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1996 Warren M. Anderson Legislative Breakfast Series

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PROVIDING AND PAYING FOR LONG-TERM CARE

A monograph of the presentation delivered at the 1996 Warren M. Anderson Legislative Breakfast Series

MAY 8, 1996

Professor David Pratt
Albany Law School

The Garden Room
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Warren M. Anderson is a distinguished alumnus of Albany Law School, and an active member of the Government Law Center Advisory Committee. Having served in the New York State Senate for thirty-five years, he is perhaps best known for his leadership during his tenure as President Pro Tem and Majority Leader from 1973 to 1988.

Warren Anderson began his legal career as an Assistant County Attorney in Broome. He then joined the law firm of Hinman, Howard & Kattell where he is currently practicing law. Throughout his career he has received numerous honors and awards.

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In furtherance of its mission to serve as a resource to government at all levels in the resolution of specific problems, the Government Law Center is pleased to present the fifth annual Warren M. Anderson Breakfast Seminar Series. Monthly breakfast programs will feature distinguished professors who will address the legal aspects of a variety of policy issues pending before the Legislature. The seminars are designed to provide access to current legal information on a given topic. The Government Law Center welcomes your suggestions for future programs.

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PROVIDING AND PAYING FOR LONG-TERM CARE

Presentation by --
Professor David Pratt*

Good morning. Those of who read John Grisham's latest book will know that the protagonist has taken a course at law school that he calls geezer law. I think that description of the elder law course is more a reflection of the fact that John Grisham has been out of law school for a while than a true reflection of the way law schools are regarding elder law.

When I graduated from law school, the one thing I was absolutely certain of was that I didn't want to practice law. So I went off to be a social worker in South London and ended up working with elderly and handicapped people. One of the things that I found out during the course of that experience was how difficult it can be to keep people at home and how distressing it is when they have to be institutionalized, even when it's people who aren't members of your own family. The necessity for institutionalization, although it is very real and sometimes unavoidable, is something that should be seen as a last resort.

We should probably start off by trying to define what we mean by long-term care. We tend to think of long-term care in terms of the elderly population, but of course, it applies to a lot of non-elderly people as well, who have disabilities at one time or another. In 1988, the Brookings Institution defined long-term care as, "help needed to cope and sometimes survive when physical or mental disabilities impair the capacity to perform the basic activities of every day life such as eating, toileting, dressing and moving about."

Right now, most of the long-term care that is provided in this country is provided at home and somewhere between 70% and 80% of that care is provided on an informal basis either by family or friends. One of the challenges we have in long-term care, particularly if we're looking to expand the care that's provided at home, is how we provide the care in such a way as to supplement rather than supplant the informal care that's being given at home.

I don't want to bore you all with statistics, but in this area it's really unavoidable to talk about demographics to some extent. In 1995, there were about 33.6 million people in this country over the age of 65 and there were about 3.6 million over the age of 85. It's quite clear from the statistics that it is the very elderly group, the ones over 85, who are most at risk for needing long-term care. By the year 2010, the number of people over the age of 65 will have increased by about 20% to 40 million, and the number of people over 85 will have increased from 3.6 million to 6 million. And by the year 2020, the number of people over 65 will have increased to about 53 million and, of those, 7 million will be over

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the age of 85. So we can see that even if costs remain stable in real terms, and in the recent past the experience has been that long-term care costs have increased significantly faster than the general rate of inflation, just the increase in the number of the elderly is going to mean a significant increase in the spending needed to care for the elderly.

On a typical day, about 4 1/2% of the elderly are in nursing homes and of those who are 85 or older almost 25% are in nursing homes. In 1990, there were an additional 4 million people who received home care services and, according to the Brookings Institution's estimate, by the year 2020, that will increase by 60% to 6.4 million. In the year 1990, there were about one and a half million nursing home residents.

