STRATEGIC HEALTH CARE

PROFESSOR JUDY FEDER DISCUSSES LONG TERM CARE POLICY REFORM

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P R O C E E D I N G S

MR. OOSTRA: Hello, my name is Randy Oostra, President and CEO ProMedica. I'm pleased to welcome you to this eight-part series of healthcare reform discussions with nationally recognized health policy experts. These interviews will discuss Medicare policy including healthcare pricing, long-term care, and the social determinants of health.

This series is part of an ongoing two-year effort by more than a dozen hospital CEOs from around the U.S. to urge Congress to take up significant healthcare policy reform legislation largely by calling for the creation of a national commission on healthcare reform. It is our intent that these policy reforms discussed during these interviews demonstrate our desire for substantive national reform, moreover that these interviews help to further inform congressional members and committee staff as they work to craft legislation to improve healthcare delivery and financing during the next Congress.

Our motivation is straightforward. Well before the onset of the COVID-19 pandemic, we were

adamant that race, age, and/or economic circumstances should not be defined as preexisting conditions, nor do we accept the premise that Americans should be resigned to live shorter lives in poorer health.

We invite you to listen to or to read the transcripts of all eight interviews. If you'd like to provide comment, you can do so via the contact information noted at the conclusion of these interviews.

MR. INTROCASO: Welcome to this series of eight interviews concerning federal healthcare policy reform. I'm David Introcaso, the host. With me to discuss long-term care policy is Georgetown Public Policy Professor Judy Feder. Professor Feder, welcome.

PROFESSOR FEDER: Thank you, David. I'm glad to be with you.

MR. INTROCASO: Professor Feder's bio is posted with this interview's audio file and transcript. On background, the U.S. has no non-catastrophic long-term care policy despite the following realities: The country is rapidly aging, by 2030, 1 in 5 Americans will be 65 or older, 2/3rds of those 65 or older need or will need some form of long-term care for an average of

3 years, 12 percent will need care for 5 or more years.

While typically associated with aging, approximately 40 percent of those in long-term care are under 65. Among other facts, long-term is unaffordable for many since monthly nursing home fees can cost upwards of $10,000 per month and assisted living can average $4-5,000 per month. Care quality unbalance is poor beyond the longstanding problem of antipsychotic misuse. A recent GAO study found 82 percent of nursing homes were cited for having infection prevention and control deficiencies. Not surprising, nursing home residents account for a disproportionate number of COVID-related deaths.

Less than 10 percent of the middle-income population aged 45 or older own a commercial long-term care insurance policy, and probably because insurance have substantially increased premiums over the past two decades, and family caregivers are 30 percent of the adult population, moreover women, frequently suffer for related emotional, financial, and physical hardship.

Long-term care coverage for a vast majority of Americans in need can only be obtained by purposely

pursuing a legally complicated asset depletion or self-impoverishment process to qualify for coverage under the Medicaid program.

So with that as background, Judy, let me begin by asking you as you're well aware, the Affordable Care Act had a long-term care provision termed the Community Living Assistance Services and Supports are a CLASS act. It would have created a voluntary public long-term care insurance option. In '11, it was found to be actuarily unworkable and was soon thereafter repealed. Subsequently in 2012, the Congress created a commission on long-term care in which you served, but it did not issue any recommendations. What can we learn from these failed efforts?

PROFESSOR FEDER: Well, thanks for the background, David. Our approach to long-term care is long and troubled, and our failure to provide adequate protection for people who need long-term care reflects a lack of political will to invest in the significant needs of the 12 to 14-million Americans who need long-term care.

MR. INTROCASO: Okay, thank you. Let's go to

recent Congressional activity, and as you're well aware as well within the Congress there's been some renewed, albeit limited, discussion about creating a Medicare long-term care benefit. For example, discussion by Frank Pallone, the Energy and Commerce Committee chair, discussion tracked with the 2018 proposal authored by you and colleagues at UMass and Urban and funded in part by HHS. Let's start with it. Can you unpack that proposal starting with eligibility?

PROFESSOR FEDER: Sure. Let me describe the overall proposal. The proposal is to recognize that long-term care, the need for it, is an unpredictable and potentially catastrophic event, and that requires insurance. Private insurance for long-term care has failed. We need social insurance on the order of Medicare or Social Security to protect people against that unpredictable catastrophe.

