Wisconsin Association of Homes and Services for the Aging, Inc.

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June 1, 2009

Jason Helgerson, Administrator
Division of Health Care Financing
Department of Health Services
P.O. Box 309
1 West Wilson Street
Madison, Wisconsin 53707-0309

Subject: LTC Task Force on Unspecified Medicaid Cuts
(*ForwardHealth Rate Reform Project)*

Dear Mr. Helgerson:

The Wisconsin Association of Homes and Services for the Aging (WAHSA) is a statewide membership association of 200 not-for-profit long-term care organizations. WAHSA member corporations own, operate and/or sponsor 183 not-for-profit nursing homes, of which 41 are county-owned and operated, 9 facilities for the developmentally disabled (FDD), 76 community-based residential facilities (CBRF), 60 residential care apartment complexes (RCAC), and 113 senior apartment complexes, as well as community service programs ranging from home care, hospice, Alzheimer's support and child and adult day care to Meals on Wheels. Our members employ over 38,000 dedicated staff who provide care and services to over 48,000 residents and tenants.

On behalf of the WAHSA membership and those they serve, I thank you for the opportunity to offer our perspective on the funding crisis facing the Wisconsin Medicaid program. At the outset, let me say that the notion that we can cut approximately $580 million from Medicaid without reducing benefits, eligibility and the quality of care and services provided is a daunting, if not impossible, task. However, as outlined in the latter sections of this memo, WAHSA does offer some areas in which we believe cost savings can be achieved.

Background

With respect to our skilled care facilities, some perspective is in order. Please consider the following:

I. Fact Sheet: Medicaid Underpayment for Resident Care

(www.wahsa.org/medicaidfact.pdf)

A comprehensive analysis of the nation's Medicaid nursing home payment systems ranked the Wisconsin system the worst in the country. The study, "A Report on Shortfalls in Medicaid Funding for Nursing Home Care" released in October 2008 by Eljay, LLP, accountants and consultants, revealed that Medicaid deficits sustained by Wisconsin's nursing facilities are 112% higher than the national average (loss per nursing home resident/day).

The national report and ranking came as no surprise to the Wisconsin nursing home community. Indeed, the Wisconsin Medicaid program's own database of facility- specific cost and reimbursement information vividly illustrates the system's inadequacies. It reveals the following:

- Medicaid recipients (21,009 residents), including Family Care enrollees, comprise nearly two-thirds of all residents served in Wisconsin nursing facilities (33,047 total residents). Source: DHFS Nursing Home Review, February 25, 2008

- Labor costs represent approximately **73%** of the total cost of providing care and treatment to nursing home residents. Nursing homes employ over 50,000 individuals; 60% of all nursing home personnel perform nursing care and services (RNs, LPNs, and certified nursing assistants).

- In the 2007-2008 payment year, the difference between the total cost of the care facilities provided their Medicaid residents and the Medicaid reimbursement they received for providing that care (i.e., the "Medicaid deficit") was **$280,448,666***.

- Direct care costs, the costs to provide hands-on care to residents, represented $163,502,104*, or 58.3%, of the total costs Medicaid failed to reimburse in 2007-2008.

- Approximately 96% of the 373 nursing facilities in the state's database received a Medicaid payment in 2007-08 which failed to meet the cost of care they provided their Medicaid residents.

- Wisconsin nursing facilities on average lose $37.65* per day for each Medicaid resident they serve. For the average Wisconsin nursing home, that results in an annual loss of $751,873* to provide care to its Medicaid residents.

- As a result of the failure of the Medicaid program to pay the resident care costs for which it is responsible, private paying residents are compelled to pay rates that average nearly **$70** per day higher than a facility's Medicaid payment rate (Average 2007-2008 Medicaid payment rate: $131 per day). It is these private pay residents, who currently are required to pay the $75 per month nursing home bed tax, who are being asked to subsidize this Medicaid underfunding.

**Excludes Family Care related losses*

II. Nursing Home Overview, February 25, 2008

Early last year, the Department produced an insightful, yet alarming, analysis of the Wisconsin's nursing facilities. The Department's staff concluded the following:

- "Nursing home rate increases have not kept pace with inflation"
- "Medicaid rates are insufficient to cover costs"
- "A significant and growing proportion of homes are financially fragile"
- "Buildings are old and poorly designed for cost efficiency and consumer preferences"
- "The acuity level of nursing home residents is increasing"
- "Nursing homes face difficulties recruiting and retaining capable and high-quality direct care and leadership staff"
- "Staff turnover is high and increasing in almost all staff classifications"
- "Family Care utilization of nursing homes has grown over time in absolute number of member-months and as a proportion of all Family Care member-months"
- "A growing number of nursing homes are experiencing financial stress"

III. Nursing Home AB 75 Funding Contributions

Nursing homes already have been asked to help balance the state budget. As shown below, under Assembly Bill 75 these facilities will contribute at least $110 million to the state budget. This number swells to over $150 million if the enhanced federal Medicaid matching rate is used to calculate the FED generated by the bed tax increases proposed under AB 75 and the reestimated CPE skim is reflected.

