer with the assistance of expensive drugs, therapies and medical technologies.

While demographics and costs will explode, the pool of paid and unpaid caregivers will shrink dramatically. Currently, family members and friends give much of the long-term care that is provided in this country, but this source of informal, unpaid care will be less and less available due to smaller family sizes, geographic separation of families, and two-wage earner families. Our paid caregiver workforce is unlikely to keep up with the exploding need because capped, inelastic and grossly under-funded government payment systems—which pay for more than 80 percent of resident care in long-term care—do not allow providers to be competitive in a tight labor market.

The inability to offer competitive wages and benefits has created the most serious professional and paraprofessional long-term care labor shortage ever. The labor shortage causes remaining workers to shoulder unrealistic workloads.

Financing long-term care

A key element of AAHSA's vision of the continuum of care is financing that allows care to be coordinated across time, place and provider, emphasizing prevention, risk sharing and appropriate use of services. Currently it is impossible to achieve this vision because inconsistent regulations and legislation fragment government health and social services for the elderly. The

objective of integrated systems and financing for older persons is to combine resources (Medicare and Medicaid, other public funds and private monies) so as to better serve the elderly and chronically ill population.

The need for a complete revamping of the nation's long-term care system is urgent, and will become even more so as the baby boom generation continues to age. Long-term care is financed through a wide mix of public and private sources, with differing eligibility criteria, sources of revenue, and limits on coverage. Public programs, which account for 62 percent of the financing of nursing home care and home health care, include Medicaid, Medicare, state programs, the Veterans Administration, and the Administration on Aging. Private financing includes private insurance, philanthropy and out-of-pocket payments by individuals and families in need of care.

Medicaid is the largest public payer of long-term care services, accounting for 41 percent of nursing home revenues and 17 percent of home health care revenues. There are strict income limits on Medicaid eligibility, however, and many individuals qualify only after spending a lifetime of financial resources on their care. In addition, the federal-state design of the Medicaid system divides financing between the states and federal government and as a result, reimbursement and service delivery vary widely from state to state. Medicare is the second largest public payer of long-term care, financing 10.6 percent of all nursing home care and 35.6 percent of all home health care. Medicare's coverage of long-term care, however, is tied to the need for skilled services, which are very narrowly defined.

The largest source of private financing and the second largest source overall is direct payments by those who need long-term care. According to the most recent data, families financed 27 percent of long-term care. Home health agencies received 21 percent of their revenues from private payers, and this source represented 29 percent of nursing home revenues. Private insurance finances less than 7 percent of long-term care. Most private insurance payments are not yet from long-term care insurance, but instead come from acute-care health insurance plans (and Medicare HMOs) that cover long-term care services primarily as an alternative to inpatient hospital services.

Other sources of funding for home- and community-based services include the Older American Act and the Social Services Block Grant under Title XX. While there were increases in FY2002 funding for Older Americans Act (OAA) programs, waiting lists for essential services such as meals programs persist, and funds for Social Services Block Grant programs were cut.

Affordable housing is also an important component of the long-term care continuum. More than 7.4 million elderly households pay more than they can afford for their housing, according to a recent HUD study, including 1.4 million very low-income elderly people who pay more than 50% of their incomes for housing or live in substandard housing. The majority of these households are on fixed incomes, and receive no housing assistance. The dynamics of fixed incomes, high costs and a limited supply of affordable housing options are compounded by an ever increasing aging population needing a range of supportive and health care services. Adding supportive services to subsidies for housing can provide low-income seniors with an affordable form of assisted living.

While consumers face inadequate coverage of nursing home and other long-term care costs that can reach $4,500 or more per month, the current system is equally precarious for long-term care providers. Because public funds make up such a large share of resources available for long-term care, government reimbursement policies largely determine the amount of revenues that providers have available to pay staff and cover other costs of care. The failure of federal and state payments to keep pace with these costs has made it increasingly difficult for providers to recruit and retain well-qualified staff. This trend is likely to worsen in the future, as the demand for long-term care increases.

Medicaid reform

Medicaid is the single largest public source of funding for long-term care in general and nursing homes in particular. State Medicaid programs are required to pay for nursing home and home-health care for persons who qualify under federal and state criteria.