Of the elderly nursing home residents, almost half rely primarily on Medicaid to cover the cost of their care. In terms of the cost of social programs generally, in 1994, the cost of federal retirement programs (social security, civil service retirement, military retirement) was about $221 billion, or 17% of federal budget receipts. By the year 2004, just eight years from now, that is scheduled to more than double to $534 billion or more than 25% of federal budget receipts. In 1994, the cost of Medicare and Medicaid combined was $242 billion and that is projected to increase by the year 2004 to $684 billion. That is almost a tripling in cost over a ten year period, to more than 32% of projected budget receipts. So, by the year 2004, if these projections are correct, approximately 58% of all federal budget receipts would go to pay for federal retirement programs, Medicare and Medicaid.

In terms of New York State's spending on Medicaid, it is sometimes difficult to identify just what the true cost to the state is, because one very often sees the gross spending, which doesn't reflect the fact that approximately 50% of that cost is paid by the federal government.

In the 1994 federal fiscal year, gross New York spending on Medicaid was approximately $21 billion, and of that over $4 billion was spent on nursing homes and almost $3 billion more on home care. One the major planks of Governor Pataki's budget proposals has been an attempt to reduce the spending on Medicaid and to restructure very significantly the way Medicaid services are delivered. So, for instance, the Governor has proposed that effective August 1 of this year, all spending through Medicaid on home and community based services should available to counties on a block grant basis so that the state would no longer define what services are available. It would be up to each county to decide what services they would provide within the amount of funds they have available.

There are approximately 3 and 1/2 million people covered by the New York State Medicaid program, and the costs have been increasing at a rate of about 11% a year. Of the population covered by Medicaid, approximately 40% are receiving Medicaid because they receive aid for families with dependent children, but that 40% group only represents about 12% of Medicaid spending. The elderly and the disabled, who constitute about 25% of the New York State Medicaid population, receive 2/3 of the spending.

For a while in the early 90s, it looked as though we might get a federal solution to the problems with long-term care. The first major initiative in this area was the Pepper Commission, which issued its final report in September of 1990.

The Pepper Commission made three main recommendations. First, it would have created unlimited public insurance coverage for home and community based care for the severely disabled, regardless of income and regardless of age, and this would have been a social insurance program rather than a welfare program. Secondly, it would have provided three months coverage of nursing home expenses for anyone who required nursing home admission, again without regard to means. And thirdly it would have instituted a new program to cover nursing home costs from the fourth month onward.

The estimated annual cost of this program, as far as long-term care is concerned, would have been almost $43 billion. The main criticism of the Pepper Commission's recommendations was that they made no recommendations at all as to how to pay for this. One may think that this was something of a gap in the report as far as its usefulness was concerned. The Commission may have been wise not to do so, but that did make the report rather less useful.

The second major federal initiative was part of President Clinton's universal health care reform proposal, and was part of the Health Security Act of 1994. Again, there would have been expanded home and community based care for all people with severe disabilities, which would have been available regardless of income or age. There would have been co-insurance features and national spending targets. Secondly, there would have been improved coverage of institutional care under Medicaid. Thirdly, there would have been tax incentives to encourage the growth of long-term care insurance. Fourth, there would have been tax credits to enable people with disabilities to work. And fifth, there would have been a demonstration study to prepare for greater integration of acute care and long-term care. The estimated cost of the long-term care program for the seven year period ending in the year 2000 would have been $80 billion. Again, this proposal became moot when it collapsed along with the rest of the health care reform proposal.

I don't think that it is realistic at this stage to expect any new federal initiatives. So it looks very much as though each state is going to have to begin to develop its approach toward long-term care. One of the problems we face right now with long-term care is that there is a significant degree of fragmentation, both in the delivery of services and the funding of services.

One of the prevalent myths about long-term care, particularly nursing home care, is that Medicare provides a significant portion of the costs. As most of you probably know, that is not true. Medicare pays for very little of the long-term care that is provided in the nursing home. As far as home health care is concerned, there is a certain amount of care available through Medicare, but there are fairly stringent eligibility requirements.

In terms of Medicaid, right now the federal government pays 50% of the cost for Medicaid provided in New York. The state pays between 25% and 50%, depending on the nature of the service being provided, and the counties provide the balance of the cost.

During the 1970s there was a policy decision made in this state that long-term care, wherever possible, should be delivered in the home and I think there were three main incentives for that policy. The first was the nursing home scandals that erupted in the early

70s. The second was the fact that most elderly people do prefer to stay at home, and the third is the belief that to provide the care at home would be less expensive. But, unfortunately, the third plank doesn't really seem to have been true.