My proposal that I developed with Marc Cohen would provide that kind of coverage, support for on a daily basis for people who need help with tasks of daily living, but only after a waiting period, and our proposal, unlike Mr. Pallone's, would have varied that

waiting period with people's incomes, longer waiting periods for people with higher incomes.

The purpose of that is to enable people who can to pay for services while they can but to set some limits on that burden so as to protect them from catastrophe, and to allow middle-income people with too much income to qualify for Medicaid unless they become completely impoverished to have a shorter waiting period to fill with their own resources or perhaps private long-term care insurance.

Eligibility for benefits under this program as we designed it would be tied to a significant need for long-term care which is typically defined as a need for assistance in two or more activities of daily living like bathing or dressing or eating.

MR. INTROCASO: Or unexpected cognitive impairment, correct, for some period of time?

PROFESSOR FEDER: Correct. There also as a -- the standard of eligibility that we applied in our proposal and that Mr. Pallone I believe adopted is the same as is intended to be the same as the HIPPA standard which is applied for tax purposes to private long-term

care insurance.

MR. INTROCASO: And the individual would qualify having had worked a certain period of time of employment, correct?

PROFESSOR FEDER: In our proposal, not Mr. Pallone's, it was designed as a contributory proposal, so very similar to Part A of Medicare to Social Security where people work a certain number of quarters. But we found that if we began such a policy now and required people to contribute for 10 years as they must for Social Security or Medicare that much of the baby-boom generation would not be able to take advantage of that benefit. Consequently, even if we're ultimately contributory to make us -- have to have a significant impact in my lifetime, we would need to support it with general revenue.

MR. INTROCASO: Right. And I think the statistic is the entire baby-boom generation will be at least 65 by 2030, so you're right; the 10 years would miss a good percent of the boomer --

PROFESSOR FEDER: Exactly, and you could phase into that. It could be contributory in later years, but

both to meet a substantial need among a growing number of people and to be politically feasible, it would be a mistake to rely solely on a contributory financing.

MR. INTROCASO: Right. Right. So let's go. What is the benefit; it's a cash payment?

PROFESSOR FEDER: The benefit would be a cash payment. It could be there -- it's alternatively you could design it as cash or a service and let the individual choose, and at the time we wrote it, we picked I believe it's $110 a day as an amount that people could receive but with no limit on it over their lifetime.

MR. INTROCASO: Okay, and let's go to the real rub here, financing. How would this be financed?

PROFESSOR FEDER: We propose that it'd be financed with a surtax on the Medicare tax which since the ACA was adopted is now a tax on -- there is a tax on unearned income, and we would propose to a buy-in a surtax on that tax.

MR. INTROCASO: And this I think I read in the proposal is a one-percent tax, correct?

PROFESSOR FEDER: If I remember correctly.

MR. INTROCASO: Yes.

PROFESSOR FEDER: It obviously would depend upon decisions made and the level of the benefit and number of people covered at the time that it goes into effect.

MR. INTROCASO: Right. So you could dial it up or down as they would say, correct?

PROFESSOR FEDER: Well, you couldn't dial it down much.

MR. INTROCASO: Well, that's --

PROFESSOR FEDER: With an aging population, we're talking about dialing up, and you asked me earlier what makes this issue so hard, and it's expensive, but the expense is now being born by individuals whether they're out of their own pockets or in terms of their -- or the sacrifices that their families are making as well as in providing insufficient care.

MR. INTROCASO: Yes, thank you. Let's go to impact, and you ran this by some statisticians who tried to calculate what this would mean relative to projected increase in move text up

long-term services and supports, et cetera, so what are

the areas in which other than the coverage and less financial stress on the patient, how does this -- what are the rippled (phonetic) benefits here?

PROFESSOR FEDER: Well, the benefits as you say, first and foremost, are for people and their families who are now going without sufficient care or making extraordinary sacrifices in order to get that care, and so there is an advantage in terms of receipt of the care closer to the level of care they need. We now know the people are getting less care than they need and suffering serious consequences like falling or going without eating because of it. So the primary benefit is in supporting adequate care.

