Making Choices:
Toward A More Efficient and Effective Long-Term Care System
Georgetown University Long-Term Care Financing Project
Washington, DC
June 11, 2007

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

[START RECORDING]

WILLIAM SCANLON, PH.D.: Settle in. Okay. Okay. Let me welcome you to the last panel, where it all comes together. As you can gather from the discussions in the last, the panel that preceded this, there's a feeling that there were good ideas across the proposals and that selecting features might be sort of the best approach. Gary did an incredible job as a moderator keeping everybody to their five minutes. So, 11 proposals went by at warp speed and there is a need for, therefore, synthesis and comparison and who better but in her deliberate style – Judy will provide that comparative analysis.

Then we are going to turn to our panel to offer commentary both on the merits, and I think hearkening back to Judy's first remarks this morning sort of the issue of how do you put long-term care sort on the policy agenda and get some momentum in terms of considerations of long-term care in policy?

Let me just introduce the panel briefly. You do have your bios sort of in the book. First is Gail Wilensky then Karen Ignagni, Steve Somers, Diane Rowland and finally Chris Jennings. I can't imagine sort of bringing together a group of people that know insurance, know markets, know states and know federal government sort of better than this panel, so we are looking forward to this session.

JUDY FEDER, PH.D.: Now, I'm sure you've all absorbed all the details of all the proposals, right? I'm not going to ask you to raise your hand like Gary did, but what we are hoping actually, and I think feel that was achieved in some sense this morning is that you be stimulated to look at all of these proposals because what we really need is to pay attention and get on with it and find that solution so we don't have a day of penance holiday in 10 years or at any time. But what I'm going go do, too, as part of bringing together, but we still won't do justice to all of the proposals, is give you a way to think about them not as 11 proposals, not even as the very private or the more public, but to think about them as new as four ways as establishing the new public/private partnership and give you our evaluation of how they look in terms of who benefits, who's left out and how we are sharing risks.

So, to set it up to begin it. Let me just begin by reminding us that we don't like the partnership we've got. This is an updated slide of the one Robert showed you at the beginning. This is 2005 data, and you can see from the blue colors that the bright blue shows that the out-of-pocket payments on long-term care. Out of pocket means that people are bearing these burdens themselves and the backup is the turquoise. It's the Medicaid last resort program. That's the bulk. That is our long-term care public/private partnership, and with apologies to Bill, these we still do count Medicare in here, but as he rightly points out, that wedge of the pie is not really about long-term care. So you really need to look at the blue ones to get a sense of the partnership.

Problems with this partnership are really fundamental problems, are two. At the top of the list, I think we should always

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

go to the people, and we know that with this partnership too many people go without needed care. When we last did a survey on this or the most recently available data shows that one in five adults who needed long-term care in the community were not getting the care they needed. This was not a trivial matter. They were far more likely to suffer serious consequences as a result being unable to eat, dress themselves, bathe, or soiling themselves. We know actually that care matters to these people. We've got some research to show that when we finance care at home unmet need goes down. Care matters. Financing doesn't do it all, but financing can make better care and more available care happen.

The other fundamental problem that has been pointed out throughout this discussion is that we are not operating here in long-term care with insurance. That in other major expenses potentially catastrophic expenses, we spread risk through insurance, and we can do that in long-term care as well. Long-term care is relatively rare event for people under the age of 65 making that unpredictable. That's an uncertain. Catastrophic can be insured, and even among the elderly where it is sometimes mistakenly thought that we are all going to need long-term care, we saw this earlier in another form lots of us, I don't know what to root for when I give these data. Lots of us are going to die without needing this care. This is a slide that shows us that the estimated years of long-term care need after people turn age 65, and we saw it in dollars before. I've forgotten who did – Bill showed the slide in the distribution of dollars. This is in distribution of care need, and you see that three in 10 at age 65 will die without needing care. At the other end of the spectrum, one in five will need more than five years of nursing home care, or excuse me, of care. And that dispersion of risk means that we can spread it and that's what insurance is for.

So, we are delighted at all the thought and energy that has gone into developing these proposals. That people have continued to think about them even after they've developed them, which is even better and that they are ready to bring them altogether and, Mark, they will find a way to do it. So, let me give you quickly, let's just look, I'm not going to go through them all, but these are what you can think of as four strategies as a way to group the proposals that we've heard.

All of them are somewhat public and somewhat private so remember it's always about a public/private partnership. The first fund would emphasize, the first strategy would emphasize private long-term care insurance. The second would expand the public safety net. The third would establish public catastrophic long-term care insurance, encouraging private insurance to fill the gap. And the fourth would establish a base of universal public long-term care insurance.

The first set of strategies, you met all of these people, all the ones that have names on them this morning, and I encourage you to look at them all. We actually looked at five strategies to promote long-term care insurance. And all of these strategies, we are attempting to look at eliminating barriers that exist in the current marketplace. This barrier that I've got on the slide is a barrier of affordability, and you can see that estimates are that only about one in five of people can afford at age 60 to 79 can afford a mid-range, private insurance plan. Fewer can afford a higher-cost plan. When we look at younger folks and look at the range of expenses they have, the estimates are not very different. So, what we see is that a minority can afford, and we know that not all the people who can afford are buying insurance.

So, our proposals are to address this barrier and other barriers like the doubts about the value of the project with specific proposals and Jim, where's Jim Knickman? I apologize, that's right, there is a fifth proposal that I will talk about or mention not on this slide, but the proposal is buried in the strategies they put forward, but they were aimed at increasing confidence in insurance products, enhancing their value, lowering their price, or altering their character by combining them with annuity. When we looked at these policies and considered them alongside the resources people have to buy insurance policies, and what we, what we know about the experience in the marketplace particularly with the federal long-term care insurance policy, we assess that we could make a real dent in the purchase of insurance with the kinds of proposals that we heard about in the first panel this morning.

