Approved: April 6, 2001

MINUTES OF THE HOUSE KANSAS FUTURES COMMITTEE.

The meeting was called to order by Chairperson Carlos Mayans at 1:30 p.m. on March 27, 2001 in Room 526-S of the State Capitol.

All members were present except: Representative David Huff - excused
Representative Carl Krehbiel - excused
Representative Laura McClure - excused
Representative Gene O'Brien - excused
Representative Mike O'Neal - excused
Representative Bonnie Sharp - excused
Representative Tom Sloan - excused
Representative Dixie Toelkes - excused

Committee staff present: Lynne Holt, Legislative Research Department
Lois Hedrick, Committee Secretary

Conferees appearing before the committee:
Dr. David Cook, Acting Director, Center for TeleMedicine-TeleHealth, University of Kansas Medical Center (KUMC), Kansas City, Kansas
Steven Moses, President, Center for Long Term Care Financing, Seattle, Washington

Others attending: See attached list

TeleMedicine/TeleHealth

Dr. Cook discussed the history and some of the impressive things done in Kansas by KUMC over the past decade and nationally to allow everyone to think about some of the questions that legislators will face. Dr. Cook's testimony follows.

"I define telehealth as the use of telecommunication technologies to provide health and educational services over a distance. The important point is telehealth is used on purpose, meaning that we have had a long history of providing telemedicine services in the United States, back to the 1950's; but in the 1990's the concept of telehealth came along. The distinction between the two may be insignificant to some but it is important. When the Center was renamed to include both titles, it was because of the use of emerging information technologies to provide healthcare and health services, and education–not just from the physician seeing the patient, but from a much broader perspective of healthcare providers. That is critical because that has brought forth new initiatives and projects for the Center in the last 5-6 years.

"The Center's TeleHealth Clinic provides an area where a pediatrician can use a traditional consult room, see a patient, go to the next room, see a patient, and "oh, by the way, there is a telemedicine consult room". The doctor can go to that room where there is a computer, monitor, small camera, fax machine, and a telephone (which shares a line with a stethoscope) to consult with a school nurse who is visiting with a child at school. In essence, the three people can talk with each other in real time, see each other, hear one another, and actually have a consult in real time. Almost any kind of scope can be added to this kind of a delivery model. Costs tends to be the barrier in all that.

"One critical component to get on to the table is "Bandwidth". This is critical – one of the real challenges to be faced in the telehealth world. It is thinking about the existing health communication lines for the appropriate image or medium you want to be broadcast from Point A to Point B. Presently telephone lines (POTS) was designed for audio. The Center has tried to test some of the limits and to determine capabilities of POTS lines to also provide video over those same lines and without doubt, there are certain limitations. Only so much can be done on POTS lines, so the Center has had to think about times and places where we needed higher bandwidth lines to push more information down that line; in other words, to have both audio and video simultaneously. Higher bandwidths is higher costs.

"It is important to recognize in the state of Kansas (and particularly the people we connect with who are providing telehealth and telemedicine) probably 99% are not providing care at full cable and broadcast quality. Now working at 384 kilobits, we actually provide health services at about a quarter broadcast quality.

"The Center works to identify places where health care is needed; for example, having someone tell us that geriatrics assistance is needed in southeastern Kansas. That is the model we prefer to work on. The western part of the state did not have an oncologist. With the addition of Dr. Doolittle, an oncologist, over the past decade we have had the most active tele practice in the world. Pediatric cardiology was incredibly busy in the early 1990's and moved towards more clinical consults. Those practices helped the Center become what it is today. Costs have gone down so there is opportunity for dreams of where the services can go. In 1991, when Dr. Doolittle and Dr. Mateo, Pediatric Cardiologist, conferred via TeleMedicine, the equipment cost about $125,000. Today, depending on "bells and whistles", about $10,000. The Center has programs going into schools, but also home health care is large. That speaks to the exciting way this is going.

"In 1993,. KUMC was one of four programs in the United States; today there are between 150 and 200 telemedicine programs. The reality is probably within the next 5-10 years there will be no telemedicine programs, because the technology will become more and more ubiquitous and not need a middle person to facilitate. We will need to re-think the programs future. We are talking about doing about 2,300 consults this past year. We are not changing the landscape of health delivery; but real pockets of difference has occurred in child and adult psychiatry, in oncology, in particular communities. The Center was the fourth most active program in the United States. Last year it received a President's Award for its historical contributions the past decade. The Center has had some success, and moving in the right direction for a long time.

"While today we talk about reaching out and the changing demographics and the aging population in Kansas, certainly we must think about how telemedicine and telehealth can reach out to communities. It is an ongoing challenge to stay ahead of the learning curve. Why the success? The one point to be highlighted is the telecommunication infrastructure that was state run and put in place in the early '90s. Actually today it is archaic and is being replaced. Don't lose sight of what that infrastructure did for us in the early 90s to today. It allowed Kansas to be one of those active states that reached out to rural areas. It helped us to stay ahead of the curve.

"Philosophically the Center recognizes that while we talk about KUMC providers, it recognizes that it is the rural areas needs that become the instruments or tools for these health care providers and administrators. Sometimes it is more exciting to talk about the clinical side of it, but the educational component is emphasized, especially for continuing education. The worldwide web pages may be in direct competition with the Center, but it supplements the Center. It is of real benefit to have interpersonal interaction.

"One of the programs operated by the Center, connects four elementary schools today by its TeleKidCare program in Kansas City, Kansas. By the end of 2001, there should be 13 elementary schools in the program for health care. From the telemedicine side, it is the idea of serving underserved children, not necessarily geographic, but social or economic based.

"Telehospice may be a program more directly related to today's program. Dr. Doolittle, the Center's Oncologist/Hemotologist, received federal funding to provide telehospice. This speaks to the telehealth model more than telemedicine, using the telephone and video component in the home. We purchased 100 of these units at a discount price, about $300 each. With costs going down to that level, we start to think about using the technology for home healthcare. Homehealth, Tele-Jail, and OAT projects are a reflection of the Center's interests and abilities to dream about how the technology can be used in a lot of different ways. The ideas underlining these different projects can be defused to other segments of the population, such as the aging.

"Everyone talks about how telemedicine will explode but there are some critical issues that first need to be addressed. Nontheless, it has defused to 46 active states (California is the most active). It is important to recognize its maturity. Two-third's of the programs are less than 12 years old. There are many challenges. So what is the future? A big part of the future is overcoming the challenges and recognizing what new information technologies can do. Today's catch phrase is "E-health world". E-health has many definitions: "Using the worldwide web to reach out to a far greater population not only to institutions that provide healthcare, but also to provide health information to those in their homes". This may not mean it is for direct clinical care, although that holds potential. It is also for home monitoring and on line medical records that brings billings, other transactions, lab work, and other items together into one record. There are costs associated to that, as well as privacy issues.

"It is anticipated that by October 1, Medicare will begin to reimburse for lab work and for broader healthcare services in the field of telemedicine and telehealth. There are still things that can be improved, but certainly it is much better than where we have been. The Center hopes to take advantage of that opportunity and approach Medicaid and third party payors to start reimbursements in the state.

"From a technological perspective, there are many things to consider. My goal was to talk about telemedicine , and think about how it can become a bridge to reach out to the changing demographics, thinking about policies. I intentionally left this at a level of abstraction on purpose so it will allow us to think about where we are going. What we will have is increasing accessability. We will have highband access to homes. What that means is a great question. Most of the time these technologies are unavailable in rural Kansas. If they are, they are not cost effective to be implemented today, but certainly will be in the not too distant future. That holds opportunity to do things that we already do in telemedicine, but will be extended to homes to provide patients with information and an interactive video. To make any connection to telemedicine in Kansas, especially in the early 90s, was to call the operator in Topeka and the operator would allow you to connect to whoever you wanted to connect with. I didn't mean to be too critical of that because at the time that was the cutting edge. Where we want to go now is to a switch system, where you pick up the telephone and call whoever you want. That will be a seamless and transparent system using the highband technology to the home.