There is also a benefit in terms of a financial benefit, some financial benefit although so much care is provided by families that much of the benefit goes as family relief, and finally there is a benefit in terms of reduced burden on Medicaid because Medicaid as our only public program for long-term care is now bearing a burden that falls on states. States are in very different positions to bear that burden, and so it would in addition provide some Medicaid relief.

MR. INTROCASO: Okay, thank you. So you do note in the report, Judy, that there is estimates that the enhanced long-term services and supports would be increased by 14 percent, and you do identify a percent of reduced move text up

out-of-pocket costs --

PROFESSOR FEDER: Exactly, and I was --

MR. INTROCASO: -- at 15 percent --

PROFESSOR FEDER: -- I've pulled it up now if you want me to say it.

MR. INTROCASO: Yes, please, go ahead. So --

PROFESSOR FEDER: The analysis showed that 14 percent more would be spent on program services than is currently spent to the advantage of beneficiaries and their families, and there would be a 15percent reduction in family out-of-pocket costs, and a 23percent reduction in Medicaid as the new program assumed those responsibilities.

MR. INTROCASO: Okay, thank you. So that's --

PROFESSOR FEDER: Yes.

MR. INTROCASO: So let me -- my last question on this is, you did participate in some discussions with

the Chair of Energy and Commerce; what's your sense or summary of how those discussions in panels progressed?

MR. FEDER: Well, Chairman Pallone has been very concerned about this issue for some time and is very committed to a Medicare benefit for long-term care which means that it'd be available universally without regard to income. As I said, his proposal was quite similar to ours but different in some ways. In particular, he thought that it would be simpler to have a fixed waiting period of a couple of years, not the income-related period, and he also recognized that it was neither desirable nor politically feasible to wait for 10 years for this program to go into effect, and so he proposed that people would receive benefits from its financed or general revenue including people who currently need care.

MR. INTROCASO: Okay, thank you. So let's go to a companion proposal that you published more recently and as we're well aware, the ongoing pandemic has put enormous pressure on state budgets, particularly on state funding of Medicaid that accounts for an average of 20 percent of a state's general fund spending. You

recently outlined this proposal relative to enhancing Medicaid in a Journal of Aging and Social Policy piece, and that in part calls for creating an aged-based funding index. So let's begin; can you explain exactly what that means?

PROFESSOR FEDER: I can, but I want to go back a little bit --

MR. INTROCASO: Please.

PROFESSOR FEDER: -- and explain that even in the social insurance proposal that we just talked about, that proposal is aimed primarily at modest middle-income people who don't qualify for Medicaid, so it recognizes that for very low income people, we talk about a waiting period, they can't handle even a waiting period of a year once they need care. So our social insurance proposal envisioned the continued operation and even strengthening of the Medicaid alongside the new social insurance program that we proposed.

The new proposal that I made was to recognize -- to essentially to put that improvement in Medicaid in motion. What we know is that Medicaid is hugely valuable to people who need long-term care. It's

essentially all we've got besides families and is very helpful in supporting people who need services now at home as well as in nursing homes. But states' ability and willingness to provide services under Medicaid for people who need long-term care has always been uneven. There's tremendous variation across states.

And all states will be hugely challenged to provide services as the population ages. That's a long-term problem, and the short-term problem in which states are hugely threatened in terms of their budgets by the pandemic both in terms of people needing Medicaid and other services whether health or long-term care, and in terms of lost revenues, they need immediate assistance, and my belief is that we ought to assist them immediately in enhancing federal resources, federal support for long-term services, and support and use this as an opportunity to change the way in which -- the basis on which we match what states spend, and include in that not only a measure of income, we pay a higher matching rate to states with lower incomes, but I propose that we pay a higher matching rate to states with older populations, measured as the proportion of

their older, poorer population to their working population. So what it would do would be to alleviate the burden on the taxpayer of a relatively large older poorer population.

MR. INTROCASO: So you do state in this article that specifically you would enhance the federal share or the move text up
so-called FMAP, federal share of state medical spending based on a ratio of its population aged 75 or over with incomes below 300 percent. So I do believe Maine has the oldest mean or average -- so Maine have the state with the oldest population, so by way of example, Maine for example would get an additional percentage match, a higher percentage map than say a state with a younger population, and I'm guessing it might be, say, California. So that's essentially how it would work, correct?