Nursing Home Funding Contributions*

Wisconsin's Nursing facilities/ICFs-MR would fund nearly $111 million in state operating costs under AB 75:

	2009-10	2010-11	Biennium
NF Bed Tax Increase used to Fund Medicaid Base ($50/bed):	$34,075,449	$32,235,416	$ 66,310,865
ICF-MR Bed Tax Increase used to Fund Medicaid Relocation Waiver :	$ 267,600	$ 296,800	$ 564,400
Additional Certified Public Expenditures (CPE) used to Fund Medicaid Base*:	$18,000,000	$18,000,000	$ 36,000,000
Additional CPE Funds used to Fund Family Care Expansion*	$ 2,596,200	$ 2,592,800	$ 5,189,000
$200 Nursing Home Survey Revisit Fee:	$ 60,200	$ 60,200	$ 120,400
Eliminate the Nursing Home Appeals Board:	$ 1,331,710	$ 1,331,710	$ 2,663,420
Total:	**$56,331,159**	**$54,516,926**	**$ 110,848,085**

****These funds would otherwise be available to fund Medicaid losses incurred by local government operated nursing homes (primarily county homes)***

Fiscal impact shown without enhanced federal stimulus matching rate

Although the doubling of the bed tax (2009-10) proposed under AB 75 will generate approximately $77.5 million in federal Medicaid funds, as it currently stands, nursing homes will receive only 22% of these additional dollars in 2009-10 (i.e., facilities will fund their own 2% rate increase and the State will use 78% of the newly generated FED to plug Medicaid budget holes).

So, in the context of helping cut $580 million from Medicaid, our nursing facilities ask the Department take into account: facilities' existing record and unsustainable losses; the unfair financial burden imposed on private pay nursing home residents; the need to increase direct care staffing; the DHS analysis of the seriously deteriorating financial condition of our nursing homes; and the level of funding contributions already required of nursing facilities under AB 75.

Medicaid Savings Options

WAHSA offers the following options to produce additional Medicaid savings. The Association is available to discuss these recommendations with you and your staff and offers to assist the Department with the analytical work necessary to estimate the savings associated with each item. We've intentionally kept our summary of each item brief in order to offer the concept without setting roadblocks to their implementation (several implementation options may be possible).

LTC Funding Solution: Most LTC financing experts agree that the current Medicaid program is unsustainable, particularly given the increasing cost of the program and the demographic tsunami heading our way. Medicaid, even if better ***managed*** under programs like Family Care, is consuming an ever-increasing share of the state budget and we simply cannot continue to "pay as we go" without bankrupting the State. In the process, we'll be placed in the position of pitting kids against seniors. Therefore, we need to begin now to look for a funding mechanism that doesn't simply raise the money today to pay for today's care. Instead, we need to pursue a program that embraces an "insurance model" under which we all contribute to a LTC fund so that we've reserved dollars to pay for our care in the future. Attached are additional informational pieces that highlight the need for a sustainable LTC Financing Solution. All the innovation related to *how* we deliver care is lost if we cannot afford to *pay* for the care and services needed. Here are some additional resources for your review:
http://www.thelongtermcaresolution.org/

Family Care Partnership & PACE: WAHSA proposes that the DHS accelerate the expansion of Partnership and PACE. We submit that a fully integrated health and long term care delivery model offer greater opportunities to both improve outcomes and contain costs. Under the current system, sending a person to the hospital offers Family Care informal stop-loss insurance, shifting costs to Medicare or Medicaid (outside the MCO's capitation payment and responsibility). Medicaid could save dollars if the managed care entity also received a Medicare payment and assumed responsibility for the enrollee's acute, primary and long term care. Related to this option, DHS should consider reorganizing the Divisions to ensure that responsibility for managing and paying for health & long term care resides with one entity.

Nursing Homes Buy-Out Options: WAHSA proposes that DHS proactively offer nursing homes the option of receiving a cash buy-out in return for substantially downsizing (above and beyond current methods) or outright closure. Under this option, Medicaid would incur some short-term expenses but gain long-term savings.