It is now possible to provide a wide array of hi-tech services at home that would not have been possible 10 or 20 years ago. Particularly in the metropolitan area, there has also been a large pool of unskilled workers available to provide services to the elderly and the disabled and, with the increasing availability and acceptability of home care services under Medicaid, the demand has grown significantly. There is a very significant difference between demand for nursing home care and demand for home care. Because most people would greatly prefer to stay at home, the availability of nursing home care does not necessarily create an increased demand. Certainly, if there is financial coverage, it is more likely that people are going to use it. But people are not going to get themselves admitted to a nursing home just because there are nursing home beds available. On the other hand, the sort of services that are provided at home, tend to be very valuable and very important to a lot of people and, if those services are available, they will use them.

So one of the big problems in the home care area is how do you keep utilization within reasonable bounds. It is almost impossible to establish a program where you only provide homecare services to those people who would otherwise be institutionalized. So, inevitably, if you provide homecare services there's going to be an increase in demand and an increase in resulting costs.

Most of the homecare services that are provided in New York State are funded through Medicaid. There are also a couple of special state programs that provide services, and there are some managed care programs that I'll talk about in more detail later. There is also the long-term home health care program, also sometimes known as the Lombardi program, or the nursing homes without walls program, and there is an expanded in home services for the elderly program which provides services for another group of people. So, the overall range of long-term home health care services in New York is substantially broader than in most states.

Now, given the demographic issues and given the cost issues that I mentioned before, one of the things that we have to do when we evaluate an appropriate approach to providing long-term care is to decide what our answer is to some fundamental questions. We know that we are going to be providing long-term care. We know that we cannot afford to provide long-term care to everyone who might benefit from receiving long-term care. So, how do we draw the line?

The first issue is, what is the scope of the family's responsibility to care for their elderly or disabled members? What is their moral responsibility? What is the scope of their financial responsibility? We find very often that the caregivers are members of what is sometimes referred to as the sandwich generation. They have elderly parents. At the same time they are also bringing up children, and they are paying for the costs of their children's education. They may have limited resources available to take on an additional financial burden with respect to their parents.

As we see an increase in the number of very elderly, we will also see an increase in the age of these people who tend to be their primary care givers. The primary care givers for the elderly tend to be first spouses, and secondly children. Where we have people living to 90, 95 or 100 years old, their children are going to be correspondingly older.

A second issue that's been raised by some people is the whole notion of intergenerational equity. The argument is that we are already spending too much on the elderly, that we have a large number of children who are living in poverty, and that it is inappropriate to funnel more funds towards the elderly. I think that in some ways the intergenerational equity argument is a false argument, as long as the people who are now providing funding for the care of the elderly believe that care, or something comparable, will be available when they themselves age. Growing old is something that happens to all of us, unless we die first, and most of us would prefer to grow old rather than die first. I don't believe that most people in this country resent the fact that they are paying social security contributions which are not directly benefiting them. The polls that I have seen are supportive of continued social security and Medicare funding, and I believe that the same sort of support is there for long-term care if the program is presented properly.

The third issue is determining what is the proper balance between public funding and private funding. How much should people be expected to put away for themselves? If you believe that people should be expected to contribute to the cost of their own long-term care, how can we make it easier for them to do it? If we have public funding, should the public funding be on the basis of a social insurance program, where it is available to everyone regardless of means, or should it be in the form of a welfare program? Right now, the major social insurance programs in this country for the elderly are Social Security and Medicare both of which enjoy enormous public support and both of which, despite their problems, are pretty efficiently run and have been very successful in delivering necessary assistance to the elderly.

In better budgetary times, one possible source of funding for long-term care would be to add an additional payroll tax which would be designed to pay specifically for long-term care. This would have the advantage of universal coverage, which means the risk would be spread. It also means that many of the problems with private long-term care insurance (such as adverse selection, predatory marketing, etc.) would not be an issue. But in the current political climate, I do not see any way in which a payroll tax would be enacted.