"With respect to the state's prison contract (of about two years ago), the Center's adult psychiatrist started working for the prison, so the project is not active. The jail project–making the distinction between prisons and jails–that adult psychiatrist was connected with the Lyons County Jail, Emporia, seeing about 30 patients a month for the course of a year." (The powerpoints of his presentation may be found on Attachment 1)

Chairman Mayans thanked Dr. Cook for his presentation.

The Center for Long-Term Care Financing

Steven Moses stated the Center is a 501(c)(3) non-profit charitable organization, a think tank and public policy group, with a mission to insure quality long-term care for all Americans. The mission is pursued by encouraging public policy that targets the scarce public resources that are available to people who are genuinely needy, and encourages everyone else to plan early for the risk and cost of long-term care by either saving, investing, or insuring. The idea is to leave the burden on the public programs and breathe some financial oxygen into the long-term care system, with the end result that everyone has access to better care.

He directed attention to the handouts he had distributed to committee members. Included were two *Viewpoint* articles, entitled *Equal Access for All, LTC triathlon*; an article entitled *The LTC Pledge for Baby Boomers*; and two *LTC Bullets: Principles of Long-Term Care* and *Surplus Won't Send Us* (see Attachment 2.)

He stated a number of resources are available on their website htpp://www.centerltc.org including three

major reports. (A copy of each report had been handed to he committee chairman and vice-chairman, and to a member of the the Legislative Research Department, and are available on their website: htpp://www.centerltc.org). The Center publishes *LTC Bullets*, also available on the website. The three reports being: (1) LTC Choice - *A Simple Costfree Solution to the Long-Term Care Financing Puzzle*, (2) *The Myth of Unaffordability: How Most Americans Should, Could, and Would Buy Private Long-Term Care Insurance*--not a promotional piece for long-term care insurance; but a question/answer format that highlights some of the key issues of local aging and the demographic problem and how it will amplify here in the United States, and what the Center believes is the key problem for long-term care. What can be done by planning ahead; how the system works now; (3) *The LTC Triathlon - Long-Term Care's Race for Survival*. In that report 119 of the leading financiers, providers and insurers of long-term care were interviewed to get their perspective of what is wrong and their ideas on how to fix it. (4) *The Magic Bullet: How to Pay for Universal Long-Term Care*. This is a state level study of Illinois, but many of the same issues and problems you will find are relevant to Kansas. It has a total of 88 recommendations of things you can do to achieve the objective of targeting the scarce public resources to the needy and breathing more financial oxygen into the Kansas long-term care service delivery system. The following is Mr. Moses' testimony.

"There is a very serious challenge in terms of our aging population and how we will care for people. That is reflected already in long-term care, probably more than in any other area. We know we have a challenge with Social Security, Medicare, and Medicaid. Long-term care is the 800-pound gorilla. Long-term care is already in a very serious condition. We have our nursing home industry, where about eight major chains have declared bankruptcy already. Fifteen percent of all beds in nursing homes throughout the United States are in bankrupt facilities. We have assisted living (a level of care that's very promising for the future, mostly private pay) but they are not filling nearly as fast as what was expected. We have a very underdeveloped home community-based services infrastructure and after all, most aged people would prefer to stay in out of nursing homes and get care at home. We have long-term care stock prices in the tank, and they were in the tank long before anything else went down. They are worse off than ever. We have a very serious problem of supply of both free and paid caregivers; which is worsening. Most Americans cannot afford expensive long-term care, and at the same time Medicaid is there. It rewards the family in essence for ignoring the problem until it's too late and takes advantage of the public programs. That ends up with the consequences of a too big a burden on Medicaid, excessive dependency on nursing homes, lack of infrastructure for home and community-based services, no market for long-term care insurance, and a lot of older people dying in nursing homes on welfare. It is completely unnecessary.

"The entitlement paradigm, if it's true, certainly explains consumer behavior a lot better than the welfare paradigm. The evidence in much greater detail is in the Center's reports and on the website and newsletters. A thumb-nail sketch of how Medicaid eligibility is defined is basically two ways: you have to qualify based on income and assets. Despite the conventional wisdom that you have to impoverish yourself before you qualify for Medicaid, income is rarely an obstacle to qualify for Medicaid nursing home care. That's because we have medical needy systems and income cap systems. In Kansas, I think you are a medical needy state. That means you subtract all of a person's medical expenses, including their private nursing home costs, from their income before you determine their eligibility. So you take out their co-insurance and deductibles for Medicare and home insurance, and deductibles for medical sub-policies, (costs of all their medical services that Medicare does not cover, such as eye care, dental care, pharmaceuticals, foot care) and, if you still don't have enough to pay for all of it, they qualify based on income for nursing home care paid for by Medicaid. So only about the top 5 or 10% of seniors in the country are disqualified for Medicaid nursing home benefits based on income.

"But with assets, that is another story. People will usually say you can only have $2,000 in assets; otherwise you have to spend down to that level. Well, technically you can only have $2,000 in non-exempt assets; but you can also have a home, and often this property regardless of value (Bill Gates with a little cabin on Lake Washington would not disqualify him from Medicaid. But perhaps his stock in Microsoft would, but not the house). But you can also have a business, including the capital and cash flow of unlimited value, and that's exempt for purposes of determining eligibility. You can have one

automobile; and because it is exempt, it is not a transfer of assets for less than fair market value for the purpose of qualifying, subject to a penalty if you give it away. So you can have a Lexus and give it away, but another and give it away, until you get down to the $2,000 level. That's what the Medicaid planning attorneys call 'The Two Mercedes Rule'.

"You don't have to hire an attorney to do Medicaid planning, you can buy one of the best selling books out there. *Avoiding the Medicare Trap* is one example. Something from that: 'So is there any practical way to juggle assets to qualify for Medicaid before losing everything? The answer is "yes". By adopting a Medicaid strategy that fits their needs, older Americans can avoid the Medicaid trap and keep their savings from flowing endlessly into a nursing home.' How do you do it: Move money into exempt assets, transfer assets directly to children tax-free, pay children for their help, juggle assets between spouses, transfer a home by retaining a life estate, change wills and title to properties, set up a Medicaid trust through a family protection trust, or get a divorce.

"So that is what a growing number of our private bar is advising people to do to prepare for long-term care. It's a pretty sad commentary. To document this, we always attend the national conferences of the medically planning attorneys and we actually got audio tapes of their training sessions, where they teach each other how to make six figure incomes. We took excerpts out of the meetings, put an introduction and a conclusion on it and came up with this audio tape that we call, *Medicaid Estate Planning - The Smoking Gun*. There are three tapes, one of which was handed to the Chairman. I advise you to take your blood pressure medicine before you listen to them. As public officials, you may find it somewhat alarming what goes on out there everyday. Of course if you listen to the radio or read the newspaper, or get on the internet, you see the ads for the agredious Medicaid planning all the time.

"Qualifying for Medicaid is a fairly simple thing to do. There is virtually no one paying privately in a nursing home in Kansas that I couldn't have on Medicaid in 30 days. The only reason you have anybody paying privately is either out of ignorance (they just don't know any better) or they choose for ethical reasons not to take advantage of the elasticities of the law.

"If it is true, that basically everyone kind of drifts on to Medicaid because they haven't prepared early to be able to pay privately, then we ought to be able to account for the cost of nursing home care without having to dig into people's assets. Nationally, 47% of all nursing homes costs are paid by Medicaid. That is a little misleading. Two-third's of all residents in nursing homes in the United States receive a portion of their care paid for by Medicaid, and 80% of all patient days are paid at least in part by Medicaid. Why do I emphasize "in part"? That is the critical thing. By reputation, Medicaid pays very little for nursing home care, which tends to drag down the industry's ability to provide quality care. Now, if you have a business where 80% of your customers are paying often less than the cost of providing the care, you have a serious problem. You are making a loss on every single customer – you can't make up for it in volume. It is simple economics.