As part of the Omnibus Reconciliation Act of 1980, the Boren Amendment required states to reimburse nursing facilities at rates that were reasonable and adequate to meet the costs incurred by efficiently and economically operated nursing facilities. The Balanced Budget Act of 1997 (BBA) repealed the Boren Amendment. As a result, states have set payment policies primarily to constrain Medicaid expenditures without regard to the potential for undermining the quality of care for Medicaid recipients. Some states have acknowledged they are not coming close to reimbursing nursing homes for their costs, even as the demands for service and regulatory burdens increase.

Studies have shown that Medicaid rates for routine room and board are often less than a night's stay in an economy-price motel. A study of Medicaid rates for non-profit facilities showed that Medicaid paid an average of $10.60 less per day than the cost to care for a resident. For this minimal dollar amount, this payment is expected to cover room, board, three meals a day, some therapies, overhead, social activities, linens, mortgage and caregivers' salaries, among other things. States also are not paying facilities for Medicare deductibles and co-payments or paying for needed rehabilitation services and other medical care for nursing home residents eligible for Medicaid.

Nursing home payments must be adequate to ensure high quality care. The non-profit and religiously-affiliated members of AAHSA have traditionally funded a higher ratio of direct care staff, necessary for high quality, which Medicaid must recognize for quality to continue.

In addition, the present Medicaid program gives little weight to consumers' strong preference for health care services to be delivered in the home or the community instead of in nursing facilities. Federal law now requires states to cover nursing home care as part of their Medicaid programs, but home- and community-based care remains a state option. As a result, Medicaid coverage of home- and community-based services often is one of the first cuts made when states face budget deficits. The need and demand for home and community-based services and supports in most states are already difficult to meet, as evidenced by waiting lists for waiver services and meals programs. In addition, the Supreme Court's recent *Olmstead* decision held that Title II of the Americans with Disabilities Act mandates that services be offered in the most integrated setting

to persons with disabilities. This decision and the President's New Freedom Initiative, which directs federal agencies and states to identify and remove barriers to providing services in the most integrated setting, will continue to increase the demand for home and community-based services and programs, especially when combined with accelerating growth in the aging population.

Solutions: the following reforms must be made in the present long-term care financing system in order to ensure that these services continue to be available as the baby boom generation ages:

- **Federal Payment Standards for Medicaid:** Provide federal payment standards for state reimbursement of nursing homes participating in the Medicaid program. Broad federal standards must adequately ensure that the rates paid by the states (and matched by the federal government) will cover the cost of hiring, retaining and paying quality health care employees and other costs needed to meet the needs of Medicaid residents.

- **Enhance Federal Matching Payments for Medicaid:** Either as an across-the-board enhancement or a pass-through to providers, an enhanced federal match would provide the needed funds to pay providers for services rendered. States would be required to adhere to maintenance of effort for state funds.

- **Increase funding at least 10% for Older Americans Act programs.** These programs pay for critical programs and services that enable persons who are frail and/or disabled to remain at home. Title III, State and Community Programs, receives the bulk of OAA funds and provides a broad range of supportive and social services including congregate and home-delivered meals, senior centers, in-home and community-based care, and the new National Family Caregiver Program. The President's FY2003 budget proposal would fund all but nutrition services programs at FY2002 levels.

- **Increase SSBG funding to $2.8 billion,** the level authorized in the 1996 welfare reform law. States must also continue to have the right to transfer up to 10% of the funds they receive under Temporary Assistance to Needy Families (TANF) to their SSBG program. The current funding amount and the President's proposal for FY 2003 is $1.7 billion.

- **Review programs such as PACE and SHMOs** (Social Health Maintenance Organizations) and demonstrations funded through the Real Systems Change Grant Program to identify and replicate more innovative and efficient home and community-based service delivery systems.

- **Support initiatives that create more choice and opportunity for consumers** such as authorization to receive home health services in adult-day settings, while insuring that regulations aren't overly burdensome for providers.

- **Increase funding for the production of new rental housing for seniors** and the modernization and preservation of housing already built. Also increase funding for service coordination and conversions to assisted living.

- **Long-Term Care Insurance:** Ultimately, part of the answer to the problem of financing long-term care must be to reduce the public's reliance on Medicaid and other public programs. As the baby boomers reach retirement age within the next decade, state budgets will be less and less able to absorb the cost of long-term care through their Medicaid programs. According to current projections, nearly half of all Americans will need some form of long-term care at some point in their lives, yet fewer than 10 percent so far have purchased private long-term care insurance. Federal and state governments must promote private insurance coverage and help to make it more affordable through tax deductions, tax credits, or possibly even direct subsidies for the purchase of private insurance. These incentives will encourage those who can afford to do so to buy coverage for long-term care so that Medicaid may continue to cover the health care costs of those who have limited resources. In addition, consumers must be protected to the extent possible from making inappropriate purchases and from fraudulent or abusive insurance practices.