Health Care Technology: DHS should explore the use of telemedicine and emerging technologies to reduce Medicaid expenses, including the use of: Assistance call systems; cognitive aids; communication devices; electronic health records; medicine management; mobility aids; personal monitoring; smart home systems; telemedicine; and wander management. It is likely some or all of these innovations, if available, could enable persons to live more independently (save MA dollars) and allow providers to deliver care and services more cost-effectively (See *Imagine - the Future of Aging* at: www.agingtech.org/imagine_video.aspx). WAHSA suggests that Medicaid and Family Care MCO payments be adjusted to pay for technological innovations that produce operational and administrative efficiencies.

Delayed Medicaid Payments: Recent changes to nursing home claims processing have resulted in a 1-2 day delay in payments to providers. WAHSA estimates that this payment delay will benefit the State of Wisconsin related to the "float," or the timeframe between the date the check is authorized and actually deposited into the providers' account. Interest earnings generated by delayed payments are estimated to be approximately $400,000 to $500,000 GPR annually.

Medicaid Divestment: WAHSA staff participated in the DHS workgroup assigned to review state regulatory changes required to implement federal provisions intended to tighten Medicaid divestment loopholes. The majority members of the workgroup rejected efforts to impose more comprehensive divestment restrictions as allowed under federal law. Given today's budget challenges, WAHSA encourages DHS to reevaluate available options to further restrict an individual's ability to divest for the purpose of achieving Medicaid eligibly.

Patient Liability Collections: WAHSA encourages DHS to review patient liability collections under the Family Care program to determine if these amounts are being fully collected and credited to the Medicaid/Family Care program. Cost share requirements and collections should also be reviewed.

Private ICF-MR Supports: WAHSA asks that the independent, non-state ICF-MR facilities be utilized for respite and short-term care and service options for persons with developmental disabilities, rather than relying on more expensive state centers to fulfill these functions. These private facilities also could provide long term placement options, as appropriate, as an option to continued reliance on the state centers.

Federalize the Nursing Home Enforcement System: Currently, for nursing homes that are Medicaid and Medicare providers, DHS may issue both federal and state citations for the same practice and may recommend federal remedies ***and*** impose state sanctions. WAHSA proposes that DHS be prohibited from issuing a notice of violation of a state requirement to a nursing home that is a Medical Assistance or Medicare provider if DHS has, in a statement of deficiency, cited the nursing home for a violation of a federal requirement that is based on the same facts. This proposal will reduce state expenses related to forfeiture specialists, hearing examiners, case

schedulers and legal counsel. Savings associated with this recommendation are estimated at approximately $400,000 annually.

Direct Appeal of LSC Code Citations: WAHSA asks that providers be allowed to petition the DHS Secretary for a variance or direct appeal to CMS to waive enforcement of any nursing home life safety code violation with an associated plan of correction estimated to cost over $5,000. This option could be available to address enforcement actions deemed to be either nonsensical or requiring an expenditure far in excess of any benefit. For example, DQA (as "required by CMS") recently told one of our member nursing homes to replace 42 internal doors, despite the fact that this facility is scheduled to be replaced in 18 months (as documented by a vote of the county board).

In summary, given our facilities' record losses; the unfair financial burden imposed on private pay nursing home residents; the need to increase direct care staffing; the DHS analysis of the seriously deteriorating financial condition of our nursing homes; and the level of funding contributions already required of nursing facilities under AB 75; we respectfully ask that DHS refrain from imposing any cuts that would reduce nursing home Medicaid payments. Honoring this request is necessary to protect the quality of care and life of all Wisconsin nursing home residents.

Thank you for the opportunity to share our cost saving recommendations with you.

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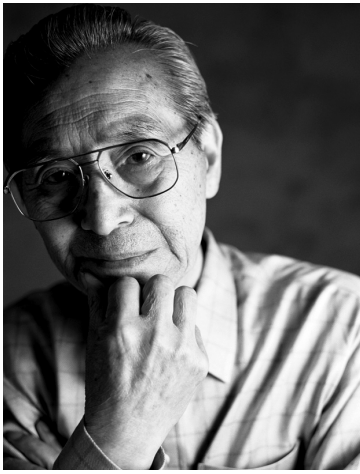
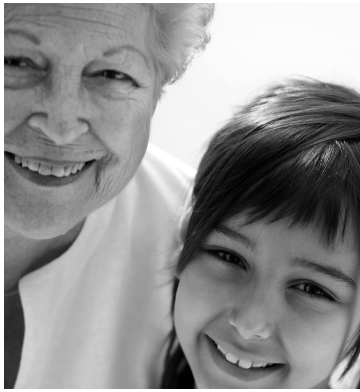
The Long-Term Care Solution

A Framework for Financing Long-Term Care





We can make it affordable to care.

aahsa®
creating the future of aging services

The Long-Term Care Solution

When it came to planning for her "golden years," Rose Shaham did everything right. She worked and saved, earning a teacher's pension. She even bought a modest long-term care insurance policy.