"So the fact that Medicaid pays only half of the cost is really misleading because it pays upwards of 80% of all patient days at this low reimbursement rate. Medicare used to be 2 or 3%. It is now 11%. Out of pocket costs, which used to be 37-1/2% are now down to 27%. The costs to Medicaid and Medicare have been rising very rapidly at the same time the so-called out-of-pocket costs have been going down. It's even worse than that, I regret. The out-of-pocket costs, which we think of people spending down their life savings for long-term care, paying their own way before they go on Medicaid, is really misleading because over half of what HCFA calls "out-of-pocket costs" are really just the spend-through of social security income. In other words, when you are not on Medicaid, you get your social security check–you pay your rent, you buy your food.

"When you go into the nursing home, it doesn't disqualify you from Medicaid because you have practically unlimited income and qualify for Medicaid, but you do have to contribute your income towards your cost of care. So you have a spend-through social security. Well, when you add up what Medicaid contributes, what Medicare contributes, you may ask most people what social security pays for

long-term care. They'll tell you nothing; but the reality is it spends through for the people on Medicaid, so it's very considerable. Then you go after looking at the private income of the public - for after all seniors have pension income (about one-third of them, and they may have asset income and other sources of income) - you are getting upwards of 85% of the entire cost of nursing home care nationally, without touching a penny of those assets. So I submit to you that collaborates the entitlement paradigm and tends to disprove the welfare paradigm.

"Finally, the other key piece of evidence. We used to think that half to 3/4ths of all people in nursing homes on Medicaid had originally been normal, middle class private pay people and they were writing these $5,000 a month checks and spent down very quickly; became impoverished and went on Medicaid. I have always said that I cannot imagine why that would be true because the Medicaid rules are so generous already and easy to evade. Why would people spend down when it isn't necessary? Well, there have been three dozen empirical peer review academic studies that show that the percentage of people who started private pay and converted to Medicaid is not half to three-fourths, it's only 15 to 25%. Because not one of those studies distinguishes between people who spent down the old-fashioned way with $4-5,000 a month checks, and people who spent down the new-fangled way through artificial impoverishment, the 15-25% (as low as it is) includes everyone who has done this fancy Medicaid planning. So, in a nutshell the welfare paradigm is mistaken and the entitlement paradigm is a more accurate description of reality. There is no wonder that people can evade the high cost of long-term care indefinitely; it's no wonder they end up in nursing homes on Medicaid; no wonder they fail to save, invest or insure while there is still time; and no wonder they think long-term care insurance is unaffordable. Nothing is affordable if you don't think you need it.

"So, if we have been trying to solve the wrong problem, the good news is that if we tackle the right problem, it's going to be a lot easier to solve. So what do we do? Well, let's take a look at what we've done already. We tried closing the loopholes in Medicaid mandating the state recoveries, even going after throwing granny in jail! That was not a big hit. Especially with the senior lobby and I don't blame them. They went after the attorneys and said throw the attorneys in jail. And that was determined to be unconstitutional. After the fact, penalty just doesn't work. It is not politically sensitive or feasible. We have to find a more creative, positive way to get people's attention before it's too late–while they are still young enough and healthy enough to plan for long-term care; so that most Americans will come in the front end insured, or at least empowered with the financial ability to go into the private market place and purchase the appropriate care–home care, assisted living, nursing home care–only as a last resort. So that instead of having 80% of all patients in nursing homes paid for by Medicaid, maybe we can reduce that to 20% and you can use those scarce resources that you have at your control to provide better care across a wider spectrum of care for people who have no other means.

"But that raises the question: How in the world are we going to do that? You often hear the solution to long-term care is to give people an education: Tell them that they are at risk. I am going to tell you right now there is a whole industry out there that's been doing that for 10-15 years and the public isn't getting it. The industry is scratching its head and can't understand why. I tell you sometimes I think the public is a darn sight smarter than the industry. Because the fundamental problem is that the public doesn't know who pays for long-term care - Medicare, Medicaid, the Tooth Fairy - nor do they care. All they know is for the last 35 years you could ignore the risk, ignore the premiums and wait until you got sick and somebody else paid. Until that changes in some real way, behavior will not change. Keep doing what you've always done, you keep getting what you always got. If you want something different, you have to do something different.

"So what can you do? You do have to educate people, but you also have to educate them that there is a consequence to failing to act. That you sign a contract, in essence, in your 40's and 50's that says 'I'm going to do it the old-fashioned way, the American Way. I'm going to buy insurance or I'm going to set aside an annuity, or I'm going to take responsibility for my own long-term care. Leave me alone.'
Or, you say, I'm going to take my chances. I may need help some day, so I recognize in writing, 20 years in advance, that my estate will be my collateral to assure my ability to buy quality care. Then, hopefully,

confronted with the reality that the estate is really at risk, most people will insure, invest, or do something to prepare. There will be some who don't. Some of those will be genuinely poor people; people who are either unable or refuse to prepare and plan. And they have nothing. That is what we want to save Medicaid for. You are going to end up with some who haven't prepared but also have income and assets, but like most seniors they are house rich, cash poor. They don't have sufficient cash flow to purchase care. Those people now are pushed into Medicaid. They are encouraged by the current system to give away all their assets (an early inheritance to the kids), take advantage of the Medicaid program, and get the care subsidized. Under *LTC Choice*, (a part of **Attachment 2**), what we would do instead is through a government-backed but privately administered program, give these folks a line of credit on their estate. In other words, they need a little supplemental income to be able to afford home care to stay at home, or assisted living to avoid the nursing home, or perhaps a little more to get into a better nursing home but stay off of Medicaid. We would extend that to them with the collateral being the estate. There is no other institution in American society that will loan you $200-300,000 with no collateral than the government. That's what we have been doing through the Medicaid program and we should not be too surprised that folks have taken advantage of it.

"If you expect collateral, a number of things will happen. Most people will prepare to avoid that eventuality. Those that don't will have then no incentive to go on public welfare, they will get their dignity back. It isn't welfare if you pay it back. That they are paying privately-owned agencies will breathe financial oxygen into your home and community-based services infrastructure, which has been completely undeveloped now because of the over-emphasis on nursing homes, which exists because that's what Medicaid pays for. You will find that the nursing home community will do much better because they will have more resources available to them. There will be relief for taxpayers because fewer people will be dependent on Medicaid. And, in the long run, everyone wins. Now the one or two parties that would lose in that are heirs who are currently having their inheritance indemnified. If you solicit long-term care for their parents, who are basically using public policy to reward people for ignoring the problem of long-term care until it's too late, taking the inheritance and placing the parents on public assistance. That, I submit, is a very negative incentive in the system.

"If you turn that upside down, behavior will change. Now, I personally have paid the premiums on my parents long-term care insurance for 12 years on the principle of why should they, out of their limited income, pay to protect my inheritance. That is my responsibility. I have insurance for myself and my wife as well. Now, if the incentives were such in the system that that behavior was rewarded, more people would do that and fewer people would be ignoring this problem until it's too late and become a burden on the programs that you are trying to administer cost-effectively.

"So that in a nutshell is the message I have. It is not a simple issue to confront, and it is politically sensitive. Frankly, I don't think we are going to solve this problem until it becomes a crisis. I predict that sometime within the next 15-20 years it will become a crisis, and there will be no solution but to change the incentives in the system. The sooner you get started, the better off everyone will be."

Representative DiVita asked if the Center for Long-Term Care Financing would be in favor of something like tax credits, similar to medical deductions? "Definitely, we encourage you to proceed with something like that. It is under consideration at the national level, something like 22 states have done tax incentives for long-term care insurance. I don't emphasize it because I don't think it will solve the problem. It will help on the margin. But people do not fail to buy long-term care insurance because it hasn't been generally tax deductible heretofore. They don't buy it because they don't think they need it. They don't think they need it because for 35 years they have been able to ignore it and still get the long-term care paid for. Until you address those incentives in the public policy, you won't solve the problem. But in the meantime, by all means, if you can afford it in your budget, encourage the purchase of long-term care insurance. The studies I have seen indicate that it doesn't cost you anything, you will gain it back in the reduction in the Medicaid program. It also doesn't save a whole bunch of money. This is being truthful about it–it's kind of a wash."

