

**SENATE SPECIAL AGING COMMITTEE
HEARING ON FAMILY CAREGIVING
10AM
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628 Dirksen Senate Office Building

**Statement by
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Mr. Chairman and members of the Special Committee on Aging.

It is an honor to be invited to address this Committee on family caregiving. I commend the Committee for exploring the largest problem facing this country that attracts virtually no public policy attention. For too long our health programs were run primarily for providers, payors and the government. Patients came last. It is time for a "Patient's First" approach.

The goal of providing incentives to keep families together is admirable. The use of tax credits to provide incentives for non-institutional Long Term Care (LTC) is headed in the right direction.

Medicaid is the federal and state governments' primary LTC program. According to Wilbur Cohen, President Johnson's last Health, Education and Welfare Secretary, Medicaid's 1965 passage was an afterthought. Inclusion of a nursing home benefit was thought to be a rounding error. Instead it created an industry. Today Medicaid covers 2/3rds of all nursing home patients and pays half of all the nation's nursing home costs.

In the 1980's, Home and Community Based Waivers were supposed to save nursing home money. Nursing home costs continued to increase, home health costs exploded and we created another industry.

I would recommend that we learn from these experiences. We need to proceed carefully lest we again suffer huge unintended consequences. That is why my first recommendation is for you to consider a demonstration project rather than to launch the tax credit program nationwide.

That also is why I applaud President Bush's inclusion in his FY2005 Budget of \$256 million over 5 years for three demonstration projects promoting home care. The budget also proposes \$500 million for a demonstration for current institutionalized patients to return to their communities.

This is the third year that total Medicaid expenditures will exceed Medicare expenditures. This explosion in costs is the primary reason states are facing a fiscal crisis. (This was recognized by Congress when you passed an emergency \$20 Billion plan for the states last year.)

The recession essentially caused the expansion of Medicaid enrollees from 40 to 50 million in the past five years. Most were children and adults who, with economic recovery, hopefully will return to the workforce. However, while less than 1% the growth due is to the elderly, blind and disabled, they were responsible for 60% of the cost increase.

It is imperative that we understand the demographic vs. services matrix. Adults and children are 72% of Medicaid enrollees, but represent only 27.5% of the total costs and only 6.4% of home health costs. By contrast, the elderly and disabled constitute 27% of the enrollees but 66% of all expenditures and a whopping 93.4% of home health care costs.

With the retirement of the baby boom generation, we can expect a possible quadrupling of LTC costs in the next 15 years. This would bankrupt every state in the union. This is why we need to model a non-institutional tax credit so that people will have the incentive to use their own resources rather than rely on Medicaid as a substitute for private LTC insurance.

I would recommend a higher deductible with a more catastrophic coverage focus. The deductible could be covered by private LTC insurance, HSA's or Medicaid. With nursing home care costing approximately \$60,000 per year, home health \$50,000 and assisted living \$40,000, we must get this detail right or we will only add to the states' plight.

Should the tax credit be refundable? I don't know, but there is a unique problem to consider. If the goal is to keep families together, most seniors wouldn't qualify for a pure tax credit. This is because a majority of seniors have so little or no income that they pay no income taxes. Perhaps, for this group, a refundable tax credit could be considered.

In addition, the majority of the disabled are under 65. I don't know if your plan includes them, but they would be difficult to exclude, given the tax credit's goals.

By using a tax credit, rather than the existing entitlement structure, you may introduce consumer choice options. Presently called "Cash and Counseling", Florida, New Jersey and Arkansas have successfully used this to reform the services for the disabled enrollees. With the disabled potentially the largest and costliest population, this approach needs consideration.

Another advantage of a tax credit approach is that it avoids all the inequities of the FMAP, commonly called the "federal match". In 1995, the Government Accounting Office called the FMAP a complete failure. Because any reform would make some states huge winners or losers, comprehensive Medicaid reform has been impossible.

Another problem that must be addressed is induced demand. Eighty per cent of all people with 2 or more ADLs receive their care from unpaid caregivers. With this credit, this demand will be unleashed. Also, since this care is usually provided by a family member, care shifts from the family to professionals. That may be good, but it should be noted.

There is one last but crucial advantage to tax credits: CMS won't necessarily have to administer it.

I would also recommend the Committee explore how this proposal affects Medicare and Medicaid dual eligibles. This is the number one priority problem for the National Governors' Association. Dual eligibles are only 6% of enrollees but 35% of Medicaid's costs.

I will stop at this point and look forward to your questions. Thank you again for permitting me to address the Committee on this important topic.