But when Rose started needing help, the cost of the home health aides quickly exhausted her long-term care insurance benefit. When she couldn't make her own meals anymore, Rose decided to move into a senior housing community. Her rent and expenses exceeded her $2,500 monthly pension and she had to spend down her savings. Eight years later, her savings were gone and her health took a turn for the worse.

That's when Rose's son, Steve, age 62 at the time, stepped in. He paid for her cereal and bananas and covered her utilities. These and other expenses quickly added up to $10,000 a year. Caring for Rose became a second job. Steve missed his own doctors' appointments and drove more than 200 miles round trip so his mother could see her doctor.

But Rose kept falling on her walks. She needed a caregiver, but she couldn't afford one, so Steve began tapping his own retirement savings to pay for the care she needed.

With no other options, Rose moved to a nursing home and went on Medicaid. Over two years, New York state paid nearly $150,000 for Rose's care in the nursing home. Steve contributed an additional $15,000 for someone to take Rose out for walks, her favorite activity. She died with less than $400 to her name, miserable about the lack of control she had over her situation.

Rose is one of millions of Americans who fall victim to the disjointed and fragmented system we have in America to pay for long-term care. Each year, these people are unable to receive the services they need, when they need them, in the place they call home. Families are stretched to the breaking point and state and federal governments are weighed down by growing Medicaid costs as people exhaust their assets and turn to the government for assistance.

America's broken long-term care financing system is working against the interests of its citizens. It denies choice, impoverishes families and threatens to bankrupt federal and state governments. Clearly, we need something new.

As not-for-profit providers of aging services, AAHSA members see firsthand how our system of paying for long-term care needs to **provide choice, promote personal responsibility and be available to all who need services.** A new system must also preserve and enhance the family safety net that is the backbone of our long-term care system.

In 2004, AAHSA embarked on a journey to understand what solutions were possible for fixing long-term care financing. A panel of members, state associations and experts convened with the charge of recommending to AAHSA's board, after appropriate study, a position for future financing of long-term care.

In these pages, we briefly outline the challenges facing America in financing long-term care and summarize our recommendations for the creation of a national insurance trust to make it affordable to care.

"We can make it affordable to care."

The Challenge

Mounting Needs and Costs

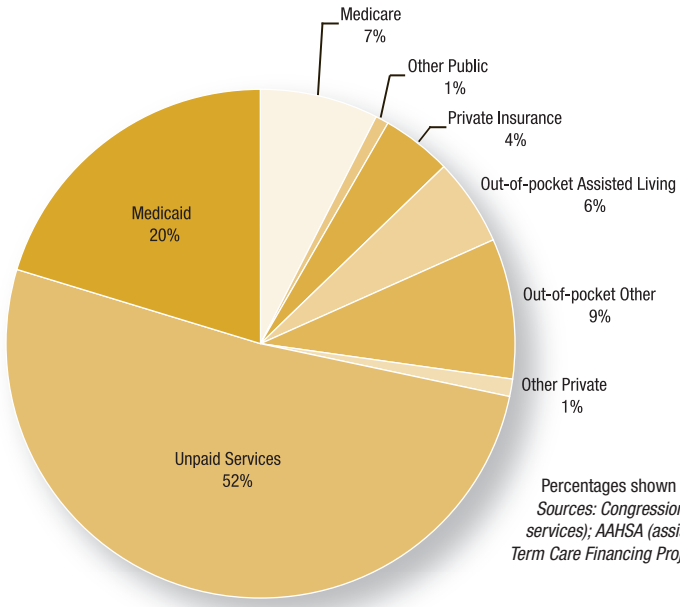
Ten million Americans, including six million over age 65, need long-term care, yet despite families' considerable efforts and substantial public expenditures, many are left to struggle with unmet needs and catastrophic costs. This problem will only get worse as the baby boomers age, doubling the need for long-term care over the next three decades.

> "Current problems with the provision and financing of long-term care will be exacerbated by the swelling numbers of the baby boom generation needing care…Taken together, Medicare, Medicaid and Social Security represent an unsustainable burden on future generations."
>
> *—Government Accountability Office (2005)*

The window of time in which to avert a national crisis is narrowing. If we do nothing, the increasing burden on individuals and families and on state and federal programs—Medicaid, in particular—is simply unsustainable.