Rep. DiVita asked if the Center has done much to determine the level of concern that the general public has about this, or the level of awareness it has about it. People in their 40's and 50's are more concerned about what happened to their parents. Mr. Moses answered, "That was the essence of my point. If this is such a disastrous consequence as it is represented in terms of spending your life savings, why aren't people worried about it? My point is that the public policy is very different than what it is represented to be in the academic and popular media. And the public, they hear all this and it's just static to them. They don't take it seriously for the simple reason that it isn't true. The consequences heretofore of not planning for long-term care just have not been that serious. But the tragedy and irony is, that they will be that serious and more serious in the future. Because for the last 35 years you could ignore the problem and get access to nursing home care (basically the only care that was out there because that's what the government paid for, and that's where everybody went). Now it's in the latter stages of collapse. We are finding nursing homes that have gone bankrupt, many have serious liability problems, the government cannot afford to pay enough to insure quality care there, and gradually the public has come to realize that the public in crisis is the tip of the iceberg. The front of the demographic boom has begun to pump financial oxygen into home care and assisted living. So you see that industry beginning to develop. But it's 100% private pay. Now, the risk is that the public programs will then respond that the public wants home care and assisted living, let's pay for that. After all, isn't it cheaper? Well, no it's not. It would be nice if it were, and certainly worth paying for. But somehow you have to come up with the money. The reality is if you take people out of nursing homes, care for them in their homes or in assisted living, they get happy, they like it, they live longer and end up spending time in the nursing home anyway. Overall it costs more. The wonderful thing: we're paying for it. But if you pay for it through the public programs, it has three consequences: First, the woodwork factor. For, everyone in a nursing home in America today, there are 2 or 3 at home of equal or greater disability; half of whom are incompetent, bed-bound, or both. They are at home because their families are struggling to take care of them. Mostly daughters and daughters-in-law are leaving their jobs, giving up income for their families, taking care of children as well as parents and in-laws. They do it for one reason: to keep Mom or Dad out of the nursing home. As soon as you start providing public financing for home care and assisted living, they will take advantage of that and swamp you in a hurry.

"There is a second kind which you don't hear talked about as much as the woodwork factor. I talked about the Medicaid timing, the artificial impoverishment. As wide-spread as that is, it is somewhat limited by virtue of the fact that now all it gets you is nursing home care. And no one wants to go to a nursing home. So it is somewhat limited. But when you can get home care and assisted living paid for through the Medicaid program then you have a much bigger incentive to do the Medicaid estate planning and that industry will explode. Finally, the third consequence has to do with long-term care insurance. The one reason to buy long-term care insurance – you don't buy it for asset protection. But if you wait until after the insurable event occurs, all you get is nursing home care. So the one thing that long-term care insurance brings you is access to home care and assisted living and the best nursing homes because you have the ability to pay privately, and everyone knows they roll out the red carpet to attract the private payors because they pay so much more than Medicaid, which is artificial and capped and you lose some for each person. The point being as soon as you get home care and assisted living paid through the public programs, you remove that last remaining – minimal as it is – incentive to buy long-term care insurance. I think that is such a key point to make. Thank you."

The Chairman expressed appreciation to Mr. Moses for his presentation.

Chairman Mayans stated this was the last meeting of the committee for the session, and requested members to share with him their ideas and suggestions for next year's committee agenda. Representative McClure had already shared some of her concerns. He noted that Vice-Chairman Bethell had distributed an article from the *Wall Street Journal,* entitled *Employers Urge Doctor 'Visits' by E-Mail* (see Attachment 3).

The meeting was adjourned.

KANSAS FUTURES COMMITTEE
GUEST LIST
MARCH 27, 2001

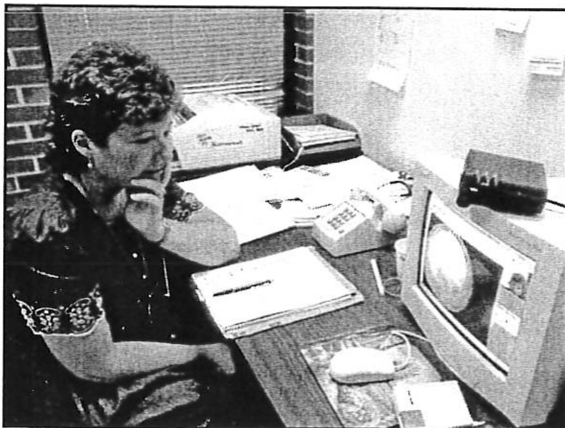
PLEASE PRINT - NAME	REPRESENTING
Patricia Maben	KDHE
Sharlee Mason	AARP Volunteer
Tom Sipe	KHA
Dave Halferty	KDOA
Patsy Samson	KDOA
Jon Josserand	
[illegible]	KABC
[illegible]	KUMC
[illegible]	Speaker Glasscock's staff
Lindsey de la Torre	& KDOA
Bill Henry	Ks Gov Consulting

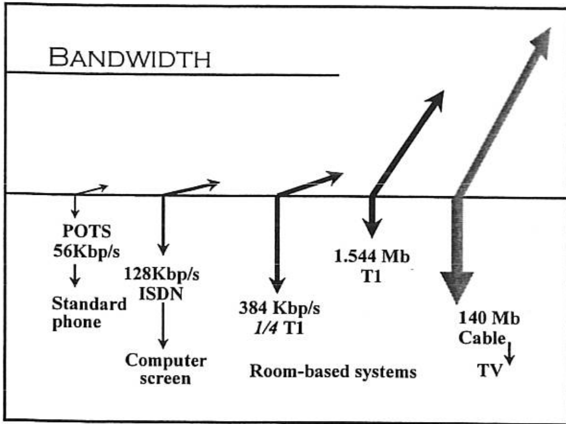
The Future of Telemedicine in Kansas

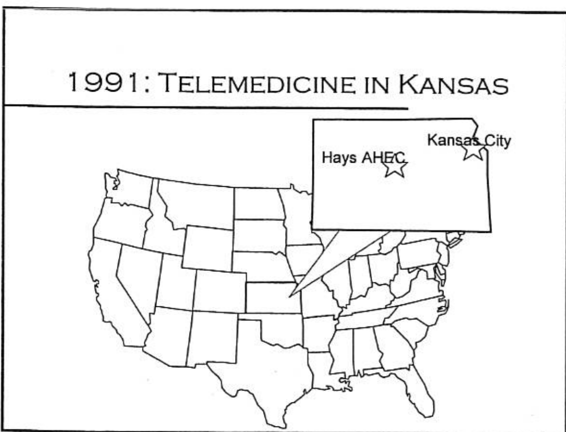
David Cook, Ph.D.
Acting Director
Center for TeleMedicine & TeleHealth

Telehealth Defined

The use of telecommunication technologies to provide health and educational services over a distance.

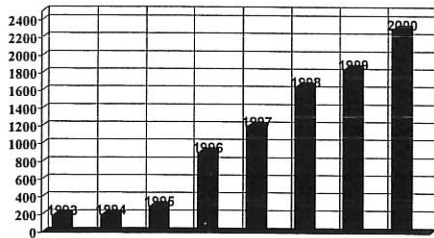



BANDWIDTH
POTS
56Kbp/s
Standard phone
128Kbp/s
ISDN
Computer screen
384 Kbp/s
1/4 T1
Room-based systems
1.544 Mb
T1
140 Mb
Cable
TV


1991: TELEMEDICINE IN KANSAS
Hays AHEC
Kansas City

2000: Telemedicine in Kansas

Telemedicine in Kansas Consults: 1993-2000



Why Success in Kansas?