We put forward a range of increased purchases, and we thought that it was reasonable to expect that these policies could increase purchase by as much as 40- to 60-percent from the seven million policy holders in 2005 to over 11 million policy holders among the adult population. A substantial expansion. The fifth proposal, Jim's for savings proposal, promotes as he explained the purchase of private long-term care insurance or increased saving by requiring people to contribute, and it has the potential to make private long-term care insurance much more like public insurance in scope, but how much more we are not willing to guess so he's not on the picture, but as you said, Jim, you fall into the public/private mold and there you are.

Now three of these proposals would do this at very little cost as they were written this morning although I heard some modifications this afternoon, excuse me, as they were written before this morning I heard some modifications this morning. One of them, the tax deduction, was likely to impose costs, and we heard from Sam that that was leading the insurance industry to move away from it, but the costs were significant in tax benefits spent primarily not on new purchasers, but on purchasers, people who were already purchasing long-term care insurance. None of these proposals including the partnership that was in the DRA was expected to reduce the safety net cost. So, the safety net remains with us.

Who would benefit the most from these policies? Well, I'm going to show you a bar that this is again meant to be illustrative, not precise. The bar range starts at the bottom with low-income and goes up to higher-income people, and what you can see here is illustrated for people of all ages and then separately for people aged 65 and over that we can with this substantial increase in insurance, we can benefit, provide some new purchasers, but they are likely to be at the high end of the income spectrum. That's who's buying today and that's who, even with improvements in the market, is most likely to be able to afford and to purchase long-term care insurance.

Who's left at risk by this strategy? For most people, and you can see from all the white space on those bars, for most people the current partnership is likely to remain in place. It would leave at risk most of the future elderly along with people under the age of 65. Young accident victims. People with intellectual disabilities. People suffering from cerebral palsy. People suffering from early onset Alzheimer's or other disabling conditions. All of those would be dependent on the partnership we have today. For those who currently need long-term care, old or young, the private insurance strategy, as we heard discussed, has no impact. That's not who it's aiming to cover.

As a result of all of these factors, it's really important to remember that aqua bar at the bottom and that's true of the four-safety net, excuse me, for savings approach as well. None of these policies eliminates the need for a safety net whether Medicaid or some other kind because except in Jim Knickman's required approach, this Medicaid would remain the primary source of protection now and in the future for most people with extensive long-term care needs.

Moving on to the next strategy. Strategy to expand the public safety net and thanks to Christine's allowing us to split her proposal in two parts, we had two safety net proposals that we heard about. They both would establish a national floor of protection standardizing benefits and protection regardless of the state in which people live and Christine emphasized the variation that we see today. They would also differ in a number of ways particularly in the way in which they structure eligibility though that's not the only way. And so what this slide shows you is the way in which they would vary and how that would affect their impact. One of the proposals, as Marty described, has very broad eligibility both in terms of the level of need, the long-term care need that would be necessary to qualify for benefits and would cover people up to three times the federal poverty level and that's the bar on the left. And if we look only at adults for whom we were best able to measure here, you see that a safety net of that scope could cover over six million, over eight million adults who currently need long-term care.

If you look at the narrower program, the bar to the right, and that was Christine Bishop's proposal, a more demanding standard in terms of need and qualifying for benefits – more higher disability – and income levels at twice the federal poverty level or three times SSI. The level in the most generous states, we'd see that that picks up 1.7 million people. Now, let me be clear these are not people who are initially covered. They are covered only if their assets satisfy the standards that are in the proposals or if they otherwise spend down.

So you can see from this that an improved safety net can dramatically and right now today immediately address unmet need and strengthen long-term care services for people who are least able to pay for it. I forgot to mention something in terms of strengthening. The proposal, Marty Lynch and his colleagues' proposal, was very strong in emphasizing home care. Christine did that, too. So, strengthening home care across the nation and Christine spoke briefly, but I think it's important to emphasize that she was also very focused on improving payment for long-term care so that we improve in ways that improve the quality of care. So those improvements should not go without mention, but a partnership that rests on a means test, means tested safety net, is not the same as insurance. It's not the full risk spreading that we've been talking about. It leaves people with modest income at risk of impoverishment or spending their, exhausting their resources more accurately and going without needed care. No matter where the line is drawn for eligibility in a means tested program, there will likely always be a significant gap between the ability to qualify for the safety net and the ability to finance people's own care needs. So the risk is that modest-income people will exhaust their resources.

Now, second reliance on a safety net will always be subject to criticism that its availability deters people from buying insurance or planning for themselves. That puts pressure on having an adequate safety net. Arguably, or the counterargument I could say, is that this is the most, the best targeted way dollar for dollar to reach people of all ages who need care both now and in the future.

Okay, moving on to a strategy to establish catastrophic health insurance, and again, we heard two creative proposals aimed at creating a public catastrophic program to enhance, really work with private long-term care insurance by enhancing its value. As was said, Sam said, the proposals are similar or theirs particularly is similar to the partnership with Medicaid, but it creates, you don't have to spend down in order to get benefits, and it relies on Medicare instead.

The two proposals were somewhat different in the way they defined catastrophe and how tightly they tied the new public catastrophic protection to the purchase of private long-term care insurance. What you can see from this overall slide, which is a little complicated so look first at the bars to the right with the white space because just like the other proposals they are showing you who's likely to benefit from these proposals, and I want to state at the outset these proposals were aimed at the 65 and older population. They were not aimed at a younger population, but you can see – you probably don't remember – the impact on the purchase of private long-term care insurance we thought reasonable to expect would be bigger with a federal catastrophic back stop program because as has been said many times, it would indicate to people that we ought to do this thing. That if you buy insurance in one proposal, you are going to get this catastrophic. That's a big enhancement of value, and it means that you could buy a policy with limited benefits and still have comprehensive, relatively comprehensive coverage. So we have the capacity here to pretty much double the number of seniors who buy private long-term care insurance. Also encourage younger purchasers and so we thought it was reasonable to estimate that as many as 6.2 million people would newly purchase long-term care insurance under this proposal. An increase of nearly 90-percent.