Without question, given the demographic imperative, a new system for funding long-term care must be implemented to address present and future needs and share the burden equitably.

Sources of Funding for Long-Term Care Expenses

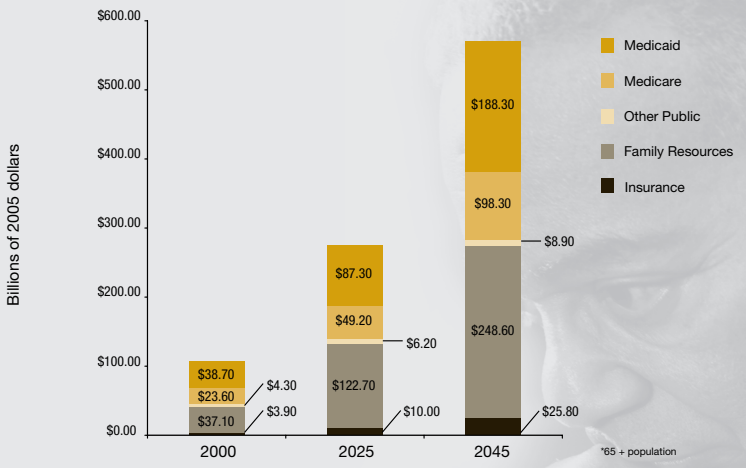


Percentages shown are for 2002 expenses.
Sources: Congressional Budget Office (unpaid services); AAHSA (assisted living); Georgetown Long-Term Care Financing Project (all other categories).

Current Strategies Are Not Working

We know all too well that Medicaid's "pay-as-you-go" welfare model leaves many people with unmet service needs and, perversely, requires that they impoverish themselves to qualify. Few individuals have the resources to pay for extensive long-term care, and state budgets are already severely stressed by Medicaid costs. While policy choices such as increasing the use of home and community-based care or reverse mortgages may improve the picture marginally, the sheer numbers of those with long-term care needs, and the increasing labor costs for this field, will continue to drive expenditures ever higher.

Growth in Expenditures for Long-Term Care, by Source of Payments*



Private long-term care insurance cannot solve the problem. Private insurance currently pays for less than 10 percent of long-term care costs. Premiums are often too expensive for most Americans and private plans' underwriting procedures exclude from 15 to 40 percent of the population for pre-existing health conditions.

Our Solution

National Insurance Trust Financed by Premiums

We believe the foundation of a long-term care financing strategy should be a broad-based national insurance trust with low overhead costs and an all-inclusive risk pool. This insurance should be financed by premiums, not by general tax revenues, with premiums and benefits aligned to produce an actuarially sound program. This approach would allow the baby boomers to prefund their long-term care needs. An independent, federally-chartered

organization could manage the premiums, investments and payments to ensure the funds are used only to pay benefits for this program.

Benefits should be available regardless of setting. The dollar value of benefits should be tied to a simple level-of-need determination that consumers can easily understand and focuses on a person's need for assistance with activities of daily living (ADLs), including bathing, dressing and eating.

Even if all or most Americans are enrolled, the benefits would not cover all long-term care costs. Some may wish to purchase extra wraparound insurance to cover full costs, and some may pay the difference with private funds. People with very low incomes will continue to need financial assistance.

The optimal financing plan is one that wraps around and extends, rather than replaces, existing Medicare benefits, which will continue to provide for the more intensely medical and shorter-term rehabilitation needs.

Future expected Medicaid costs could be mitigated, helping to ensure the sustainability of Medicaid as a safety net. But near universal participation will be required, which could be achieved through a mandate or—perhaps more likely—through a strategy in which people are automatically enrolled in the plan and can opt out if they wish.

Key Features

Key features of the new insurance plan:

- Cash should be one, if not the only, choice of benefits to be used at the beneficiary's discretion.
- Benefits should be tied to a simple level of need based on functional status, not age.
- Benefit levels should provide for a foundational level of services for people in the community and in residential settings, consistent with keeping the program actuarially sound.
- Systems to ensure that beneficiaries can access with appropriate help selecting and securing needed services must be available. Because the program would provide cash benefits, there must also be protections for vulnerable adults to minimize exploitation.