- Rural health care needs
- Telecommunications infrastructure
- Political climate
- Educational needs
- Medical Center's mission

Center Mission

- Health Services
- Educational Services
- Research & Development

KU Clinical Consults in 2000

- Pediatric Cardiology
- Neurology
- Adult Cardiology
- Adult Psychiatry
- Child Psychiatry
- Rheumatology
- Dermatology
- Pulmonology
- Pain Management/ Palliative Care
- Allergy / Immunology
- General Pediatrics
- Family Medicine
- Behavioral Pediatrics
- Infectious Disease
- Oncology
- Hematology
- Endocrinology

Educational Services

Continuing Education

- CNE
- CME
- Allied Health
- Patient Education

Innovative Projects

- TeleKidCare
- Telehospice
- Home Health
- Tele-Jail
- OAT

Research Activities 1999-2001

- Over 2.3 million in grants since 1999
- Almost 2.1 million pending in 2001
- Over 30 publications
- Over 30 academic presentations

United States Study in 1999

- Slight Growth since late 1980s
- Growth is Extensive, not Intensive
- Prison programs are most common
- 46 States with Active Programs
- California has the most programs
- 40 programs cross state boundaries
- 2/3 of the programs < 4 yrs old

Telemedicine Challenges

- Medical culture
- Organizational
- Liability
- Licensure
- Privacy and confidentiality
- Reimbursement
- Research

Access Issues

"To gain access to telemedicine in the current institutional climate, one must have the right clinical condition, be located in the right part of the state, and perhaps have the right kind of insurance."

–ATSP report, 1999

What is the Future?

- Medicare legislation
- Move toward economic feasibility
- Home Monitoring
- EMRs
- Professional education
- Evolving toward E-health model

Columbia & SUNY Project

- HCFA awarded 4 year, 28 million demonstration project
- Targets underserved rural and inner-city residents with diabetes
- In-Home Monitoring & Internet
- 1,500 initial patients

Department of Defense: 2001

- 20 million over 3 years to develop web porthole
- health information
- EMRs
- Billing transactions

Future Technology Considerations

- Increasing accessibility
- Becoming seamless & transparent
- Integration of information
- Growing privacy concerns

dedicated to ensuring quality long-term care for all Americans

The Center for Long-Term Care Financing is dedicated to ensuring quality long-term care for all Americans by promoting public policy that targets scarce public resources to the neediest, while encouraging people who are young, healthy, and affluent enough, to take responsibility for themselves and plan ahead for the risk of long-term care.

Services provided by the Center include:

- *LTC Bullets* – Free Online Newsletter Covering Hot Topics in the LTC Arena *
- Public and Private Sector Consulting
- Media Articles and Interviews
- Research Studies
- Training for LTC Professionals, Providers, and Agents
- Public Speaking at Conferences and Legislative Hearings

Stephen A. Moses, Center President was formerly the Director of Research for LTC, Inc and a senior analyst for HCFA and for the Inspector General of the U.S. DHHS. Mr. Moses has published extensively and has testified before half of America's state legislatures. He frequently addresses law, aging, and insurance conference audiences.

David M. Rosenfeld, J.D., M.S.W., Executive Director was formerly Counsel for public policy at LTC Inc. Mr. Rosenfeld previously practiced law specializing in insurance defense litigation. Mr. Rosenfeld's most recent publications include "Whose Decision Is It Anyway? Identifying the Medicaid Planning Client" published in the Univ. of Illinois Elder Law Journal.

* To subscribe to our newsletter, simply send your name, email address and complete contact information in the text of an email message to info@centerltc.com or visit our website at www.centerltc.com

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Attachment 2

Equal Access for All

How can we create an incentive strong enough to persuade the financially able to take responsibility for their long-term care so we can save the publicly financed programs for those who truly need them?

By Stephen A. Moses

The United States is the wealthiest nation in the history of the world, yet its long-term care system is struggling. A seamless web of caring services for ailing seniors is desperately needed, but, for some reason, the country has failed to enable all Americans to obtain quality long-term care in a desirable setting at the most appropriate level of care.

Most opinion leaders, policy makers, and legislators are puzzled by the problem and stymied by the solution. Does the answer lie in greater individual responsibility and reliance on the marketplace? On more social responsibility and public financing? Or is the solution some kind of partnership between the two? Consider these facts:

- A recent survey shows 89 percent of state nursing home associations fear for their industry's survival.
- Assisted living has been slow to develop until recently and already faces a daunting challenge in serving lower-income Americans.
- Medicare recently put the brakes on a rapidly accelerating home health services delivery system even though most infirm seniors prefer to receive care at home.
- Medicaid and Medicare financing of nursing home care is constricting while public financing of far more cost-effective home and community-based services languishes.
- Long-term care is the single-biggest financial risk older Americans face, yet only about 7 percent have purchased private long-term care insurance.

NOT A NEW PROBLEM

Long-term care already was a problem for American families by 1965. At that time, a thriving private market could have developed for geriatric care management, home health care, and assisted living, with long-term care insurance to finance all of them. But it didn't. Instead, with every benign intention, Medicaid started paying for nursing home care.

At first, Medicaid's reimbursement rates were excellent and eligibility limitations were minimal. Families could pay out of pocket for grandma's long-term care in the community, or they could put her in a nursing home and get the government to pay. Many chose the nursing home option. Quickly seeing a profitable opportunity, the nursing home industry started building new beds as fast as the public could fill them. By the mid 1970s, Medicaid nursing home costs were spiraling out of control and the government had to act.

First, they capped bed supply with Certificate of Need programs, on the principle that "you can't pay for a bed that does not exist." But that just motivated nursing homes to charge higher rates. The government reacted by capping Medicaid reimbursement rates, but that merely drove up demand for and occupancy of the less-and-less profitable Medicaid beds. To make ends meet, nursing homes either had to attract more private payers at higher rates (for which they were attacked for discriminating against Medicaid patients), or they had to cut corners on costs (for which they were attacked for quality-of-care deficiencies). Caught between the rock of reimbursement and the hard place of quality care, nursing homes took the battle into court with a long series of lawsuits demanding higher reimbursements. In the end, the government won on all fronts.

Today, nursing home providers are plagued by Medicaid rates often below the cost of providing care, by onerous regulations tying their service delivery in knots, and by an enervating sense of hopelessness about the future.

DANGEROUS PATH FOR ASSISTED LIVING

The nursing home experience with Medicaid clearly is not a path assisted living providers should follow. But it's exactly what some very thoughtful people are recommending. They say, "Pool

Medicare home care money and Medicaid nursing home money, manage the resources and the care, and offer more Americans access to cost-effective, publicly financed home care and assisted living." It sounds so logical and appealing.

The fallacy in this proposal, however, is that a big pool of new public financing will once again invite induced demand and adverse selection. Just as families eagerly sought Medicaid-financed nursing home care in 1965 to avoid out-of-pocket costs, they will be even more attracted today to the highly desirable options of home care and assisted living.

Increased public financing of home care and assisted living undercuts the public's sense of urgency about early long-term care planning, thereby discouraging the purchase of private long-term care insurance and encouraging the practice of Medicaid estate planning (artificial self-impoverishment to qualify for public benefit programs). Why worry about saving or insuring for long-term care if you can ignore the risk, avoid the premiums, and get the government to pay—not just for nursing home care, but for home care and assisted living as well?

RETHINK PUBLIC POLICY

The nation's long-term care problems are self-inflicted through counterproductive public policy. Our financing system anesthetizes the public to long-term care risks and rewards failure to save or insure for those risks by providing free or highly subsidized nursing home and home care. Generous public financing of long-term care impedes the development of a private market for geriatric care management, home care, assisted living, and long-term care insurance.

The solution is to remove perverse incentives in the current public policy that discourage responsible behavior and reward thoughtlessness. Specifically, aging Americans need to be confronted with the reality of long-term care risks when they are still young, healthy, and affluent enough to save or insure against these risks. A public financing system should be implemented that guarantees every American access to quality care at the appropriate level in the private marketplace, but requires the quid pro quo that financial assistance in obtaining such care constitutes a dollar-for-dollar spend down of one's estate assets payable after death. Only with this kind of system can an incentive be created that is strong enough to persuade the financially able to take responsibility for themselves so that publicly financed programs can be saved to serve those who cannot provide for themselves.