The argument against having a social insurance program is that it would benefit the wealthy, and the wealthy don't need the coverage. On the other hand, if you provide it as a welfare program, you are forcing people who may well have been self-sufficient all their lives to deplete themselves of assets, either by spending money on their care or by transferring assets to relatives in order to qualify for benefits under Medicaid. That is demeaning and in my view sends the wrong message to the people who are caught in the middle: it's pointless to save, because if you need long-term care, you'll end up destitute anyway.

The advantages of public funding are several. First, if coverage is universal, it

spreads the risk over the widest possible group of people. Right now, of those who reach the age of 65, men have about a 1 in 3 likelihood of requiring nursing home care at some time during their lives and women (because they live longer) have an over 40% likelihood of requiring nursing home care. But it's totally unpredictable who within that particular age group will require it. It's an eminently insurable event and, the broader coverage you have, the more affordable it is for each individual.

Secondly, if the funding is done publicly, there are several different ways it could be paid for. As I said, I don't think a payroll tax is politically acceptable currently. It would be possible to pay for the program out of general revenues. It would also be possible, as was proposed by President Clinton in his health care reform proposal to pay for it largely with sin taxes, such as increased taxes on tobacco and alcohol.

The third advantage of public funding is that we wouldn't be requiring people to spend down their assets in order to qualify for Medicaid. And if the program were made available publicly, it should be more affordable because, unlike private insurance, the public authority would not need to make a profit. There would be no marketing costs and we would not have to protect the elderly against inappropriate marketing techniques.

The main arguments for private funding are really two. The first is political reality: it could be very, very difficult to enact new taxes or to set aside sources of tax revenue in the current budget situation even if long-term care had much more universal support than it does. Secondly, the main beneficiaries of public funding of long-term care are not so much the elderly but their heirs; if the elderly are allowed to keep the assets that they've accumulated, they can pass them down to their children. Why should the heirs benefit from this public funding?

Another issue that we have to address, that we have not adequately addressed to date, is the issue of Alzheimer's disease and the expenses that result from it. If we assume, which is probably a conservative assumption, that approximately 20% of the nursing home residents suffer from Alzheimer's, then the total spending through Medicaid on Alzheimer's patients was almost $6 billion in 1991, far more than all the spending on AIDS patients. Of those between the ages of 65 and 74 only about 3% have Alzheimer's. The percentage increases to about 19% for those who are aged between 75 and 84. Over the age of 84, the percentage is over 40%. They are very, very substantial percentages.

We are spending far less right now on Alzheimer's research than we are spending on research for cancer, AIDS, or heart disease. As we see a significant increase in the group of people over the age of 85, the number of people with Alzheimer's disease is going to increase correspondingly. Unless we can find some more effective way of identifying people at risk, and perhaps find a way to delay the onset of the disease, it's going to result in enormous spending 30 and 40 years in the future.

Now, in terms of private funding for long term care, one of the problems is that there are really not very many satisfactory vehicles available at present. One of the reasons why transferring assets to qualify for Medicaid is seen as not only being legal but also morally appropriate by many people is they really don't believe that they have any other alternative.

They believe the present system leaves them with the alternative of either transferring their assets or subjecting themselves to impoverishment.

Part of the problem is that long-term care insurance is not recognized as a need early enough in life. Most people 30 or 40 years old do not believe that it's ever going to happen to them. By the time they get to 65 or 70 or 75, the insurance is correspondingly more expensive. So, if we are to try and encourage people to provide to some extent for their own future, and if it is not likely that a mandatory program is going to be enacted at any time in the near feature, then we have to find ways of encouraging the purchase of private long-term care insurance.

As of the end of 1993, there were approximately 93,000 long-term care policies in force in the state of New York. As of the beginning of 1995, almost 5,000 policies had been purchased under the special Robert Wood Johnson program that was implemented by the State (and there are three other states that have similar programs) under a special Medicaid waiver. Under the program, an individual who lives in New York State can purchase a long-term care insurance policy that meets certain minimum standards, two of which are that the policy must provide benefits for at least three years and the minimum daily benefit must be at least $110. If that individual actually requires institutionalization, and collects benefits under the policy for the three year period, then that person becomes eligible for Medicaid without regard to the usual asset test. Any income that the individual has may be used to pay nursing home expenses, but their assets are disregarded.