Now if as in the one proposal that linked the availability of catastrophic insurance to the purchase of private insurance, this would be all the proposal would do. Leaving 80-percent of the future elderly population at risk of catastrophic costs or inadequate care. I think one way you can think about this proposal is that you really have two catastrophic programs. You have the public catastrophic for those who could buy the private long-term care insurance and then you have the existing partnership Medicaid for the rest.

Now, if instead as in the other proposal — Christine's — the public catastrophic benefit were available with or without the purchase of insurance to everyone over 65 needing care after three years, many more could benefit from the new program significant new investment, but that's, so we have got it there so that's why there is a shaded bar to tell you if you make it those three years everybody gets it. Everybody over 65. But making service available is not the same as eliminating risk. Especially financial risk in managing in those three years. So, the question is, how many people could buy private insurance to fill the gap? This is the concern that Josh was raising when he asked a question about that gap filling.

These pies show you based on Kaiser research looking at the current elderly, is it the elderly on the left? Yes. In the community, all elderly on the left. People who need long-term care on the right. It shows you who could afford to manage the cost of at least a year in the nursing home and given the limited resources of the elderly population and this is true in the future as it is today, only a third of older people could cover nursing home cost for even a year, and when you look at people likely to need long-term care, the proportion is significantly smaller. About 16-percent.

So, although the new benefit would assist everybody regardless of income who could manage the waiting period or elimination period with informal care. The public catastrophic program spreads risks most effectively for the better off among the elderly population whether because they can afford private long-term care insurance or still have resources left even after that period, it's this population that gets the greatest, gets that comprehensive protection that people are after.

Who's left out? Because of their limited resources in which we have to keep in mind, the bulk of the older population remains largely unprotected against financial catastrophe. Alternatively stated the current partnership remains in place and

Medicaid or the safety net remains vital, which Christine recognized, which is why she combined the two in her proposal.

Finally, we move on to a strategy for universal public insurance. Again, we have a variety of options here. These are not all the same, and I guess I wanted to call particular attention to the class act and to some extent the proposal Richard Johnson did with Lynn Berman [misspelled?] because they, particularly the class act, is focused on the, it starts out by focusing on the working aged disabled or working aged population, who are the first to participate, and I think what that highlights for us is that we can't all the time think about this as an old people future problem. This is a right now, today problem, now and in the future for people of all ages.

Let's see when we look at the way, now going back to the impact. This has strife all along because everybody gets something here, but not all by itself. There is a role for private long-term care insurance or private resources as well as family care. There is also a role for a safety net. How much actually these proposals do depends on this – and this is where we saw the variation in the proposals – big variation in terms of the level of benefits being proposed. We can do, it's been proposed that we do a basic benefit package. A more comprehensive package. Exactly how we define those is one of the things that we should be looking at to avoid our day of penance, but I think that it's important to recognize that these are not necessarily, were not ever designed to cover everything for everybody even comprehensive is not designed to do that.

Another issue here is whether the benefits are phased in pre-funded or immediate, and we heard also that Jim Knickman was making a big focus having, had a big focus on pre-funding in his proposal. That has a tremendous fiscal advantage in having the future elderly, me and my friends here many of whom are represented at the table. Yeah, okay. That essentially pooling our resources to pay for our future needs – not sticking it to our kids – but it also does pose the problem of what are we going to do for people until we get there? So it's got, as all things do, strengths and weaknesses as all four strategies do.

So let me take us, whoops, wrong thing I clicked. Can it just go away? No. It can't go away. I was doing so well. Click outside. You've got a plan? Okay. You've exhausted your knowledge. Oh, whatever you did you fixed it. Great. Thank you. Okay.

So, let me take us to the bottom line and then engage to close this meeting in what I hope will only be the beginning of a new round of engaged discussion of how to address our long-term care financing problem and care problem because we clearly need to do it.

The bottom line is that we have heard a number of proposals that will enable us to do better in the future, but we do have a choice. Without an explicit choice to act differently, the implicit choice is to continue reliance on the current public/private partnership, which is failing us miserably. Over time, private insurance will likely grow expanding protection among the better off and alongside it as many have pointed out, the public safety net may well deteriorate under the pressure of growing need.

So the outcome of the path of least resistance is really quite clear, but it's hardly desirable. An explicit choice means that we have to decide whether the future long-term care financing partnership should rest on a private or a public foundation. Remember, it will always be public and private and private, the question is what do you want for the core?

Analysis tells us that policy changes can improve and extend private insurance, but its benefits will inevitably be limited to the top tier of the income distribution. It has little potential to spread risk for the rest. Even if it's accompanied by universal public catastrophic benefit, a strategy grounded in private insurance will enhance protection primarily for older people with higher incomes, leaving most older people and/or younger people at considerable risk.

Making private long-term care insurance better for those who can afford it makes sense, but making it the centerpiece of the nation's strategy for long-term care financing does. If we want to spread risk across the broad population, we need public financing at the core, public insurance at the core of future policy. To make it fiscally manageable, it's benefits can be basic rather than comprehensive. We can phase them in over time rather than shifting across to our children, and we must remember that no matter how generous it's going to leave plenty of personal responsibility and responsibility for families to care for their loved ones as they make one hell of an effort to do now and are always likely to do whatever the system.

Now not only does the limits in any benefit mean that there'll always be a private part of the public/private partnership. It also means that we can't ignore, today or in the future, the importance of an adequate public safety net. No matter how thoughtfully we design policies, there will be inevitable gaps, and it seems that as we look at what to do both now and in the future, policy must, therefore, place a high priority on improving that safety net if not specifically as we've said, as we've heard suggested today, certainly to assure an adequate and safety quality of life for everybody in need of care regardless of where they live. Thanks.

[Applause]

GAIL WILENSKY, PH.D.: This is an interesting challenge to try to respond to 11 earlier proposals, which I only partly heard and Judy's summarizing and to do so in about four minutes. Let me share some general responses I had to the part that I listened to and then leave maybe with a provocative thought to pass on to the other panelists.

