Testimony of

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on

The Role of Long-Term Care in Health Reform

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Chairman Rockefeller, Senator Hatch, and members of the committee, I am pleased to testify before you today on the need for public action to improve long-term care services and supports. I know you share my view that the nation's economic stability depends on the well-being of its families and that support for people impaired in the tasks of daily life is key to that well-being. Sadly, that support is sorely lacking under current policies.

Both during the presidential campaign and since the election of President Obama, we've heard much about the need for health reform as critical to restoring prosperity for families and the nation's economic and fiscal health. Health reform is not only essential to assuring all of us affordable health care; it is also essential to slowing cost growth in our health entitlement programs, Medicare and Medicaid.

But we cannot achieve health or fiscal security unless health and entitlement reform address the need for affordable long-term care. Mr. Chairman, you alerted the Congress and the nation to the importance of long-term care reform as well as health reform when you chaired the U.S. Bipartisan Commission on Health and Long-term Care Reform (the Pepper Commission) twenty years ago. And since then, families' problems have only gotten worse.

People with health problems that create both acute and long-term care needs do not distinguish between the two when it comes to finding or paying for care. Both threaten their health and financial well-being. Our current entitlement programs serve people who need both sets of services. About 16 percent of Medicare beneficiaries are eligible for both Medicare and Medicaid ("dual eligibles"), more than half of whom need long-term care.[1] More than a third of Medicaid expenditures are devoted to long-term care services—at home and in the community as well as in nursing homes.[2] We cannot effectively address the needs of people served by these entitlement programs—or their costs—without addressing responsibility for financing long-term care.

Sadly, the mythology about long-term care that the Pepper Commission report sought to counter has continued to impede effective long-term care policy. We still hear claims that the need for long-term care only arises when people get old, that it happens to just about everybody, and that it is the responsibility of individuals and families simply to "plan ahead" and take care of themselves or their family members "when the time comes."

Such claims egregiously misrepresent the reality of long-term care needs and the extraordinary commitments families make to address them.

- The need for long-term care is not limited to older people. Of the just over 10 million people estimated to need long-term care in 2005, about four in ten were working-aged

[1] Kaiser Commission on Medicaid and the Uninsured, *Dual Eligibles: Medicaid's Role for Low-Income Medicare Beneficiaries,* February 2009; and Centers for Medicare and Medicaid Services, "2003 Section 8. Medicare Dually Eligible Population," *The Characteristics and Perceptions of the Medicare Population,* 2003, http://www.cms.hhs.gov/MCBS/Downloads/CNP_2003_dhsec8.pdf.

[2] Kaiser Commission on Medicaid and the Uninsured, *The Medicaid Program at a Glance,* November 2008.

adults or children.[3] Simply telling families to "plan ahead" is useless for the millions of people who experience disability at a young age.

- Even among older people, the need for extensive long-term care varies considerably. Among the population turning age 65 today, three in ten are expected to die without needing any long-term care.[4] By contrast, one in five will need five or more years of care. Looked at in terms of expenditures, half the people turning age 65 today can be expected to live their lives without spending anything on long-term care; another quarter are expected to spend less than $10,000 (in present discounted value). At the other end of the spectrum, 6 percent can expect to face over $100,000 (in present discounted value) in long-term care expenditures.[5]

- Far from avoiding responsibility for long-term care, it is families whom most people who need long-term care count on for support. Unpaid care provided by family and friends accounts for an estimated 85 percent of the care people are receiving at home.[6] That care comes at enormous cost to overtaxed caregivers, both in economic opportunities foregone and in health burdens associated with caregiving.

  And, despite substantial effort, even extensive family care too often leaves significant needs unmet. The last public survey of unmet need for long-term care found one of every five individuals at home and in need of care going without care they needed—and facing increased risk of serious health consequences as a result: falling, being unable to eat, bathe, or dress, or soiling themselves.[7]

The problem with today's long-term care system is not that individuals and families fail to take enough responsibility. Rather, they simply do not have enough to give. The need for extensive long-term care is an unpredictable and catastrophic risk. Typically, as, for example, in health care, we rely on insurance to "spread" such risks—having a large population contribute to a fund that is then distributed to the minority for whom catastrophic risk becomes a reality. For long-term care, however, instead of insurance, costs are concentrated on the individuals and families of those who use service, backed only by a public program (Medicaid) that finances care—primarily nursing home care—as a "last resort"—only after they have spent virtually all they have.

Despite considerable recognition among experts of the need for better insurance against the risk of extensive long-term care needs, policy action to develop better insurance has been

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[3] Judith Feder, Harriet L. Komisar, and Robert B. Friedland, *Long-Term Care Financing: Policy Options for the Future* (Washington, DC: Georgetown University Long-Term Care Financing Project, 2007), http://ltc.georgetown.edu/papers.html.