Now this is clearly very advantageous for those people who have sufficient assets to worry about their assets being depleted, but are not so wealthy that they can afford to pay nursing home costs indefinitely without depleting their assets. There are, however, some major problems with the Robert Wood Johnson program.

The first is the general issue that not enough people realize the importance of providing for long-term care. The second problem is affordability. In 1995, the average premium for $110 a day of coverage for a 65 year old was $1,500, which is a significant amount of money. The third problem is whether the coverage under the policy will in fact meet the cost of nursing home expenses. The Robert Wood Johnson policies are required to provide a minimum benefit of $110 a day. In 1994, the statewide average cost of nursing home care was $176 a day, $205 a day in the New York Metropolitan area and $153 a day upstate. So if you have someone who had a Robert Wood Johnson policy providing a $110 a day benefit, there would be a shortfall of over $15,000 a year for someone in an upstate nursing home and over $34,000 a year for someone in a downstate nursing home. If the person purchases additional coverage to make sure that the entire nursing home costs are covered, then the cost of the premium would obviously be correspondingly higher.

Another problem with private long-term care insurance right now is that the tax status is very unclear. It is not clear that the premiums are deductible as medical expenses. It is not clear that any benefits received are excludable from income.

There are pending tax proposals. The House Ways and Means Committee passed a tax bill in March of this year which would clarify that long-term care insurance proceeds

are excludable from income. It would also provide a tax exclusion for employer provided long-term care insurance: there are now about 900 employers throughout the country that make long-term care insurance available to about a half a million employees. One of the employers doing so is the California Public Employees Retirement System which makes comprehensive coverage available at a low price.

One of the problems with the current tax proposal at the federal level is that although it would generally grant an exclusion from income for employer provided long-term care insurance, that exclusion would not be available if the long-term care insurance were made available through a cafeteria plan, a plan where employees chose the benefits they receive. That is fundamentally misguided, because a lot of employers who are interested in providing this insurance will not want to mandate it as part of their basic benefits package, but they may well want to make it available as an option for employees to use part of their benefit dollars to pay for this coverage.

The additional proposal, which is also in this bill, would allow the tax free receipt of certain accelerated death benefits under life insurance policies if the individual either is terminally ill or is chronically ill. This is a very significant improvement.

So, under current law, the individual patient has basically three options. The first is to purchase private insurance. The second is to spend down their assets until they are poor enough to apply for Medicaid. The third is to transfer assets until they qualify for Medicaid.

To quote an article by Sean Regan, "Realistically, individuals will find ways to circumvent the law as long as Medicaid estate planning remains the most rational option available. In this way, Medicaid estate planning is a symptom of a broader problem, the lack of dignified choices for financing long-term health care." And I believe that is true.

The ability to transfer assets was restricted very significantly in 1993 by the federal budget legislation. However, no matter how tightly those restrictions are increased, people will always find a way around them as long as they feel that they have no acceptable alternative.

I'd like to talk a little about some housing issues, because one of the fundamental ways in which we can help to reduce the need for long-term care, and help people to age in place, is by providing additional housing assistance. This is one of the areas where fragmentation becomes a problem, because medical services are provided by one agency, social services in general are provided by other agencies, and housing issues tend to be treated in a totally separate area.

In this State we provide several programs to help people to be able to afford to live in their own homes. There are real property tax abatements. There are real property tax credits for lower income people. There are low interest loans for home repair assistance. There is an increasing availability of reverse mortgages. About 75% of all seniors own their own homes, and most own their homes free of mortgage. So, one of way of helping them attain access to that cash is through reverse mortgage programs. There's a home energy assistance program which helps with energy bills.

There are various types of supportive housing, and that is something that we have not explored as much as we might. These supportive housing environments tend to be significantly less expensive than nursing home care. Finally, there are enriched housing arrangements and this is also something that we need to pursue much more aggressively.