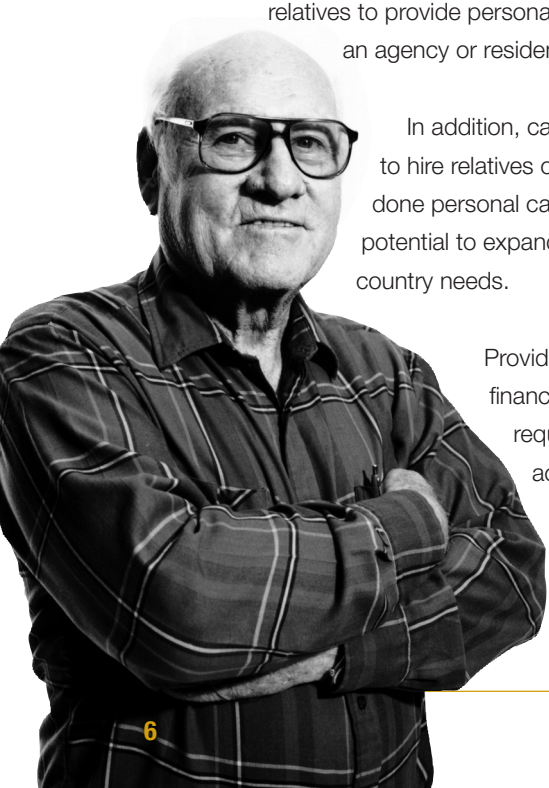
A Disability Insurance Model Offers Consumer Choice

Disability insurance programs give beneficiaries the funds to purchase the services they need. Because long-term care services focus on maintaining well-being in the face of disability, we believe a disability insurance plan that allows consumers to determine what services and supports best meet their needs would work best. Help for consumers in choosing and accessing services will likely be needed and can be contracted to public or private organizations with expertise.

Successful cash payment programs for long-term care already exist in the United States, including the Cash and Counseling demonstrations already tested in three states and in the testing process in 12 more. These programs offer valuable lessons in designing a national system. For example, when the financing system was changed to provide cash to beneficiaries to hire their own workers, unmet needs were substantially reduced.

Cash Benefits: High Flexibility, High Satisfaction

In the Cash and Counseling demonstrations, researchers found that those in the cash benefit group were significantly more satisfied with services than those in a traditional plan. Cash benefits provide consumers with maximum choice in meeting their needs, including such options as making home modifications, employing relatives to provide personal care services or purchasing services from an agency or residential care provider.



In addition, cash benefits make it possible for beneficiaries to hire relatives or neighbors, who may not have otherwise done personal care services work. This approach has the potential to expand the supply of long-term care workers our country needs.

Providing greater choices for beneficiaries through financing based on a disability insurance model requires that consumers also have improved access to information to evaluate choices wisely; speeding development of this must be as much a priority as implementing a national insurance plan.

Structuring a Cash Benefit Plan

There are a number of different ways to design benefits where cash is at least one option. Variations include such issues as who gets the cash—the individual or a fiscal intermediary? How much control does the beneficiary have over what may be bought with the cash? If there are choices among types of benefits, is the value of each the same or different?

Could a National Insurance Trust Work?

AAHSA commissioned The Moran Company, a nationally known economics consulting firm, to model a national long-term care insurance trust that would provide a daily cash benefit for people needing assistance with two or more ADLs and be fully funded for at least 75 years. The model provided premium prices for one, two, three and five-year benefits as well as a lifetime benefit. For simplicity, participation was determined to be mandatory for all adults.

The study found that for about the cost of a large cup of coffee each day for each of us, we can create a national insurance trust that would pay a benefit of about $27,000 per year to each adult who needs assistance with two or more ADLs.

Premium Prices for the New Insurance

The Moran Company explored various scenarios for plan details and estimated premium prices using two different assumptions regarding disability rates, which are key drivers of costs. The chart below shows premium prices for a program that includes everyone age 21 and up, has a five-year vesting period, and pays $75 a day to people with qualifying disabilities (2 or more ADLs). Various numbers of covered benefit years are shown below:

Number of Benefit Years Covered	High (annual premium assuming high rates of disability)	Medium (annual premium assuming medium rates of disability)	Mid-Point	**Premium Costs Per Day**
1	$318	$213	$266	**$0.73**
2	$557	$373	$465	**$1.27**
3	$171	$490	$614	**$1.66**
5	$971	$641	$806	**$2.21**
Lifetime	$1,270	$826	$1,048	**$2.87**

Next Steps

Imagine if Rose and the millions of elderly and people with disabilities like her had access to a national insurance trust to help pay for the care she needed. We want to make this vision a reality for all Americans.