- **Public Education.** The public must be far better educated and informed about the likely need for long-term care, its potential costs to families, and the importance of responsible financial planning to cover these costs.

Conclusion

While Medicaid is an essential part of the long-term care picture, AAHSA hopes that the committee will examine it in the context of the larger continuum of health care, housing, and supportive services that people require as they age. Medicaid reform, as necessary as it is, will not alone achieve both the economies that states are seeking and the variety of long-term care options that consumers require. AAHSA appreciates the opportunity to submit this statement, and we look forward to working with Congress on the development of a healthy, affordable, and ethical system of long-term care for all Americans.

Statement on "a new approach to funding long-term care" for Hearing on "Broken and Unsustainable: The Cost Crisis of Long-Term Care for Baby Boomers," Special Committee on Aging, United States Senate, April 4, 2002.

Mr. Chairman: I appreciate the opportunity to present for your consideration a new approach to funding long-term care as I lend support to the formation of a Medicaid Commission. For the record, my name is Yung-Ping Chen. I am the Frank J. Manning Eminent Scholar's Chair in Gerontology at the University of Massachusetts Boston. My academic and professional background in the field of Social Security and economics of aging includes the following: member of the technical panel of actuaries and economists of the 1979 Advisory Council on Social Security; delegate or consultant or both to the 1971, 1981, 1995 White House Conferences on Aging and the 1998 White House Conference on Social Security; and faculty appointments at several colleges and research organizations. I am a member of the American Economic Association, a founding member of the National Academy of Social Insurance, and a fellow in the Gerontological Society of America. I currently serve on the board of directors of the National Council on the Aging. The statement I am presenting, I should state, is based on my research that has been supported by the Home Care Research Initiative of the Robert Wood Johnson Foundation. However, the views I express are those of my own and do not necessarily represent the positions of any organization with which I am affiliated.

As baby boomers begin to reach older ages beginning in a decade or so, the implied growth in the need for long-term care services is substantial, despite reported declines in the prevalence of disability in recent years. Further declines in disability rates, as currently projected, would not be sufficient to offset the projected rise in the older population, especially those in the more advanced ages. Therefore, there is in all likelihood a growing need for long-term care services by the aging baby boomers in the next few decades.

This statement serves two purposes:

- I propose a three-legged stool funding model with social insurance providing a basic protection that would be supplemented by private insurance and personal payment. Medicaid will be restored to its original role of helping the poor.
- I support the formation of a Medicaid Commission for the purpose of fundamental reform of long-term care funding.

Insurance in theory and in practice

The uncertain need for long-term care services is a recognized risk that may carry with it substantial—even catastrophic—financial consequences to an individual or his or her family, but it actually occurs only to a relatively small and predictable proportion of persons in a population at any one time. This type of contingency is best protected by insurance mechanisms.

In practice, however, insurance is used in a limited way to fund long-term care by either the public or private sector. Current funding for these services relies heavily on personal payment and public welfare (Medicaid) but only lightly on social insurance and private

insurance.[1] This method is akin to sitting on a two-legged stool, which is unlikely to be stable and sustainable, because it tends to impoverish many people and thereby severely strains Medicaid budget nationwide. One may regard it as a catastrophe waiting to happen. I agree, Mr. Chairman, with the premise of this hearing and commend you for conducting it.

Heavy reliance on out-of-pocket payment and public welfare has spawned many calls for reform over the years. But all proposals face the same question of how to obtain additional funding. Many have come to realize that neither the public nor the private sector alone has the financial wherewithal to meet the high and growing long-term care costs. A significant challenge for policymakers is how to secure funding from both public and private sectors. New approaches are needed.

A three-legged stool funding model: A new approach

In my view, a better funding method could be found by (a), more widespread use of the insurance principle for both private–and public–sector programs, and (b), linking several sources of funds in each sector that already exist to generate resources to pay for both social and private insurance. Therefore, I propose a new funding model, one in which social insurance and private insurance will pay for the bulk of the costs, supplemented by personal payment. I call this a three-legged stool funding model.[2] When these three sources fail to provide for some individuals, public welfare (Medicaid) will serve as a safety net. These are the same sources of funds presently in use, but will be deployed vastly differently in the proposed model.