To be eligible for enriched housing, an individual must be at least 55 years old, and at least 75% of the residents of the facility must be 65 or older. It does not necessarily have to be a separate building. It can simply be a group of apartments in an apartment complex. The individual must have a disability or a health condition that prevents him or her from performing on a regular basis the activities required for independent living. So, for instance, it might be a person with a mobility problem. It might be someone with impaired eyesight who has some difficulty with getting around and living totally independently, but by and large can cope fairly well. Finally, the individual must not require continuous medical or nursing care.

Within the enriched housing environment, there is made available to the individual a wide range of services, and the individual pays an all inclusive fee for those services. So there are meals available. There are social activities available. There is access to medical care. In general, the enriched housing environment should be part of a residential neighborhood so that people have available shops, cinemas, laundries, whatever they need. This is something that I saw work when I was a social worker in London and, although there is a significant up front expense in developing this housing, I think it's very important that we explore this as another way of enabling people to stay at home.

Given the increased numbers of elderly people and given the fact that even without inflationary factors this is going to lead to significantly increased spending on both home care and institutional care, what should we be doing in terms of policy approaches. There are two main themes that emerge from the literature as things that we should think about. The first is that in this society, we rely on institutional care to an extent that is not matched anywhere else in the western world. We are necessarily not doing a worse job with long-term care than other societies. Most other societies are having similar problems, but we do focus our funding on institutional care to an extent that it is unmatched anywhere else. Until recently, the total public spending on long-term care was allocated about 82% to institutional care and about 18% to home care. We have to move away from that percentage, not just because if done rightly it is possible to save costs but certainly because in general if we can keep people at home, it is better for them and it is better for their families.

The second thing that we have to move towards is greater integration of both the services that are provided and the funding sources. As long as there is fragmentation, there is inefficiency, there is frustration for the patient and the family and inevitably there are increased costs. So, we have to try and develop models where the delivery of care is coordinated, so that people receive the care they need and they don't receive care they don't need. The financing mechanisms must be coordinated, so that when there are cost controls put in one part of the program that doesn't balloon into increased expenditures in

other parts of the program.

I think that the most promising models were explored in some detail at hearings held by the Senate in March of this year. Right now, in this state, we have two PACE (Program of All-inclusive Care for the Elderly) programs, one in the city and one in Rochester. There are two more programs that are proposed to start up later this year: the Eddy, here in the Capital District and Loreto in Syracuse. The PACE programs are designed to provide a program of all-inclusive social and medical care for the frail elderly who would be nursing home eligible. So these are people who, but for the availability of the program, would almost certainly be institutionalized.

In addition to these four programs, we have a fifth program, a social HMO at the Metropolitan Jewish Geriatrical Center in the city. A social HMO differs from a PACE program in that the social HMO covers a broad cross-section of the elderly, from people who are very healthy to people who are relatively frail.

The distinguishing feature of the PACE program is that there is an all-inclusive fee paid per month, for each person who is covered by the program, which is the same regardless of the nature and type of services which they receive. So this is a program where there is full capitation, and the care is managed overall within the limits of the budget available. The distinguishing feature between full capitation and partial capitation is that if you have partial capitation, where some of the services needed are on a prepaid basis, on a fixed basis, there is an inclination to use services that are not subject to capitation. There is a financial incentive for providers to use the services that are not capitated, even if that is not in the best interests of the patient.

The Governor's budget proposes that there be a total of 15 long-term care demonstration programs. We have the five programs that are currently in place. There are an additional six programs that are likely to be put in place pursuant to a request for proposals that was issued by the Health Department in March of this year. That RFP is for a partially capitated program, rather than a fully capitated program, basically to avoid the necessity for getting up front waivers from the federal government. But the intention of the program is to move towards full capitation when it becomes possible.

The Department of Health program has five enunciated goals. First, to increase the choices available to patients. Secondly, to increase the satisfaction of clients and their families, first by making it easier for them to receive the services that they need and secondly by coordinating the delivery of the services, so that's it's less frustrating to find an appropriate provider. Third, to improve outcomes by reducing the level of hospitalizations and reducing the number of nursing home admissions. The PACE programs that are already in place have been very successful in showing a significantly lower incidence of hospitalizations and nursing home admissions than would be typical for a population having the characteristics of their members. Fourth, by providing services in this coordinated fashion, they hope to delay the decline in the individual's facilities, and to foster continued independence. Finally, the fifth goal is to reduce expenditures. The PACE programs that are in place now are operating at a cost of about 95% of the regular Medicare expenditure

for that locality, and are saving Medicaid somewhere between 8 and 11% of the typical expenditure. So there are genuine cost savings which can be achieved within this managed care environment. The Department of Health program would initially exclude both acute and primary care but the intention is to integrate them as soon as it can be made possible.