With the proper incentives in place, most Americans will plan early, insure fully, and pay privately for assisted living. With most people protected in this way, Medicaid will be able to afford full and fair financing of assisted living for those relatively few families who still fall into the social safety net. ●

RESOURCES

The Center for Long-Term Care Financing publishes a free online newsletter, *LTC Bullets*, which periodically develops and substantiates the themes covered in this article. To subscribe, e-mail your request to info@centerltc.com. The center also has conducted a series of studies including *LTC Choice: A Simple Cost-Free Solution to the Long-Term Care Financing Puzzle*; *The Magic Bullet: How to Pay for Universal Long-Term Care*; *Long-Term Care Public Policy & The Future of Seniors Housing*; and *The Jersey Share: How to Pay for Long-Term Care with Less Federal Money*. For more information, visit The Center for Long-Term Care Financing's Web site at www.centerltc.com.

Stephen A. Moses is president of the Center for Long-Term Care Financing in Seattle and is a former senior analyst for the Health Care Financing Administration and for the Inspector General of the U.S. Department of Health and Human Services. He can be reached via e-mail at smoses@centerltc.com.

BY STEPHEN A. MOSES

LTC triathlon

SEVEN NURSING HOME CHAINS HAVE DECLARED BANKRUPTCY. New assisted living facilities are filling too slowly. Our home and community-based services infrastructure is under-developed and starved for financing. LTC stock prices are down and capitalization by debt or equity is stymied. The supply of both free and paid caregivers is drying up. Most Americans cannot afford expensive formal long-term care services. Medicaid and Medicare pay too little to assure access to quality care. Few seniors and almost no baby boomers own long-term care insurance. Aging demographics guarantee an ominous future for long-term care. What is wrong and how can we fix it? That's what this article will explain.

How did we get into such a muddle in the first place? The answer to this question points to a solution. Thirty years ago the need for long term care was increasing rapidly. Left to their own devices, the public would have voted with their dollars for a seamless continuum of care. Low cost, unintrusive options such as chore services, home care, adult day care and assisted living would have thrived immediately. Expensive institutional care in nursing homes would have been used only as a last resort. Private insurance products designed to price and spread the risk of catastrophic long-term care expenses would have evolved early and fast. By now we would have the comprehensive service delivery and financing system that we only dream about today.

America's long term care service delivery and financing system is a mess

Unfortunately, the market was not allowed to work. Instead, with every good intention, the government made free or subsidized nursing home care available through Medicaid. If you wanted home and community-based care, you had to pay for it out-of-pocket. If you were willing to go to a nursing home, Medicaid would pay and enforce quality care.

The public is smart. They sent Grandpa and Grandma to the Medicaid-financed nursing home. The nursing home industry was smart. They built more beds as quickly as possible to take full advantage of the funding bonanza. The new beds filled with Medicaid recipients as fast as the industry could build them.

Before long, Medicaid nursing home costs were out of control. The government tried to stanch this fiscal hemorrhage by capping the supply (certificate of need or CON restrictions) and price (limits on reimbursement) of Medicaid beds.

Predictably, demand skyrocketed. Occupancy jumped to 95 percent. Nursing homes could easily fill every bed if they were willing to accept Medicaid's low reimbursement rates. But they could not survive financially without attracting enough private payers at a much higher market-based rate of payment.

If the nursing homes appealed to private payers by offering better services, they were accused of discriminating against Medicaid patients. If they tried to economize on their growing Medicaid census, they were accused of sacrificing quality of care. Slowly, the vise closed on the nursing home industry. Inadequate reimbursement squeezed in from one side. Quality of care mandates (OBRA '87) squeezed in from the other side.

In the meantime, a whole new sub-practice of law evolved promising access to Medicaid nursing home benefits for everyone, regardless of wealth and without spending down their own assets. (See August 2000 *CLTC*, "Elder Law," page 28.) Medicaid estate planning attorneys can artificially impoverish almost anyone overnight by taking creative advantage of loopholes in the welfare law. They've successfully evaded every effort by the government to control this practice, including criminalization. Nowadays, they are working the back end, too. They litigate against the very same nursing homes whose cash flow they destroyed by overloading them with Medicaid residents.

To add insult to injury, the government repealed the only legal assurance of adequate reimbursement the industry has ever had (the Boren Amendment). The last straw came when Medicare imposed a prospective payment system on nursing homes without adequate compensation. The logical consequences of these counterproductive policies are proceeding inexorably toward a dismal end that was predictable from the very beginning.

So, here's the history of long term care in a nutshell: The government anesthetized the public to the cost of long term care by providing free nursing home care through Medicaid and extended home health benefits through Medicare. Consequently, privately financed home care and assisted living developed slowly and private long term care insurance remains stunted. Without a reliable source of adequate financing, nursing homes are going under, long term care stocks are in the tank, and the future looks bleak for long term care in general—just as the Age Wave begins to crest!

What can we do? First, we have to wean the public and the industry off their excessive dependency on government financing. Second, we have to infuse long term care with a reliable source of private financing for assisted living and nursing homes. Finally, we need to get out of the way and let the private marketplace fill the long term care continuum with home and community-based services that support and prolong the independent living seniors crave.

How do we do all that? The Center for Long-Term Care Financing has devised a public policy proposal called "LTC Choice" to achieve these goals. In briefest outline, the plan is (1) to educate people about the risk and cost of long term care while they are still young enough, healthy enough, and prosperous enough to plan, save and insure, (2) to notify people simultaneously of the "LTC Contract" by which every

American must acknowledge individual responsibility for his or her future long-term care expenses, (3) to extend to people who fail to insure against this risk a line of credit fully collateralized by their estates which enables them to purchase LTC services in the private marketplace, and (4) to recover the cost of care funded by such lines of credit from the estates of people who failed to plan early, prepare diligently and insure fully.

With the "LTC Choice" plan in place, most Americans will insure for the risk of long-term care to avoid putting their estates at risk. Those who fail to insure will gain access to quality LTC services in the private market financed by a government-backed, privately administered reverse mortgage on their estates. Some people will remain who neither purchased insurance nor possess estates. They will rely on a financially re-invigorated Medicaid program that no longer has to support middle and upper-middle class people on public assistance. In other words, if we remove the perverse public policy incentives that have trapped them on welfare, most Americans should, could, and would take responsibility for themselves, pay privately for their own care, and create a new source of private financing for all sectors of the LTC service delivery system.

To make "LTC Choice" a reality, however, we must forge a new economic and political force that will advocate for it in the halls of power. The three major stakeholders in the private long-term care marketplace—the financiers, the providers, and the insurers—have to pull together in common purpose toward this end. Unfortunately, these groups have rarely communicated with each other, much less worked together. Yet each stands to prosper if public financing is targeted to the genuinely needy and everyone else is encouraged to save, insure, and pay privately for long-term care.

The Center for Long-Term Care Financing is starting a campaign to build bridges of communication and cooperation between these critical groups. We will interview the major financiers, providers and insurers, bring them together for a weekend intensive, and publish a report with a plan of action. If these major suppliers of LTC capital, services, and revenue recognize and act upon their common interests, they can quickly cure what ails the long-term care system. But there is no time to waste. This is a race for survival. Call it the LTC Triathlon. And let it begin now! CLTC

Stephen A. Moses is President of the Center for Long-Term Care Financing in Seattle, Washington. The ideas and proposals in this article are fully developed in two white papers: "LTC Choice: A Simple, Cost-Free Solution to the Long-Term Care Financing Puzzle" and "The Myth of Unaffordability: How Most Americans Should, Could and Would Buy Private Long-Term Care Insurance." The Center for Long-Term Care Financing also publishes a free on-line newsletter called "LTC Bullets." For further information, consult the Center's web site at <www.centerltc.com>.