As not-for-profit providers with a long tradition of leadership in aging services, AAHSA is uniquely positioned to lead this effort, and we invite you to lead with us. Help us begin a national conversation about why we must approach the financing of long-term care in a new way. There are three things you can do to help:

1. Think about your experience with long-term care as a family member, neighbor or friend to someone who has needed supports or services.

2. Call your member of Congress. Tell them we need a national long-term care insurance trust now.

3. Invite policy makers to meet with an AAHSA representative to talk about the solution. Tell them they can make it affordable to care for the price of a cup of coffee every day.

It's time to advocate for yourself and to tell your members of Congress to fix this financially unsustainable system. Let's support American families. We can make it affordable for people to care.

American Association of Homes and Services for the Aging

MISSION:

- Create the Future of Aging Services
- Increase the Value of Membership

VISION:

Healthy, Affordable, Ethical Aging Services

IDEALS:

- Dignity of all persons of every stage of life
- Services people need, when they need them, in the place they call home
- Quality that people can trust
- Mission-driven, not-for-profit values
- Advocacy for the right public policy for the right reasons
- Leadership through shared learning

About AAHSA

The members of the American Association of Homes and Services for the Aging (www.aahsa.org) help millions of individuals and their families every day through mission-driven, not-for-profit organizations dedicated to providing the services that people need, when they need them, in the place they call home. Our 5,800 member organizations, many of which have served their communities for generations, offer the continuum of aging services: adult day services, home health, community services, senior housing, assisted living residences, continuing care retirement communities and nursing homes. AAHSA's commitment is to create the future of aging services through quality people can trust.

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creating the future of aging services

Briefing Paper for Meeting of the Senate Committee on Health, Education, Labor and Pensions

May 21, 2009

A New Vision for American Health Care: Strengthening What Works and Fixing What Doesn't

Overview and Background

For the greater part of the last 100 years, Americans have sought ways to provide affordable and quality health insurance coverage to all our citizens. In this journey, we have achieved notable successes, including the creation of Medicare and Medicaid in 1965, the inception of the Children's Health Insurance Program in 1997, the expansion of prescription drug coverage for seniors in 2003, and more. We have also witnessed setbacks and defeats, including the failure of reform efforts during the Administrations of Presidents Harry Truman, Jimmy Carter and Bill Clinton.

In recent years, the drive to cover all Americans has been joined with the imperative to reform a health care system which consumes far more of our nation's resources than merited by the results produced. While the men and women who work in U.S. medicine perform miracles and wonders every day, our health care system wastes precious dollars to produce uneven results.

For the past year, Democratic Members and staff of the Senate Committee on Health, Education, Labor and Pensions – along with our colleagues at the Senate Finance Committee, the House of Representatives and the Administration – have been laying groundwork and preparing legislation to reform the U. S. health care system. As we near the point of introducing legislation to achieve our vision, we issue this policy overview to lay out our priorities for the legislation.

We begin with our goals for the improvement of American health care**:**

- Assuring reliable, high quality and affordable health insurance for all Americans
- Improving value by creating a higher quality, more efficient delivery system
- Building a new framework to enhance prevention and wellness
- Creating a durable structure of long term supports and services for seriously disabled Americans
- Rooting out fraud and abuse in the public and private health systems
- Establishing shared responsibility and paying appropriately and fairly for reform

Changing medical school and residency curricula: Currently, health care professionals receive little or no formal training in prevention and public health. The Hippocratic Oath says: "First, do no harm." A reformed curriculum will teach the next generation of health care professionals: First, prevent unnecessary disease.

Promoting the benefits of wellness and prevention: People need information to take charge of their health. This includes educating the general public and health care providers about the benefits of lifestyle changes that keep people healthy and out of the hospital. Also, we must support health literacy programs to relay information in the most understandable manner.

Encouraging workplace wellness programs: We must give employers technical assistance and evaluations of effective workplace wellness programs.

Creating a federal-level Prevention and Public Health Council: The goal of the Council will be to improve coordination among federal agencies to incorporate wellness into national policy and to develop a national strategy with public health goals and objectives for the nation to achieve.

Fourth, Financing Long-Term Services and Supports

Health care reform must ensure that vulnerable populations have access to coverage that meets their needs. For persons with disabilities and seniors with chronic illness, long-term services and supports are their primary unmet health care needs. These are critical to promoting health, preventing illness, and helping people to function independently instead of in institutions. Ten million Americans need long-term services – personal care, assistive technology and other supportive services – a number that will increase to 26 million by 2050. Over 200 million adult Americans lack protection for the costs of long-term services and supports. The nation lacks a coordinated, national public-private system to deliver quality long-term services and supports. Nearly half of all funding for these services is now provided through Medicaid, a burden on states requiring individuals to become and remain poor to receive help.

