Approved: April 6, 2001
Date

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-l/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.