The LTC Pledge
for Baby Boomers

Check if Applicable

- ❑ I am an American Baby Boomer (born between 1946 and 1964)
- ❑ I know the aging of my generation will place great stress on America's social insurance programs including Social Security and Medicare.
- ❑ I know that providing and paying for long-term care (LTC) for aged and disabled baby boomers will be especially difficult for the government and for individuals and their families.
- ❑ I know that friends and families provide 80% of LTC in their homes, which places a huge emotional and financial burden on wives and daughters especially.
- ❑ I know that the probability of needing 5 years or more of nursing home care after age 65 is almost 1 in 10 and that the need for care in an assisted living facility may be even higher.
- ❑ I know that the average annual cost of nursing home care in the U.S. is over $50,000, that assisted living costs nearly $25,000 per year, and that these rates will undoubtedly increase.
- ❑ I know that Medicaid pays for 3/4 of all nursing home patient days, but that it rarely funds the home and community-based care or assisted living which the elderly prefer.
- ❑ I know that Medicaid is a means-tested public assistance program (welfare) that requires strict income and asset limits, and imposes severe penalties for transferring assets to qualify.
- ❑ I know Medicaid is intended only for the needy and that people who shelter assets to qualify must repay the program from their estates (including the value of their homes) when they die.
- ❑ I know that Medicaid's rules for LTC eligibility are elastic, however, and that the non-poor often qualify, especially with the aid of Medicaid estate planning lawyers.
- ❑ I know that Medicaid-financed nursing home care has a reputation for serious problems of access, quality, reimbursement, discrimination, institutional bias, and welfare stigma.
- ❑ I know that Medicaid faces severe funding deficiencies and that nursing homes across America are declaring bankruptcy for lack of adequate public financing.
- ❑ I know that the likelihood of a new entitlement program to pay for quality LTC is nil, because the government must save the Social Security and Medicare programs first.
- ❑ I know that people who pay privately for LTC command red-carpet access to top-quality care and they can choose between the best home care, assisted living, and nursing facilities.

Please Turn the Page Over

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- ❑ I know that discussing the risk of LTC with parents is extremely difficult and that considering the possibility I may need such help someday myself is even tougher.
- ❑ I know I want my family to be part of the LTC solution, not part of the problem.

Therefore:

- ❑ I pledge that I will start working on the problem of paying for LTC no later than age 40 and that I will have a solution (LTC insurance or a very large, earmarked estate) by age 50.
- ❑ I pledge that I will discuss the risks of needing LTC and the rewards of paying privately for care with my parents and with my siblings.
- ❑ I pledge that I will explore the alternatives available to me for financing my family's LTC, including private insurance or self-insurance (by means of savings and investment).
- ❑ I pledge that I will help my parents protect their nest egg (my inheritance) from the ravages of LTC by contributing to the cost of their insurance premiums or their long-term care.
- ❑ I pledge that I will not retain a Medicaid planning attorney to impoverish my parents prematurely and put them in a nursing home on welfare, if and when they need LTC.

or…

- ❑ I already own private long-term care insurance.

This LTC Pledge for Baby Boomers was prepared by the Center for Long-Term Care Financing in Seattle, Washington. The Center's mission is to encourage private financing of long-term care and to reduce middle-class dependency on Medicaid.

We do not endorse particular LTC insurance carriers, but we will provide a list of leading companies and their phone numbers upon request. The Center also publishes a free online newsletter called "LTC Bullets" which anyone is welcome to receive.

For more information about the Center for Long-Term Care Financing, including our speakers' bureau, publications and online newsletter, please consult our web site at www.centerltc.com/ or call 425-467-6840.

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Please Turn the Page Over

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LTC Bullet: Principles of Long-Term Care

Tuesday December 5, 2000

Seattle—

The Center for Long-Term Care Financing was recently asked by the President and CEO of a major long-term care provider chain to suggest talking points for a public policy briefing. We thought you might like to see how we boiled down the complex issue of long-term care service delivery and financing into a single page. For more details, consult the Center's website at www.centerltc.org and read our three major reports: "LTC Choice: A Simple, Cost-Free Solution to the Long-Term Care Financing Puzzle," "The Myth of Unaffordability: How Most Americans Should, Could and Would Buy Private Long-Term Care Insurance," and "The LTC Triathlon: Long-Term Care's Race for Survival" (forthcoming December 7, 2000.)

Principles of Long-Term Care

The Problem

*Americans are living longer, but dying slower often in need of expensive long-term care (LTC).

* Trends in aging demographics guarantee that LTC will become a much bigger and more expensive, possibly catastrophic, social and political challenge in the future.

* America's LTC service delivery and financing system is severely dysfunctional in terms of access, quality, reimbursement, discrimination, and institutional bias.

* LTC places a huge financial burden on U.S. social programs (principally Medicaid and Medicare) while private financing of LTC, especially insurance, is very limited.

* In the absence of adequate public and private third party financing for professional LTC services, American families struggle to provide informal care at home with little help.

* Related problems are growing, such as, physical and financial abuse of the elderly exacerbated by economic and emotional pressures on the "sandwich generation."

The Reason

* Ironically, well-intentioned public financing of LTC since 1965, although helping many people in need, has inadvertently created and exacerbated the status quo.

* Medicaid financing of nursing home care led to institutional bias. Neither Medicaid nor Medicare can afford to provide the community care most seniors prefer.

* Simultaneously, public financing of LTC inhibited the growth of a private market for home care, assisted living and the private insurance products to pay for them.

* Limited provider reimbursement by Medicaid and Medicare caused access and quality problems, which led to discrimination against public recipients and in favor of private payers.

* Consequently, private payers are migrating to home care and assisted living leaving public payers and nursing homes with the highest acuity, most expensive patients.

Ramifications for staffing, litigation, liability insurance, capital financing, stock prices, and viability [illegible] system are approaching the end game.

* In the meantime, relatively easy access to Medicaid nursing home care and Medicare home care has desensitized the American public to the risk and cost of formal LTC.

* Thus, most people who need formal long-term care still end up in nursing homes paid for by Medicaid and very few Americans plan, save or insure for LTC.

The Solution

* The good news is that America's LTC crisis is relatively easy to solve, because it is self-inflicted by well-intentioned, but negative incentives in public policy.

* In America today, one can ignore the risk of LTC, avoid premiums for private insurance, qualify much more easily for public benefits than is commonly understood, or dodge "spend-down" requirements entirely.

* Stricter eligibility rules (e.g., "Throw Granny in Jail") and mandatory estate recovery have failed to save Medicaid or encourage individual responsibility because they come after it is too late to save or insure.

* To solve the LTC crisis, we must: (1) educate everyone by age 50 about the risk and cost of LTC, (2) enforce "LTC Contracts" before retirement whereby everyone acknowledges the personal responsibility to save or insure for LTC, (3) extend to all uninsured Americans the "LTC Choice" of a publicly backed line of credit on their estates so they can purchase quality LTC in the private marketplace at the most appropriate level of care, and (4) faithfully recover these secured loans from the estates of deceased borrowers in order to encourage their heirs and all other Americans to plan early and insure fully for LTC.

* Benefit payments can be administered through vouchers or formal loans, but they must be secured by collateral and recovered upon death of the last surviving exempt dependent relative, such as a spouse or disabled child.

* With these positive programs and incentives in place, fewer people will depend on Medicaid or Medicare for their LTC and those programs will be better able to serve their legitimate recipients and beneficiaries.

*** Forward freely; encourage subscribers! ***

The Center for Long-Term Care Financing is a 501(c)(3) charitable non-profit organization dedicated to ensuring quality long-term care for all Americans. Ask how you can support the Center today! Visit our website at http://www.centerltc.org/needhelp.htm or contact Amy Marohn at amy@centerltc.org for details.

This e-mail is the latest installment of "LTC Bullets" - the Center's periodic online news service covering the latest information and trends in long-term care financing. We welcome responses to the material presented.