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[1] Combined, out-of-pocket payment and Medicaid defrayed 70 percent of the total expenditures. Out-of-pocket payment—sometimes called self-insurance—fails to use the insurance principle of pooling risks. Self-insurance, by definition, is assuming the risk by oneself, rather than with others in a large group of persons exposed to the same type of risk.

Medicaid has been regarded by some analysts as a public insurance program, but is is not insurance because it lacks risk pooling. Labeling Medicaid—a welfare program—as insurance appears to use the term in a vernacular sense ("something to fall back on"), rather than in its actuarial sense, in terms of risk pooling among a large number of persons exposed to the same type of risk.

[2] The idea of a three-legged stool is patterned after the way, as a model or an ideal, we provide retirement income and acute health care for the older population. Retirement income is provided using Social Security for a floor of protection, with employment-based (occupational) pensions and personal savings supplying supplemental income. When these three sources fail to provide for some individuals, public welfare (Supplemental Security Income) serves as a safety net. Similarly, acute health care for the elderly is provided by Medicare, supplemented by employer-provided health benefits for retirees and by individual payments for noncovered expenses in some cases through Medicare Supplemental (Medigap) policies. When a person's health care needs cannot be met by these sources, public welfare (Medicaid) acts as a safety net. The three-legged stool funding model may be regarded as a policy approach that would simultaneously foster self-reliance (by means of private insurance and personal payment) and collective assistance (in the form of social insurance).

In the same vein, building a three-legged stool funding model for long-term care would begin with creating a social insurance program for a basic amount of long-term care coverage. This social insurance program would then be supplemented by private long-term care insurance and by personal payment.

A trade-off principle for merging resources

Assuming acceptance of this model, where might the funds for a new social insurance program and for the purchase of private insurance be found? Many people seem unable or unwilling to devote new resources for meeting long-term care costs. At least part of this may stem from the fact that people, in general, tend to compartmentalize or categorize their total resources (financial and non-financial assets as well as income) into different expenditure items such as food, housing, and the like. Once compartmentalized or categorized, resources will only be available for designated purposes or accounts.

Merging resources could then increase the total utility of existing resources for meeting various costs. In order to merge or combine resources together, it is necessary to create linkages in both public and private sectors. Therefore, I suggest the use of the trade-off principle.

Trade-off is ideologically and politically neutral

The trade-off principle can be applied in both the public and private sectors, as will be illustrated below. While the trade-off is suggested to generate new funding for long-term care when government resources are not available and when individuals are either unable or unwilling to devote new dollars for it, the suggestion does not imply that this method will cover all long-term care needs. Far from it—implementation of the trade-off principle in the public sector would still leave much room for private-sector initiatives such as personal insurance and personal savings. Therefore, the concept of trade-off is ideologically and politically neutral in that it favors neither social nor private insurance; it can apply to either or both.

A SS/LTC plan and it could even by voluntary

Applying the trade-off principle in the public sector, one could fund a social insurance program for providing basic coverage for long-term care by diverting a small portion of a retiree's Social Security cash benefits for this purpose. I call this a "Social Security/Long-term Care (SS/LTC) Plan", in which retirees would trade off a small portion of their current benefits to join SS/LTC, which would exempt low-income Social Security beneficiaries from the trade-off.[3] The SS/LTC plan could be voluntary. For example, all eligible recipients of Social Security benefits may be given a one-time opportunity at age 62 or 65 to elect into or out of SS/LTC.

The trade-off principle can and should be applied in the private sector as well.[4]

Private long-term care insurance

With respect to private long-term care insurance policy, there are many reasons for the unwillingness of people to buy it. One of the most important reasons on the demand side may be

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[3] Broad outlines of this plan are available in Chen, Yung-Ping (1993). A 'three-legged stool': A new way to fund long-term care?, Care in the Long Term: In Search of Community and Security (pp.54-70). Washington, D.C.: National Academy Press.

[4] A fuller discussion may be found in Chen, Yung-Ping (2001). Funding long-term care in the United States: The role of private insurance. Geneva Papers on Risk and Insurance, 26(4), 656-666.

that some people resist buying because it provides no benefit if they do not need services; they dread the so-called "use it or lose it" syndrome. Another reason is the high costs of private long-term care insurance policies for older people.