First point in thinking about long-term care insurance is maybe we need to extend what is sometimes done in discussions of Social Security and Medicare. That is, thinking about together as a joint retirement package, to think about three pieces now. Social Security, the pension or money retirement. Medicare, the acute care and then long-term care, that long-term care piece, and to recognize that we need to think of these as a package. That will be the good news and the bad news because with that come all of the liabilities mostly unfunded for Medicare in particular. Less so for Social Security or at least much less of a problem for Social Security than Medicare, but it probably is a wiser way to think about these because it will make for an incentive the kinds of obligations that we are going to face in the future and may make some of the tradeoffs a little easier or clearer at the end of the day given the kind of choice structures that will be out as to who you want to subsidize and for how much. So, that's the first observation.

A second observation has to do with whether or not there may be any help in thinking about long-term care support slightly differently. Now, I'm going to say something that may just reflect my ignorance about the nature of long-term care insurance rather than be a solution, but since I haven't had a chance to really share those with experts in the area, I'll share it with you publicly. [Laughter] Yeah, and that is long-term care as it is provided at least institutionally seems to me to have two rather distinct components. Part of it is a medical, and I include those skilled and unskilled medical support and the rest, and it seems to me bulk, has to do with non-medical related areas. It's basically lodging and food. The reason I've been making this distinction, at least in my mind, is that other than for major indigence, we don't normally think about an important public role for providing lodging and food for seniors and that perhaps it would be a more manageable way to think about the various choices that Judy summarized and that were included in the 11 plans, if we think about the medical versus the lodging and food support as separately and attempt to finance them particularly when we were thinking about major governmental support that these are really very different functions, and it's not at all clear to me other than as I've indicated that when you have major indigence and lodging and food actually would be a governmental support why we can't pull that off. So it is a way as in the same trend of thinking in the first part that I mentioned, which is we need to think about all of the obligations we are going to be making to the over 65 population together, and therefore, think about what is reasonable to be a public sector obligation and what is reasonable to be a personal or a private sector obligation that we ought to strip out what is normally going to be supported even by quite low-income seniors - that is, their lodging and food from the medical, but including the non-skilled aspect.

There's a [inaudible] area that I wanted to raise. This is somewhat more provocative, and then indicate why among the various strategies I find one of them more attractive or more consistent with the issues that I've raised in the other. Judy mentioned that inevitably if we have private insurance as the basis, we will be talking about reaching out to the higher income seniors in terms of who it is that will be protected, which I don't disagree with, but if I think about long-term care as in many ways primarily protecting assets and protecting assets for the next generation, I'm not sure if that's entirely a criticism. So that's sort of the long term, that's the provocative thought that I want to leave you with. That's really what this is all about it seems to me or that you can argue it seems to me is whether or not you are predicting the ability to transfer on assets to the heirs and therefore, looking at insurance that is protecting higher income people more than lower income whether or not that is inappropriate as long, particularly, if you have some sort of reasonable safety net at the bottom for those who will not be able to avail themselves of the insurance.

As I'm looking at the various strategies, it seems easiest to say that universal long-term care is not likely given the kinds of obligations we have already taken on with regard to Medicare to say nothing of Social Security. So, then I tried to think about which of these other strategies makes sense, and the one without having giving this the kind of thought I would want to before really staking out support, is thinking about whether establishing public catastrophic insurance, which is working with private long-term care insurance, may not be the way to try to balance these interests, but as I've indicated that is really without understanding fully the implications that would result. I have always found attractive partnership that the Robert Wood Johnson Foundation had promoted in the early 1990s, where individuals who bought private insurance would be able to have private insurance to protect their assets, would be able to make use of that and not have to actually spend down in order to avail themselves. The Gene Lambu [misspelled?] paper seemed to be a continuation of that concept that continues to have some real level of appeal and attraction to me that you allow people to protect their assets if they can and wish to and that that protects them from having to make themselves destitute to go into Medicaid. Thank you.

KAREN IGNAGNI: Good afternoon. It's a pleasure to participate in this panel. I thought the paper, Judy, was terrific, and I found myself having to make a cheat sheet as I went just to keep all of the things in my mind in terms of tradeoffs, but I thought you did a fantastic job and kudos to your colleagues.

I came at this in a way that Gail did, and I suspect most of us might, I'm very much reminded of the discussion we are having now with respect to how do we get people under 65 basic health care? And I think as a country we've come around to the idea that it shouldn't be either public or private, but it should be a reasonable blend. That's pretty glib to say. The question is, where do you put the fulcrum and how you actually do that? And here are a couple of thoughts that occurred to me as I was reading the paper.

First, we are having this discussion and one of the final questions that was posed to the previous panel made this point I think very saliently that one, we haven't figured out how to raise the revenue to deal with basis access to care. Number one, we've got to take account of that.

Now, I'm not going to say that we put this at the bottom end of the hierarchy, but I want to come back to that point in a moment. We are also having the discussion when all of the policy insiders, virtually everybody in this room, thinks the problem of trust funds is quite acute, but many individuals believe that as a country we probably won't get our hands around them until it's staring us in the face in the way that Social Security did in '83, and I think that's unfortunate in terms of potential strategy here as well.

The third point is that the AARP has done terrific research to show that, in fact, many people believe they are covered for long-term care and it's a cruel awakening to many families when they find out that they are not. And then finally we are on the press of the baby boomers retiring when it's going to be very, very clear that we have to solve this problem. So, where do we go?

I think that it has to be a blended approach for us. The NEIC has done some very, very good work in setting up regulations for insiders, they are called, and they are mentioned in the paper of suitability requirements so that you don't sell or try to sell long-term care insurance, private insurance individuals with roughly incomes under $30,000. We think that those regs have been very helpful. It's a very good educational point for individuals. It's very interesting also given those regs that a third of long-term care purchases have incomes under $50,000, which is very, very interesting. I also thought, which was what we knew, we had a hunch was the case, that the paper really brings this out to the extent you do, you move forward as a country with above the line deductions and strategies of that sort. You do reduce the effect of cost of purchasing private long-term care, and I think that that's worth looking at as well.