These are key goals we hope to achieve through long term services and supports:

- Supporting America's workers with a new financing alternative for long term services and supports
- Promoting individual choice and independence through self-determination
- Ensuring fiscally responsible and affordable premiums

- Strengthening Medicaid for those who need it by reducing dependence on Medicaid for long term services and supports

- Retaining the role of private insurance in providing long term services and supports

Supporting America's workers with a new financing alternative for long term services and supports: Through participation in a new voluntary nationwide insurance program, people with disabilities and chronic illnesses will have a cash benefit to pay for and choose the services and supports they need to function and independently.

Financed through voluntary payroll deductions (with Medicare Part B-style enrollment opt-out), this program will remove barriers to independence and choice (e.g., housing modifications, assistive technologies, personal assistance services, transportation) by providing a cash benefit to individuals who become disabled. We will help employers by providing support to persons with disabilities to enable them to work and to working caregivers to help reduce absenteeism and maintain productivity

To qualify for benefits, individuals must have contributed monthly premiums through a voluntary payroll deduction for at least five years. Tiered benefits ($50 - $100.00 per day) will be payable to individuals unable to perform two or more Activities of Daily Living (ADL's) or have the equivalent cognitive impairment.

Promoting individual choice and independence through self-determination: Benefits will be accessed using a "Life Independence" debit card to purchase non-medical services and supports the individual needs to maintain independence at home or in a community residential setting of their choice, including home modifications, assistive technology, accessible transportation, homemaker services, respite care, personal assistance services, and home care aides. These cash payments avoid bureaucracy and empower consumers to control what services they get, how, where and from whom.

Ensuring fiscally responsible and affordable premiums: The program will be self-funded through participant premiums and will be a primary payer to Medicaid. Premiums will be limited to $65 per month; those with incomes below poverty will pay no more than $5 per month. Younger participants will pay less than older participants, and no one will pay over $65 per month. The Secretary of Health and Human Services, with assistance from the Treasury Board of Trustees and the CLASS Independence Advisory Council, will monitor fund solvency and make recommendations 20 years ahead of time if solvency is in question.

Strengthening Medicaid for those who need it by reducing dependence on Medicaid for long term services and supports: One essential element of reform is ensuring health security. Individuals and families should not go bankrupt in paying for needed care. Reform must help Americans who are forced to pay the highest, catastrophic, out-of-

pocket costs. Under our current system, families impoverish themselves by spending down their life savings before receiving the care they need through Medicaid. This program will offer an alternative and be payer of first resort to Medicaid.

Retaining the role of private insurance in providing long term services and supports: Benefits will cover about half of the current average cost of long term care, retaining a role for private insurance. This balanced public/private structure, with a broad-based public option to "provide a minimum floor of protection", supports the purchase of private insurance wrap-around products – thus creating a flexible way to help families and disabled individuals meet their unique circumstances. Long term supplemental coverage can be made available through the American Health Benefit Exchange.

Fifth, Rooting Out Fraud and Abuse

The National Health Care Anti-Fraud Association estimates that at least three percent of all health care spending – or $72 billion in 2008 – is lost to health care fraud. Other estimates are as high as 10 percent. Fraud committed by providers, medical equipment suppliers, drug companies, and by corrupt plan operators and brokers increases costs for everyone, puts families' security and health at risk, and undermines public trust. The HELP Committee has responsibility for oversight of private health insurance, and our goals seek to advance the rooting out of fraud and abuse in the private sector and to link better private and public sector efforts.

Establishing a Health Care Program Integrity Coordinating Council: The Health Insurance Portability and Accountability Act of 1996 (HIPAA) established a national Health Care Fraud and Abuse Control Program to facilitate collaboration among federal, state, and local law enforcement. As healthcare reform expands coverage for all Americans, we need broader and more inclusive coordination. We will establish Health Care Program Integrity Coordinating Council (PICC) to provide more effective coordination and strategic planning to address.

Create senior level positions at the Departments of Health and Human Services and Justice to coordinate health care anti-fraud activities: The persons serving in these two positions would serve as the "point persons" for purposes of inter-agency coordination, coordination of program integrity efforts with respect to private plans, and coordination with State-level entities such as insurance regulators and State Medicaid Fraud Control Units.

Address unauthorized and sham health insurance plans: The private health insurance market has serious problems with operators of phony health plans who prey upon small businesses and self-employed individuals by collecting premiums for health insurance