On the supply side, insurance companies are concerned about moral hazard (greater use of services induced by insurance) and adverse selection (buyers are those who suspect they will need long-term care services).

To substantially reduce the degree of these reservations, the trade-off principle may be used to enhance the willingness of individuals to purchase long-term care insurance, by linking it to life insurance or annuity products.[5]

A combination policy: Example of a trade-off

Linking long-term care benefit to life insurance or annuity products already exists in the market; it combines long-term care protection with income protection through life insurance or annuity. For example, for a single premium of $100,000, a 65-year-old woman could buy a life insurance policy that provides an initial death benefit of $190,000. The death benefit, by definition, is payable on the death of the insured. The death benefit can also be used by the insured prior to death to pay for long-term care expenses, such as nursing home or home health care for at least 50 months—at lesser of actual cost or at a monthly rate of 2 percent of the death benefit or $3,800 per month.

In short, with a rider for long-term care, a life insurance policy pre-pays the death benefit for long-term care expenses. If the insured does not need long-term care, then the funds in the insurance policy (such as universal life or variable universal life) continue to grow. Stated differently, unused long-term care benefits will pass to the beneficiaries of the policy. Under this arrangement, in essence, the policyholder trades off some or all of the death benefit for long-term care.

Providing a long-term care rider to a life insurance policy could also reduce, if not eliminate, this moral hazard problem: there would be a built-in resistance to over-using long-term care benefits because that would reduce the eventual insurance proceeds. The adverse selection problem could be limited, too, because such a combination product would appeal to both healthy and not-so-healthy people. The high cost issue could also be moderated, in addition, because people could buy long-term care insurance coverage at younger ages.

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[5] Also, it may be possible to increase the ability of individuals to purchase long-term care insurance by linking it to occupational pensions from employers. This includes Teachers Insurance and Annuity Association–College Retirement Equities Fund and government employee retirement programs at federal, state and local levels; or by linking it to individual retirement accounts (IRAs), Keogh plans, or other employment-based saving vehicles, such as 401(k) plans; or linking it to homeownership through home equity conversion plans (e.g., reverse mortgages).

Conclusion

In summary, we need fundamental reform of the ways in which we pay for long-term care and I have suggested some potentially viable ideas. Moreover, I wholeheartedly support the creation of a Medicaid Commission, as proposed by the National Governors Association and persuasively articulated by Governor Paul Patton of Kentucky, as a vehicle to explore alternative methods of reform.

The American Health Care Association is a federation of state affiliates representing more than 12,000 non-profit and for-profit nursing facilities, assisted living residences, and facilities for people with developmental disabilities caring for more than 1.5 million of our nation's seniors and people with disabilities.

We want to thank Chairman Breaux for holding this important hearing related to the many challenges facing the nation's Medicaid program, and we're pleased that National Governors' Association Vice Chairman, The Honorable Paul E. Patton (D-KY), will be outlining to you, and your colleagues, the deteriorating situation at the state level.

Like Governor Patton, and like virtually every NGA member, we understand and sympathize with the plight of state level officials and the seniors they serve who are vitally dependent upon Medicaid for their well being.

Mr. Chairman, consider the following recent headlines from newspapers around the country:

From the Arkansas Daily Gazette on January 22, 2002: "16 States Besides Arkansas Paring Medicaid In Slump";

From the Bangor Daily News on January 23, 2002: "Maine Legislators Question Medicaid Cuts";

From the State Times on February 2, 2002: "Mississippi House Tries To Cure Ailing Medicaid Program";

And, finally, from the Associated Press in Hartford: "Rowland Proposes To Cut $7 Million To Nursing Homes".

Without a doubt, we have a growing crisis on our hands, and it's only going to get worse unless the federal government finally decides to make the proper level of investment in Medicaid as we now watch it teeter ever closer to insolvency. Forty of our states are projecting budget shortfalls in 2002, and cuts to Medicaid are imminent. States need this Committee's help now.

According to a recent analysis of the nation's Medicaid program released by the national accounting firm, BDO Seidman, Medicaid is already under funding senior's nursing home care by at least $3.3 billion annually. This is a worsening crisis that threatens access to quality nursing care and perpetuates a nurse staffing, recruitment and retention crisis.