So, if you marry up all of these concepts, I think we come to the same kinds of discussions we are having in the basic access issue. One, how do we establish a safety net that will work for individuals below a certain income level? I think we need to do that. Clearly in the area of SCHIP, clearly in the area of Medicaid and traditional health care we also need to do it here. This is the third leg of the stool.

Second, the question is from a safety net perspective for people at the lower end of the economic distribution, should we begin as a society to frame the issue that was framed 20, 25 years ago, but you are coming back to it in the paper, but should this continue Medicaid and long-term are expenditures be a burden primarily for states? We need to think about that as a society and where do we go from here?

Third, I think that as we begin to marry up strategies, it would be great to begin to think about what could we do to facilitate private purchase for individuals who with a little bit of subsidy and help could purchase where they can't today? And I want to talk about three proposals. And then at the same time not to the exclusion of the safety net, but at the same time marry up safety net changes so that as a society every one could feel that there's something here for them.

Now, it sounds easy to say, but it's very, very difficult to do, as I think the paper points out. But if we were to set that up as a goal, one of the things that occurred to me if we were at the point where we are actually going to look at the entitlement problem seriously, you could look at things like taking the cap off Social Security, the income cap doing what was done on the HI fund, you could look at things like surcharges on income tax. You could do some progressive things that could allow you to establish the beginnings of a private and public strategy. In other words, where are we going to get the resources to do the above the line because people don't have the 7.5-percent and then they begin to spend after that? So clearly, I think thinking about tax subsidies would be helpful to people not only at the highest end of the income distribution but looking at the data people in the middle as well married up with a safety net strategy. On the tax side, we talk in the paper about the above the line, which we believe would have the effect that the paper suggested would, which would reduce the cost of purchase. If we couldn't afford to do all of that at once, then the two strategies that occur to us is to allow people with flexible benefits who have resources at the end of the year that they either turn back or buy the third pair of eyeglasses to be able to use those plans to invest in long-term care.

Four, in the traditional health care — in the under-65 — we are talking about premium support tax subsidies. We could be thinking of that as a middle line strategy, and then, of course, the above the line. I think that on the public side shore of the safety net and figuring out the right set of strategies, again, the continuum of strategies to allow individuals to feel that they are not being ignored here is terribly important. I think we could take some of the learning that's been done in the under-65 market in the area of high-risk pools, ways to pool purchase for people again over a certain income level. If you require guarantee issue that's simply going to push up the cost for everyone else buying it so that's not going to be the right strategy, but if we figured out a pooling strategy, then I think that would also be a middle ground.

Finally, I think we should also look at not only the cost of insurance, but the cost of care. The average stay in the nursing home now is roughly $75,000. Few Americans have the assets for that. So we have to look at the kinds of tools and techniques like care coordination and the sorts of initiatives now that are working very effectively in the under-65 market. Again, I don't mean to state this glibly. These are strong challenges not easy to do, but I think as we, as a society if we could marry up what needs to be done to facilitate private purchase, what needs to be done to facilitate public safety net and to shore that up it would be a better conversation.

So I think, for me, the takeaway it's not an either or, but how do we do the right kind of blended approach and the questioner — and I couldn't see I was in the back — who asked the, but how do you basically do this strategy that would allow us to develop this continuum if we are not able to do it altogether? I think is just the right way to begin talking about these issues.

STEPHEN SOMERS, PH.D.: Thanks. I want to join Karen in complimenting Judy and her colleagues and the Robert Wood Johnson Foundation. I got this this weekend, and I actually opened it on a Sunday morning, and I actually read it, which is a testimony to its 60 or 70 pages.

JUDY FEDER, PH.D.: No, it's 80. [Laughter]

STEPHEN SOMERS, PH.D.: No, wait a second. That was the bibliography. The bibliography doesn't count. The point being that it was refreshing to see it all in one place. It's not something that's been done recently, and it was a great opportunity to catch up on this, and I will say catch up because I am if I look around here, I'm a token outside [inaudible] person on this panel. So it would be foolish for me to start talking about big picture policy issues and what the Center for Health Care Strategies really focuses on as implementation issues. So I am really going to make one comment about the implementation side of all of this.

I work with states on both sides, too, on the Long-term Care Partnership Program with Mark Meiners in the expansion of that program that RWJ just funded, but also with states as they go about experimenting being laboratories for innovation on managed long-term care and some of the issues that Marty mentioned earlier. And as I was reading the first part of this I want to remark, and I don't know if it's a glass that's half full or a glass that's partially full, but there has been some progress over the years, and the Home and Community Based Services has gone from 14- to 30-percent of Medicaid expenditures. That's good news. The Cash and Counseling Program that Barbara talked about a lot is something that has been accomplished in understanding the consumer direction can be an important piece in this. I think that's important.

Private insurance. This has been mentioned a number of times is better by virtue and part of the long-term care partnership program. It's better quality and has inflation protection, and I should mention that in the expansion program the intent would be to work with those ten states that have been selected to push those same kinds of protections that were in the, and qualities that were in the first round of the partnership program, but moving forward as policies get developed, I think the important thing that I would want to put into the mix and Bill anticipated this a little bit in his earlier remark about the financing and the policy halfway up the mountain and the other half is figuring out how to deliver they services and what the service system should look like. And I just want to push for integration as much as possible and the separation between acute and long-term care is unhealthy, I guess. Jim alluded to that earlier, and it's gratifying for me to see some more movement, paces, you know 15,000 beneficiaries, Medicare/Medicaid Demonstration Programs in three states with 40,000 beneficiaries. Managed long-term care, which tries to do some integration across a number of states may be getting close to 100,000 beneficiaries. It's small numbers by comparison to what we are talking about, but something to note and some progress.

And I also mentioned and Karen, the special needs plans were a hope for greater integration in terms of acute and long-term care, and I used the past tense. I probably shouldn't have. Karen bolstered me on this. There's still some hope there that you can get greater integration through the special needs plans for [inaudible], but I'm just saying that any policy that is taken or chosen among all of those that have been laid out, I would hope that it not be a fragment. To think about things as part of a whole and that there be as the policy is being designed that there be attention paid to how is this going to be, how is this going to further promote or enhance integration of acute long-term care service, behavioral health services, social services, et cetera, over time? Because that's where we have to go with some of these programs and that's what states are struggling with with the populations that they are most responsible for right now. Thanks.