PROFESSOR FEDER: That's how it would work, but I'm leaving those specifics to you, David. I haven't looked lately at that list.

MR. INTROCASO: Okay. But again, the bottom line here is that states with older populations

specifically as you design here meaning those --

PROFESSOR FEDER: States with older poorer populations --

MR. INTROCASO: Correct.

PROFESSOR FEDER: -- and the relative to their working-age population who it largely pays for it would get a higher percentage federal match.

MR. INTROCASO: Okay, thank you. Now there is another element to this proposal as outlined again in the Journal of Aging and Social Policy and that is you're suggesting that the federal government take responsibility for long-term care for dual eligibles; is that correct?

PROFESSOR FEDER: That's an alternative proposal.

MR. INTROCASO: Okay, so is it either/or? Is that correct?

PROFESSOR FEDER: That's correct. And but either way what the proposal is, is to enhance federal funding for Medicaid long-term care to alleviate both the variation across states, the inequity and the inadequacy across states, an inadequacy that's going to

grow over time with the aging of the population.

MR. INTROCASO: Okay, thank you. Has this proposal been discussed, or this idea have any discussion on the hill to date?

PROFESSOR FEDER: I've shared it with people on the Hill and I would argue that it fits with lots of efforts that we are seeing to get more federal money to states through the Medicaid program, so it seems to me a timely proposal because they are looking at changes in the match of other kinds.

MR. INTROCASO: Okay, thank you again. While we have a few minutes, Judy, let me ask you: obviously you're well aware of related proposals made by the Biden campaign over the last several months, do any of these -- any proposals by the Biden campaign are particularly of interest to you?

PROFESSOR FEDER: Yes. The Biden campaign focused particularly on waiting list for home and community-based services. As we discussed, the state's willingness to provide home and community-based services are often limited. Most states provide their services under waivers from Medicaid requirements that everybody

who qualifies gets a benefit. The waivers allow them to cap enrollment, and that means that the services are falling significantly short of the need.

The Biden campaign focused on the waiting lists, but waiting lists, they're -- because it's a clearer measure, it's clear evidence of a problem, but they are poor measures. We know from looking at the variability of these services that they are inadequate in many places. And what I've heard discussed to implement the campaign proposal is to make the home and community-based services which are now optional under Medicaid mandatory which would be akin to the mandatory nursing home benefit.

Now home and community-based services are optional, only nursing home services are mandatory. My belief is that to fulfill that promise, it will be necessary to pursue the other strategy that we talked about which is enhanced federal match for Medicaid whether it be a bump in the match for home and community-based services which was included in the House-passed CARES Act or going further than that, going to the age-based long-term care match that I talked

about.

MR. INTROCASO: Okay, thank you. There is and we don't need to get into this, but they did it in the proposal outline a "pay for" for this, but I do --

PROFESSOR FEDER: And I actually -- I used the wrong act, David. It's rhe Heroes Act.

MR. INTROCASO: Okay, thank you.

PROFESSOR FEDER: Yes.

MR. INTROCASO: Thank you.

PROFESSOR FEDER: It may have been -- yes, it can't have been CARES. They passed CARES. It's The HEROES Act.

MR. INTROCASO: Okay, and The HEROES Act which of course the House passed but didn't go --

PROFESSOR FEDER: Exactly.

MR. INTROCASO: -- get to the floor of the Senate, correct?

PROFESSOR FEDER: Exactly.

MR. INTROCASO: The Biden campaign also mentioned this, establishing a long-term services and supports innovation fund. Do you have any idea, or can you expand upon what that amounts to?

PROFESSOR FEDER: I can't, and what I believe as campaign proposals often are it was a signal of interest in this area without a lot of detail, and what I would say about that is that grants programs, which is what that sounds like, are not by no means a substitute for entitlements to needed services, so my hope would be we would go in the direction of an enhancement to Medicaid funding and to its benefits.

MR. INTROCASO: Okay, that I'll just note the Biden campaign identified tax credits for informal family caregivers. Also Social Security credits for people who care for their loved ones are again informal family caregivers. There are various other issues I do want to ask you about, and this is the --

PROFESSOR FEDER: Yes, let me just comment on that.

MR. INTROCASO: Please.