Unsubscribe by simply using your reply button to send a request. Please put your e-mail address and name in the body of your message. Your e-mail address will be deleted from the Center's mailing list before our next mailing. We apologize for any inconvenience. We do not intend our "LTC Bullets" to reach anyone not interested in receiving them.

All past issues of LTC Bullets may be read on the Center's web site at www.centerltc.org

Please direct any questions or requests to info@centerltc.org

LTC ... et: Surplus Won't Save Us

Wednesday March 14, 2001

Seattle—

In testimony before the U.S. Senate Budget Committee last month, David Walker, Comptroller General of the United States, delivered a sobering message about our national budget surplus and the future of federal retirement security and health programs, including Medicaid. His message: Don't be fooled by the surplus, however large and however much we save of it. We're still on course for a fiscal train wreck absent serious entitlement reform. To this end, the Center for LTC Financing's offers it's "LTC Choice" proposal to reform long-term care so at least the Medicaid program can survive to provide high quality care to the truly needy long into the future. The Center's policy paper, "LTC Choice: A Simple, Cost-Free Solution to the Long-Term Care Financing Puzzle" is available in .pdf format at http://www.centerltc.org/pubs/CLTCF%20Report. You can also order a hard copy of the paper [$24.95; free to media and lawmakers] by sending your request and complete contact information to info@centerltc.org.

Below are excerpts from Comptroller General Walker's compelling testimony:

"Our [GAO's] long-term simulations . . . show that spending for federal health and retirement programs eventually overwhelms even today's projected surpluses. This is true even assuming no additional spending for defense, education, or a Medicare prescription benefit—i.e., even if the entire unified surplus was saved." (p. 3)

* * *

"Although the ten-year horizon looks better in CBO's [Congressional Budget Office's] January 31st projections than it did in July 2000, the long-term fiscal outlook looks worse. In the longer term--beyond the 10-year budget window of CBO's projections—the share of the population over 65 will begin to climb and the federal budget will increasingly be driven by demographic trends.

"As more and more of the baby boom generation enters retirement, spending for Social Security, Medicare, and Medicaid will demand correspondingly larger shares of federal revenues. Federal health and retirement spending will also surge due to improvements in longevity. People are likely to live longer than they did in the past, and spend more time in retirement. Finally, advances in medical technology are likely to keep pushing up the cost of providing health care."
(pps. 5-6)

* * *

"The message from our long-term simulations, which incorporate CBO's 10-year estimates, remains the same as it was a year ago. Indeed, it is the same as when we first published long-term simulations in 1992. Even if all projected unified surpluses are saved and used for debt reduction, deficits reappear in 2042. If only the Social Security surpluses are saved, unified
deficits emerge in 2019. . . . In both scenarios deficits would eventually grow to unsustainable levels absent policy changes.

"To move into a future with no changes in federal health and retirement programs is to envision a very different role for the federal government. Assuming, for example, that Congress and the President adhere to the often-stated goal of saving the Social Security surpluses our long-term model shows a world by 2030 in which Social Security, Medicare, and Medicaid increasingly absorb available revenues within the federal budget. Under this scenario, these programs would require more than three-quarters of total federal revenue.

Little room would be left for other federal spending priorities such as national defense, education, and enforcement. Absent changes in the structure of Social Security and Medicare, some time during the 2040s government would do nothing but mail checks to the elderly and their healthcare providers. Accordingly, substantive reform of Social Security and health programs remains critical to recapturing our future fiscal flexibility." (pps. 8-10)

* * *

"As we have stated elsewhere, early action to change these programs would yield the highest fiscal dividends for the federal budget and would provide a longer period for prospective beneficiaries to make adjustments in the own planning. This message is not changed by the new
surplus numbers. It remains true that the longer we wait to take action on the programs driving long-term deficits, the more painful and difficult the choices will become." (p. 20)

Source: "Long-Term Budget Issues: Moving From Balancing the Budget to Balancing Fiscal Risk," Testimony before the Committee on the Budget, U.S. Senate, Statement of David M. Walker, Comptroller General of the United States, February 6, 2001, GAO-01-385T,
www.gao.gov.

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Attachment 3

Employers Urge Doctors to Make 'Visits' by E-Mail

By ANN CARRNS
Staff Reporter of THE WALL STREET JOURNAL

Contacting the doctor is about to get easier for some in Silicon Valley.

Six of the area's major employers are taking part in a pilot program to offer employees online communication with their physicians. The six – Cisco Systems Inc., Oracle Corp., Adobe Systems Inc., Cadence Design Systems Inc., the NEC Electronics unit of Japan's NEC Corp. and another large technology company that asked not to be named – belong to the Silicon Valley Employers Forum, a nonprofit coalition. The group seeks ways to use technology to offer quality, affordable health care and other employee benefits, and increase worker satisfaction.

"The impetus was really to take advantage of the technology that's out there," says Cindy Conway, director of corporate benefits at Cadence, based in San Jose, Calif.

The initiative is the latest bid by big employers and some health plans to manage the costs while improving the quality of health care by using information technology. This year, General Motors Corp. announced a plan to promote the use of electronic prescribing tools and computerized 'ical records. First Health Group Corp., a

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Employers Urge Doctor 'Visits' by E-Mail

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health plan in Downers Grove, Ill., has started offering a cash incentive to doctors who communicate by e-mail with chronically ill patients. And Kaiser Permanente, the big Oakland, Calif., nonprofit health-maintenance organization, lets patients schedule appointments or ask questions of nurses via e-mail.

Patients generally approve. Frustrated by rounds of telephone tag when they call their doctors to discuss lab results or request prescription refills, they are increasingly clamoring for e-mail communication. But physicians remain reluctant; a recent Harris Interactive survey found that just 13% of all doctors communicate by e-mail with any of their patients, a percentage that has remained stagnant for two years.

Physicians fear they will be inundated with voluminous messages from patients. They are also concerned about computer security, liability and how they will be paid for the time they spend handling messages.

The pilot program in Silicon Valley attempts to address those concerns by using an online system provided by Healinx Corp., an Alameda, Calif., start-up. Doctors will be paid $20 per Web "visit," which employers say is competitive with what doctors often end up getting for an office visit under discounts negotiated with managed-care plans.

All six companies in the program are self-insured, which means that they fund their own benefit programs and hire health plans to administer them. Employees in plans administered by Aetna Inc. and UnitedHealth Group Inc. will be eligible for the pilot.

Starting in mid-April, about 2,000 employees who see roughly 100 doctors primarily in and around Silicon Valley will be offered the service. Doctors will recruit patients into the pilot, to ensure that participants already have an established relationship with the physician.

Patients will log on to their doctor's Web site or the Healinx site to send a message about nonurgent health matters. If a patient has a sore throat, for example, he or she is prompted to fill out a questionnaire that seeks information such as the duration of the problem, body temperature and other symptoms.

The form creates a simple narrative in a concise format for the doctor to evaluate. "It structures the message for the physician, so he doesn't get a rambling e-mail," says Giovanni Colella, chief executive of Healinx. (Patients can choose to send a free-form e-mail, he says, but aren't encouraged to do so.) A nurse or physician evaluates the message and, if the symptoms are serious, arranges to see the patient in person. Otherwise, the doctor can respond with a message recommending self-treatment, or issue a prescription that is automatically faxed to the patient's pharmacy for pickup.

The messaging system functions like e-mail, but the messages are encrypted and are stored solely on Healinx's secure server, rather than on multiple servers that may not be secure, says Dr. Colella. The Healinx system automatically submits an electronic claim for each Web visit to the patient's health plan, which pays the bill on the employer's behalf. Healinx receives a fee from the employer for each transaction. Healinx estimates its system can reduce office visits by 20%, says Dr. Colella.

The pilot's success will be determined by worker and doctor satisfaction with the system, employee absenteeism rates as well as costs over a six- to nine-month period. "If we find employees aren't getting a lot of value out of it, we won't continue it," says Stirling Somers, executive director of the employers forum.

A spokeswoman for Aetna says the insurer is participating to support its self-insured clients but does not itself have a formal agreement with Healinx. UnitedHealth declined to comment.