DIANE ROWLAND, SC.D.: Well, I want to thank you all. I know how long most of you have been here so I want to thank Judy and Robert for the wonderful paper they gave us and the audience for still being here at ten after three after starting in the morning with so much enthusiasm, and it's really hard when you are at the end of a panel to find something innovative and new to stay and especially hard at the end of a day when you've all covered so much territory, but I think one of the things that struck me that Judy and Robert and colleagues have put on the table that we have to remember is that two out of five long-term care users are children, are working adults. Not just the over-65. And I think that's a fundamental issue in how we look at redesigning long-term care and there may be, we talk about it in health insurance for the under-65, but there may be different strokes for different folks and what may work well for an elderly population may need to be tailored somewhat differently as we look at the choices and options for those who may have an unanticipated injury at work that causes them to be disabled or a child born with cerebral palsy. So I think that's one thing that's been useful to put on the table.

The other thing that struck me from today and from looking at all of the plans is that no matter in the world of modeling we can make assumptions and we can assume things that we would like to have happen in the real world, but no one was able to really assume out the need for a safety net program. In all of these proposals, we see that this is an area just as I believe in health insurance for the under-65, where a safety net is important. We'll always have individuals who have a need for some kind of public assistance whether it's at $30,000 to buy a private insurance plan or whether it's because they didn't anticipate their level of disability or because they are born with severe disabilities and need help that is not available from the general plan.

What I thought was interesting in Judy's slides was that she portrayed the safety net as aqua, which is also the word for water and is also the sort of, the people who are sinking beneath the tide and under water, and we need to somehow give them a life boat to lift them out. I have a new image of Judy. I know Judy likes to use graphics occasionally, but now I have these little boats floating on the water that are helping our people who need safety net services. But I thought the other point and one that Gail reinforced for me was the wall that we create too often between acute and long-term care and the fact that part of that wall comes from the way we deal with food and lodging and housing, and it's been a particular challenge as we look at trying to provide broader access to home and community-bases services where you don't have that lodging and food component in there and so how do we really deal with at least for the safety net looking at how to separate those two out as well as separating out issues for the elderly and for the people with disabilities who are not in the over-65 group?

And that leads to points that I know Steve always makes and has just made so effectively that we really do have to think about how we integrate the services across lines and across programs and Medicare and Medicaid interaction especially for people who are dual eligible since it's not been a very positive one and can be clearly improved, and I think those are the places where this report leads us to really look at the safety net and irrespective of where we draw the line for that safety net of who gets into the safety net and who gets private insurance, how do we make that safety net itself stronger and more positive in terms of its direction for coordination of services for chronic care management and for really trying to help people remain in the community as long as possible? But I think that when I come back to the end of the day and what we've learned, I go back to something Karen raised that I had thought about before walking into this room is this is kind of our health insurance problem all over again. It's the same set of issues who currently is assisted and who was in whose, how much unmet need is there out there? What level of a safety net do you need? Do you set it at 300-percent of poverty? One hundred-percent of poverty? Gail's always pointed out in many of the discussions that there's little disagreement on what we do for people under poverty, but then where do we draw that line on the next level up?

So I think that, at the end of the day, we have got a lot of good information about ways to think about moving this debate forward. I think we have some lessons about how difficult it will be already from the health insurance debate for the under-65 population, and I hope that this will bring the long-term care debate up to the level where we are already at with the uninsured debate at least getting it on the table and not making it the backburner issue. It always turns out to be behind the health insurance issue because it is a continuum, and we are not really going to have good coverage for our population unless we look at both the health insurance side and the long-term care side to figure out how to put them together with a good safety net base for those most in need.

So I think once again we are talking about a blend, and I think the question as everyone says, how do you make the blend the right blend so that everybody has their — as Barbara put it — their mocha latte or whatever we want to have at the end of the day.

CHRISTOPHER JENNINGS: So, I'm the last that was an inaccurate portrayal of your presentation, but I can't wait to add on to these extraordinary comments. I thought, Judy, I want to, I thought your summary was really great, and I thought, I have to commend the researchers and the authors for their, both of their analyses and their recommendations, which I think was quite solid. And I think that most importantly it reflected the current environment. It wasn't a nirvana set of recommendations. None of them would suggest that it was. It was what they thought could be done even in a hopeful world, which I'm afraid sometimes we don't have.

Now, last time I did a long-term care with you, Judy, I was so depressing that I didn't want to say, oh, long-term care, it'll never happen, so go back to your, you know, caves. [Laughter] But the truth is the best way to do this politically I think is to integrate it into the larger debate on health care. I think as a standalone it's hard, and we have to recognize that states don't really differentiate in their world right now between long-term care and coverage. It's just cost. It's a lot of money and happens to be a lot of money of costs on long-term care side. In fact, it's what? Two-thirds of the budget or something along those lines. So, I would suggest that we do, when we do these type of analysis, we don't just talk about the issue of long-term care as a standalone, but if you are going to provide a specific look about the cost benefit that accrues to the state, who are already incurring substantial cost and then integrate that into your larger coverage discussion that will inevitably take place, I'm reminded of Ronald Reagan's SWAP [misspelled?] proposal. Well, he's one of the swappers, certainly, and I've become a swapper on occasion too. Whatever works is my world. Because in the end of the day, that's really what the definition of long-term care should be. Whomever's proposal actually can be passed and actually help relieve some of the burdens is what we want.

My instinct on the whole range of policies, and I've written about this one of those rare things as inspired by both Anne and Jean's work has been the catastrophic not because I think it's better or worse than anything. It's just kind of going with the flow and by that I mean that it does seem to be in this country for whatever reason at this point in time in the world order, that we think that federal subsidies for catastrophic health care expenditure is something that Republicans and Democrats generally agree on. It's not something that's better or worse. It just seems to be the reality, and alone those lines when you have catastrophic cost covered, you buy out some of the current state liabilities, and I think you free up for low income that could be used for the safety net. It also provides an incentive for what obviously is a disincentive for purchasing private long-term care policies, which is that they are worried about their back end liability, and it reduces premiums accordingly.