PROFESSOR FEDER: I think that the supports for family caregiving are important, but it would be a mistake if we thought that by bolstering families we were solving the problem. It is given the burden of caring for someone who needs extensive services to rely

largely on unpaid family members and underpaid direct care workers as we do now is providing long-term care on the cheap. We invest less than other industrialized nations. We need to up our game, and support for caregivers will be welcome and important, but it’s no substitute for a social insurance program that actually provides people the services they need.

MR. INTROCASO: Good point, well taken, thank you. Let me do ask about one specific, and this is cited repeatedly in rather the quality issue and we should touch upon it. It’s important to do so. And then as I saw nothing in the campaign or the debates concerning a staffing ratios. This is always cited when we look to explaining the low-care quality in long-term care in nursing facilities. There is one state, California, that has passed a staffing-ratio requirement. What’s your sense at the federal level?

PROFESSOR FEDER: I think it’s an abdication of responsibility for the care that we’re delivering in long-term care facilities. And states pay nursing homes in various ways, and the worst is to simply pay them a daily rate and allow them to use the money as they see

fit with no requirements. There has to be some kind of tie to direct services otherwise we're paying for profit and not services. Medicare which does not pay for long-term care.

It pays long-term care providers like nursing homes for people who need skills care but not the personal care services that we're talking about. Medicare, by contrast, overpays nursing homes allowing them to earn double-digit profits because we pay them in a way that it does precisely what I said, let's them take the money and not provide the services, and we have ample evidence that they are profiting and not investing in service.

So what we need in both Medicare and Medicaid are payment methods that actually tie the payments that are made to the delivery of services including to staffing to personal protective equipment to other services that people need.

MR. INTROCASO: Okay, and my final question for you is, and this is formula: There are state efforts at trying to improve long-term care for state residents. I'll mention one, the state of Washington

has instituted a state payroll tax in an effort to try to create a long-term care social insurance benefit. What do you see coming from the state of promising from state efforts that might be useful at the national level?

PROFESSOR FEDER: I think it always helps to have a state do something that needs to be done as a push to federal policymakers and as a demonstration that it can be done. We saw that in the Affordable Care Act in essentially Obamacare after the enactment and implementation of Romney Care in Massachusetts, so I think it's a big plus, but there is a tremendous challenge to states in raising their taxes to provide these services because businesses and people can move elsewhere. So I would say it's valuable. Those efforts are valuable to the citizens of the states that enact it, that adopt it, and valuable as a lesson to us, but I sure as hell hope we're not going to wait for a long time to watch those services come into play because we need to act now.

MR. INTROCASO: Yes, and maybe just to revisit from my last question, the pandemic has certainly laid

bare a number of inadequacies in how we deliver in finance care and certainly it can be argued that the greatest inadequacy or the greatest failing the pandemic has revealed is in how we provide long-term care in this country, and particularly when you look at obviously the disproportionate effect on mortality from the pandemic relative to the number of infections this subpopulation has suffered. So what's your hope that we'll actually take this lesson seriously and because of the pandemic drive towards some final legitimate long-term care policy?

PROFESSOR FEDER: My hope is that there's outrage at what we've seen with the pandemic in nursing homes for both residents and caregivers. We're treating residents and so-called essential workers as disposable, and I find that horrifying. I hope that other people share that horror and that it motivates us to stop denying that it is a communal and therefore a government responsibility to assist people who need long-term care services whether in nursing homes or even more importantly at home where people want to be, people of all ages, and not just old people, but as you said 40

percent of the people who need long-term care are under the age of 65. It's time we stepped up and took on that responsibility and I’m hopeful that this horror will motivate us to do precisely that.

MR. INTROCASO: Okay, Judy, thank you so much for this review of long-term care policy. It’s very helpful, and I’m very appreciative.

PROFESSOR FEDER: You’re very welcome, David.

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I, Carleton J. Anderson, III do hereby certify that the forgoing electronic file when originally transmitted was reduced to text at my direction; that said transcript is a true record of the proceedings therein referenced; that I am neither counsel for, related to, nor employed by any of the parties to the action in which these proceedings were taken; and, furthermore, that I am neither a relative or employee of any attorney or counsel employed by the parties hereto, nor financially or otherwise interested in the outcome of this action.

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