This comes at a time when Medicaid now pays for two out of every three nursing home patients, and when the federal government not only continues the under funding status quo, but when it is considering new and higher standards for the numbers of nursing staff in nursing homes – standards that would cost billions of dollars annually.

The disturbing fact is that Medicaid pays only between $4 and $5 per hour, per patient – less than most families pay for a babysitter. This meager federal investment for the care of our seniors is supposed to cover room, social activities, three meals per day, nursing care, various therapies, linens and still other items.

Mr. Chairman, any reasonable person would agree this is – to put it charitably – an unrealistic expectation, and an untenable situation for patient, provider and policymaker alike. We're certain Governor Patton and his NGA colleagues would certainly agree.

A recent Kaiser Foundation study noted that while Medicaid spending grew at the relatively modest average annual rate of 5.5% between fiscal years 1996-99, it grew by 9% in fiscal year 2000 and by an estimated 11% in fiscal year 2001. Soon after many states expanded the scope and purpose of Medicaid spending, they began to experience fiscal difficulties due to the downturn in the economy. Since the incidents of September 11th, the rate at which states' fiscal conditions are deteriorating has accelerated – and many, many states have either made budget cuts or announced plans to do so.

The Kaiser study also found that while most states do indeed have some reserve funds, it appears likely these funds will not be sufficient to tide states over until the economy improves. It is concerning to note that, during the relatively modest economic recession of the early 1990s, states would have needed reserves that equaled approximately 17% to 19% of their state general funds budgets to maintain expenditures through the recession without raising taxes.

At the beginning of fiscal year 2002, states had reserves that equaled 5.9% of general fund expenditures – just a little more than a third of what would have been needed to get through the last recession without spending cuts or tax increases.

One other piece of new research is very noteworthy and deserves examination, and the American Health Care Association will be discussing it in more detail on Monday at a National Press Club press presentation. The unfortunate fact of the matter is that, increasingly, Medicare is now being forced to cross-subsidize Medicaid because the federal government just isn't making the financial commitment to the program that is necessary.

But while Medicare is now helping to prop-up Medicaid, the FY 2003 federal budget has targeted Medicare for a sizable and unwarranted 17% cut that will not only harm the Medicare program and its beneficiaries, but, inevitably, further destabilize Medicaid. Despite the attempt by Congress and MedPAC to view Medicaid and Medicare as separate and distinct programs, with separate and distinct financing mechanisms, it is no longer viable to view their financing impact on nursing care independently – for they are intertwined.

It's incumbent to not just look at short and long term policy prescriptions, but to actually put them in place. Mr. Chairman, this is what we recommend:

In the short term, immediate help for the states should come in the form of an across-the-board FMAP increase, or from another type of short-term grant program. Whether the relief format is an FMAP increase or another form of aid is not as important as ensuring the immediate financial help is made available to ensure the millions Americans who count upon the program to receive the care they absolutely require.

AHCA supports HR 3414, the State Budget Relief Act, sponsored by Rep. Peter King (R-NY) and co-sponsored by more than 100 members. This legislation would provide an immediate 2% FMAP increase across the board to all states. If, however, a state were experiencing levels of unemployment above a benchmark threshold, the state would receive an additional 2.5% increase. This legislation is essential to those states – and the seniors in those states – suffering through no fault of their own as a result of the budgetary chaos. Additionally, we call upon the Senate to support amendments or free standing legislation that would accomplish similar goals.

From a broader perspective, long term care for our nation's frail and elderly must be placed on a firmer financial footing Medicaid programs account for as much as 20% of state budgets and are straining under increased costs and enrollments yet still chronically under fund nursing home services. As we have noted, until we see a proper and realistic level of investment in this long term care, access to quality patient care will continue to be threatened – not just now, but also several years from now -- when the imminent wave of 77 million baby boom retirees will overwhelm our current ability to meet demand for care. We must begin to look at comprehensive public/private long term solutions that allow the nation and its citizens to move beyond today's pay as you go financing system.

Mr. Chairman, we thank you for holding this critically important hearing, and we look forward to working with you, Governor Patton and his NGA colleagues, and all other parties to this debate in a constructive and bipartisan manner. We hope today's hearing amounts to a red alert that complacency is no longer an option. We must finally begin to ensure Medicaid meets today's retirement necessities as well as tomorrow's enormous, and ever-growing, retirement challenges.

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