So, you know, there is some argument for it, notwithstanding the fact that it does leave all the holes that I think Judy's analyses are laid out. I encourage all researchers of these proposals to look at the various players of long-term care who are starving for attention. By that I mean the states are starving. They can't wait to rid themselves of some of the liabilities. The providers are frustrated with Medicaid reimbursement rates. They want to find a way to get some private/public approach, and they recognize neither is going to be adequate by itself. Labor desperately wants to become a player in the provision of home and community care services and want to play a role in terms of training. Insurers want to sell products, the federal government wants to figure out a way to be hopefully constructive.

All these things have to start and end with the families who are burdened overwhelmingly by this. You know, one way or the other we are going to have a system. It may not be something that we actually pass, but we have a system now that's called primarily Medicaid and people, and it's over burdening them and there will be a reaction to it. There is already beginning to be a reaction to it.

I'm hoping that Washington can be a constructive role, but I would go back to I think something Gail and Karen says, integrated in a broader discussion of all these other initiatives because I think as a standalone issue it is just too tough to be anything other than the second best, the second issue in everyone's priority list, which is not going to cut it here.

So, but I want to conclude with something constructive and encouraging, which is to say that I think all these players that I just referenced are ready to play, and I think your contributions have been substantial and are realistic, and I think will make a big difference. So, I'll conclude with that.

WILLIAM SCANLON, PH.D.: Thank you very much. I think it certainly exceeded any expectations we had. We have time for a few questions. Does anybody on the panel want to add a word? Okay. Any questions? This is a great opportunity.

MALE SPEAKER: Thank you. In terms of the political feasibility, maybe a couple of you could comment. I've been struck, of course, by the whole global warming parallel here that we've had a total turnaround in a very short period of time, and I guess Al Gore is not making a movie yet as far as I know about long-term care, but would any of you – Michael Moore maybe – would any of you anticipate a tipping point down the line here where we are going to swing on long-term care going from second best issue to going over the top because of the amount of personal anguish or experience that's happening over time? Any speculation on that?

GAIL WILENSKY, PH.D.: No, I don't think so. I think it's the thing that we'll be tipping, and I can't remember which of you made, several people said, is when Medicare is overwhelming general revenue, which is probably going to happen before the Part A becomes insolvent, it will drive some changes and whether or not there is an ability to link thinking about acute care and at least long-term care if not the Social Security retirement pay, might be able to allow for some more sensible strategies. I think all of us agree that the dual-eligible population, which is the most expensive, works badly and is just an example of the kinds of problems you get when you don't integrate these programs. I think the most interesting thing is that there was not nearly as much division of opinion on the panel as you might have thought just looking at who's up here.

MALE SPEAKER: Josh Weiner [misspelled?]. This question is for Karen. I was pleased to see you support making the safety net broader and better. There are a number of people in the insurance industry who have argued that a good quality Medicaid program is the enemy of private long-term care insurance would you care to opine on that?

KAREN IGNAGNI: I think I know many of them in the insurance industry and what I hear people saying is that it would be great from a public policy perspective to jump start the purchase, help support the purchase, so we've been looking at a variety of tax incentives as I said. The most expensive is the above the line, but it does most in terms of what the surveys tell us about how it would help private purchase. At the same time, we've been very supportive of the suitability standards that the NAIC has laid out and been very much supportive in the context of our own proposal for health care reform, which we offered some seven or eight months ago in terms of repairing the safety net. So in that proposal, we are talking about dealing with the SCHIP problem, dealing with the Medicaid problem, doing away with these crazy categories that we have in Medicaid, having adjusted income tests making it very, very straightforward. So I think perhaps, Josh, we one could say we are enlarging our thinking and spending more time than we had previously looking at what the public sector can do to repair the safety net, which is something everybody in our society should be concerned about because we know just from a productivity standpoint if we don't, you know, better than anyone, that costs yet just reapportioned in a very inefficient way.

So, just structurally it makes complete sense for us to proceed in tandem, and I think the papers lay out the real opportunities for some public support on both sides, both to support private purchase, but as well as dealing with the safety net, and you'll find that you were spending a great deal of time in the SCHIP debate and on the Medicaid question, and we are going to do that in the area of long-term care and the safety net as well and perhaps the issue hasn't been framed as specifically, but you'll see us there on both sides.

FEMALE SPEAKER: With some of the call to thinking about what you familistically call acute care in conjunction with long-term care, I wonder if you might not do well to split the two major populations that use long-term care. It seems that the call on the community is different. The services end up being awfully similar, but the call on the community for a person with lifelong disability or long, long-term disability that's relatively stable is a somewhat different call than the call to the community for persons who are disabled as a conjunction of the illnesses that are associated with aging. Again, everybody deserves to prevent a pressure ulcer, the opportunity for savings in the first case is often pretty thin and the opportunity for savings in the second case it's much more substantial and also the fact of impeding death conditions what makes sense to do for a person who is 22 with a spinal cord injury should have just about anything else the health care system can dish up, but the person who is 80, the fellow who was seen in the video today, it's not entirely clear that the community intends to make fully available dialysis or heart transplant or $200-a-day pills. So the priorities, it seems, may end up being somewhat different and edges us into a group of things we don't necessarily, none of this is anything we [inaudible] talking about, but I wonder if when you think about financing the long-term care and especially building the political base that would manage to get us seriously talking about any of this in public, if the fact that the caregivers of the elderly can be convened about a set of issues that are rather different might provide a leg up and likewise those who are, all of us who are concerned about long-term disability since all of us are only temporarily, you know, able to be here, that might tap into some different roots. To think about some different splits rather than acute and medical or long term, you know, sort of as a general group. It seems that there's some different calls in terms of the public dialogue.