Now, the Governor's program suggested that there be 15 long-term care demonstration projects. If you look at the five that are already in place, and the six that will be added under to the Department of Health's Commonwealth Fund project, that takes 11 of the 15 slots. One of the criticisms made of the Governor's budget proposal is that 15 projects may not be enough: given the variety of conditions throughout the state, the variety of needs, and the variety of services that may be required, we probably should have more demonstration projects to enable us to review a wider range of alternatives.

Another initiative was introduced by Senator Hannon, the Integrated Continuing Care Partnership Act. Like the Governor's proposal, this focuses very heavily on integrating the sources of care and the sources of financing, but would have more of an emphasis on full capitation than on partial capitation. The other thing that is noteworthy about Senator Hannon's bill is that it would simplify the approval process. The Loreto, one of the PACE projects expected to get underway later this year, first started applying for the approvals needed at the state level in 1992 and, according to testimony given at the recent Senate hearings, they have spent $300,000 so far in efforts to obtain the necessary approvals. We have to try and simply that structure. We clearly do require regulation, but right now we have regulation in too many different agencies. For organizations that are trying to do a wide variety of things, we need too many different approvals. One of the focuses of Senator Hannon's bill would be to locate the approval process in one place and have one global approval that would cover all the activities that these organizations are trying to achieve.

One of the people who testified at the hearing in March was Brian Ellsworth, the director of long-term care in the Division of Health and Long-Term Care at the Department of Social Services. He said in his written testimony that "We believe that our program and policy goal should be clear in the arena of long-term care. A broad range of service delivery systems which can integrate primary, acute and long-term care services, reimbursement arrangements which pool Medicaid, Medicare and other private financing and ultimately assumption of full risk by integrated delivery systems. One of the eventual keys of maintaining quality and access will be competition among capitated providers for voluntary enrollments of chronic care persons. In addition, we will all need to work creatively to find innovative ways for these programs to leverage more private financing including private long-term care insurance."

Finally, I would like to quote a report by two researchers at the Brookings Institution, who produced a report to the AARP Public Policy Institute at the end of last year. They concluded as follows: "Although integrating acute and long-term care carries risks such as over medicalizing long-term care and loss of funds transferred to acute care from long-term

care, the overlap of acute care and long-term care needs of many persons with disabilities makes the integration of the financing and delivery of these two systems a worthwhile goal. However, integration faces numerous technical, political and attitudinal barriers. To a large extent, policy makers and providers are just beginning to learn how to create a seamless financing and delivery system to persons with disabilities. Indeed, the ideal model may not yet exist."

So, in conclusion, what I would suggest as the appropriate way of proceeding for this State is to make available to different organizations the ability to experiment with different approaches, to recognize the fact that we have a wide variety of situations and a wide variety of needs. The approach that may work in the metropolitan area may not be the right approach for Rochester or Albany or Syracuse. The right approach for Albany may not be possible or even appropriate for some of the rural areas of the state where we have a problem in ensuring adequate access to providers of services.

We have to try to integrate the various delivery systems and the various sources of funding so that they can operate in a coordinated fashion. We have to try and make it easier for people to provide services on a coordinated basis. And, I think that if we don't do this we are going to have very severe problems. We are already encountering budgetary problems and yet we haven't even begun to experience the aging of the baby boom generation. In 15, 20, 30, 40 years from now we will have a significantly larger population who are requiring these services and, unless we can now start to put in place efficient and cost-effective ways of providing the necessary services, we are going to have problems in the future that make today's problems seen very minor by comparison.

We cannot afford to let the program be dictated totally by budgetary considerations, but obviously budgetary considerations are very important, and we have to try and find an affordable way of delivering as much service, in as cost-effective a way, as possible.

Thank you.