FEMALE SPEAKER: I think it's an interesting thought that I have not raised particularly in that way. I think it's interesting.

WILLIAM SCANLON, PH.D.: You are getting agreement here, and I think one of our problems is while there are opportunities to try and think about things in a unified way, there are so many segments of this problem including sort of what you have identified in terms of the time period with which someone is going to need care as well as their ability to finance it personally as well as there's other circumstances and all of those things influence what might be a good solution.

FEMALE SPEAKER: I was just going to quickly say that I think it's another way to keep on the table and in front of everybody the under 65 population as Diane reiterated that two in five of the long-term care population are under the age of 65, and in so many of our policy discussions we act as if this is only a problem for older people.

WILLIAM SCANLON, PH.D.: Who would like to have the last question? Okay.

MALE SPEAKER: This is directed at Judy.

WILLIAM SCANLON, PH.D.: Sorry, we have one more. We'll do two.

MALE SPEAKER: [inaudible] [Laughter, Applause] As a follow-up, Judy, I would like if you could briefly tell us whether or not you brought up long-term care in your last campaign, and if so, how did it resonate with the public?

JUDY FEDER, PH.D.: And [inaudible] was not a plant. What I found a very moving issue talking to people is it really follows what I just said. Families who are, have children with disabilities was one of the, I think most profound family moving experiences I had because they were so concerned about issues like stem cells, as well as care, education, the kinds of support they need. So you talk to people all the time who are coping with older family members, but young parents of young children, at least I ran into quite a lot, and would like very much to be able to, I think all of us are aiming, to improve the system for everybody.

FEMALE SPEAKER: Most of the changes in long-term care over the last 10 or 15 years have been incremental changes. Most of all, these proposals deal with large-scale changes in the financing and somewhat the delivery, and we know that there are many, many kinds of things that could be changed. I'm wondering if the panel or any of the authors have thought about incremental changes and how would you prioritize incremental changes that could be made pending the time that there be large-scale financing reform?

JUDY FEDER, PH.D.: I think the easiest kind of incremental changes is to have targeted or generalized subsidies, and we heard a number of them being raised subsidies either above the line or however to encourage the purchase of long-term care insurance, the subsidies to encourage people to buy insurance that protects specific assets so they don't spend down. Those kind of targeted changes tend to be incremental by nature. The other is the rollout in which you do some of the changes. So, if you do expansions with regard to a safety net how you stage it. In general, we do things incrementally and you can, it's helpful when you have a vision of where you want to go, but the actual changes are likely to be incremental. Again, particularly given the incredible unfunded liabilities that we are facing with regard to current promises for future benefits of the elderly.

CHRISTOPHER JENNINGS: I just wanted to add one thing, which I think we, this goes back to my integration of every issue. You know in the late ’90s, we had the charge, of course, that Medicare Acute was paying for a lot of long-term care expenditures, and I think we are starting to pick that up again. Every sort of cycle it's sort of like my garden, you know, and we come back and we trim back, but I think that there are two issues. One, there's that and as the baseline increases and there's more of that happening and there's some money in the system and there's this greater interest and intrigue with chronic care manage, chronic disease management, that we might be able to fold that into a larger discussion into the

Medicare Reform discussions and the Medicaid Reform discussions into coverage discussions as a whole because I think we are seeing more and more of that debate raised as the drivers of cost for the under-65 as well as the over-65 population. So, I would, I see some hopeful signs about these issues being engaged in a more integrated way, and that's how I am going to conclude my comments.

FEMALE SPEAKER: Carol, I would say that clearly on the incremental side, one can begin to look back at the safety net. One of the progressive things happening, of course, in Medicaid was the development of more home and community-based services, but really to look at how to make those more available. Are there ways to point back to the disability issues the disabled community has always used home and community based services much more extensively than institutional care, but what can we learn about some of these experiments that are now on the table for consumer-directed care and for other ways to really shore up that safety net?

And I think we really need to look at how we deal with the income and assists eligibility criteria for the Medicaid program and that that's an area where incremental reforms can help to at least establish some kind of a level playing field across the states for individuals with those disabilities.

FEMALE SPEAKER: I agree with Diane exactly on those two strategies on the public side of things. We've been working very closely with ADAPT [misspelled?], an organization that many of you know of, and we have been talking about how to team up to really get to an expansion of home and community-based waivers. We've been looking at the assets test and looking at a range of things. I think on the tax side, there are a continuum of things that one can do depending upon how many dollars are available, and you could line the strategies up so that you have sort of a beginning strategy, a middle strategy, and then the ultimate "how do we fix it" strategy.

And I think that it would be very, very useful to incorporate many of these kinds of things that we are thinking about when we think about the program and the challenges of Medicaid and the burden to states and how we address those, and we also think about what baby boomers are going to be looking for in terms of support for their purchase of long-term care needs, but I think you could line them up together. I think we get into trouble as a society when we start picking one or the other, and I think that would buy a number of individuals in to do something responsible, productive and stage it in a positive way.

I think the final comment is that I'm more optimistic about us coming to solutions on this because I think historically, Chris, I think you may have implied this and may have exactly said it, that when the baby boomers are interested in something, things get framed and things get done. And so I was delighted to participate in this because I think you've given us a critical path for actually looking at how you do both on the public and private side so at the end of the 80 pages, I really felt good about there's a strategy here that I can get my hands on. So I think you guys have done a wonderful public service in producing these materials. Thank you.

[Applause]

WILLIAM SCANLON, PH.D.: I'm going to turn it over to Judy for the last word, but let's also thank the panel.

[Applause]

JUDY FEDER, PH.D.: Thank you, Bill. I want to give a particular recognition to Harriet Comesar [misspelled?]. [Applause] and Robert Friedland, my colleagues, and again it was not a public service. It was a service sponsored by the Robert Wood Johnson Foundation. [Laughter] So I think let's all of us baby boomers and those ahead and behind, let's get out there and make long-term care part of the conversation so that we can indeed move forward. Thank you all.

[Applause]

[END RECORDING]