[4] Peter Kemper, Harriet L. Komisar, and Lisa Alecxih, "Long-Term Care Over an Uncertain Future: What Can Current Retirees Expect?" *Inquiry* 42, no. 4 (winter 2005/2006):335-350.

[5] Ibid.

[6] Mitchell P. LaPlante, Charlene Harrington, and Taewoon Kang, "Estimating Paid and Unpaid Hours of Personal Assistance Services in Activities of Daily Living Provided to Adults Living at Home," *Health Services Research* 37, no. 2 (2002):397-415.

[7] Judith Feder, Harriet L. Komisar, and Robert B. Friedland, *Long-Term Care Financing: Policy Options for the Future* (Washington, DC: Georgetown University Long-Term Care Financing Project, 2007).

stymied by endless debate about whether our long-term care financing system should be "public" or "private". Such ideological rhetoric obscures the facts. The reality is that we already have a mixed public-private long-term care financing system and that we will always have a mixed public-private long-term care financing system. The real policy choice is whether we want a public-private system that works, or we want to retain today's dysfunctional combination.

We currently dedicate substantial public and private resources to long-term care—but we do not use our resources effectively. Instead of insurance we have a combination of out-of-pocket private financing (very little private long-term care insurance) and last resort public financing (mostly through Medicaid).

In 2005, we spent over $200 billion in public and private dollars on long-term care supports and services.[8] Three quarters of those dollars were public—about half through Medicaid, which explicitly covers long-term care, and about another quarter through Medicare, which covers long-term care-like services, but for relatively short periods, typically associated with acute illness. But private financial contributions grossly understate the private role in today's financing system—in part because of the enormous contribution of unpaid family care and in part because of the enormous contribution—as a share of income—made by affected families.

No one likes this system. Individuals in need face financial catastrophe, too often do not get care at home where they want it, and, even when they do, too often get inadequate care. Families face overwhelming care-giving burdens. State and federal governments face growing fiscal burdens, leading them to focus more on how to limit what they spend—simply shifting burdens to individuals and families—than on how to build a system that works.

We can and must do better. With current leadership committed to investment in our future, now is the time to exert public leadership to build an effective public-private long-term care system—one that assures sufficient public and private resources to spread risk for people of all ages, supports access to quality care at home as well as in institutions, protects people who need care now as well as in the future, and shares financial responsibility fairly across taxpayers and affected individuals and families.

A better system will require a clearer, more effective public role. Fortunately, we have many ways to move forward. Today I will outline four—drawing on some of the proposals experts developed for our Robert Wood Johnson-funded Georgetown University Long-term Care Financing Project (http://www.ltc.georgetown.edu/), as well as proposals under discussion in the Congress.

The first two options focus on better long-term care services for people least able to protect themselves—low income people eligible for Medicaid. By extending Medicaid support for home and community-based care and improving services for low income Medicare/Medicaid beneficiaries ("dual eligibles"), policy can promote better access to services at potentially lower

[8] Judith Feder, Harriet L. Komisar, and Robert B. Friedland, *Long-Term Care Financing: Policy Options for the Future* (Washington, DC: Georgetown University Long-Term Care Financing Project, 2007).

costs than the current system. Such policy changes are an obvious target for immediate action in the current fiscal environment.

But our current fiscal problems should not obscure the importance of building a long-term care system that goes beyond the low-income population. Now and into the future, as the Pepper Commission recognized, reliance on a means-tested program will continue to leave modest and even better-off people of all ages at risk of impoverishment and under-service if they need extensive long-term care.

The third and fourth options therefore look at proposals for phasing-in broad public long-term care insurance that will spread the risk of needing long-term care across a broad population, assuring access to better support for people who need care.

MORE EFFECTIVE, EFFICIENT MEDICAID LONG-TERM CARE

Extending Medicaid Support for Home and Community-Based Care

First on the list is a proposal to broaden Medicaid coverage of long-term care supports and services at home. We start here for two reasons: first, because as a safety net, Medicaid focuses on people least able to protect themselves, because of limited resources, and second, because evidence suggests that expanding home care in Medicaid can efficiently improve access to needed care where people prefer to receive it—at home, rather than in nursing homes.

Despite its enormous value to people who need help, Medicaid is frequently and legitimately criticized for inadequate support for long-term care outside of nursing homes. Medicaid gives states the primary role in defining the scope of both eligibility and benefits. States vary substantially in their investment in all long-term care services, but particularly in investment in home and community-based care. In 2005, spending per low-income resident in the five highest-spending states ($1,137) was nearly three times the national average ($383) and nearly eight times the average spent in the five lowest spending states ($145).[9] Research at Georgetown shows that differences in state policies have enormous consequences for people who need long-term care. A person who is financially eligible and sufficiently disabled to receive Medicaid services in one state might not be eligible for Medicaid in another and—even if eligible—may receive a very different mix or frequency of services.[10] Further, research on unmet need indicates that states with a broader use of home-based services had a lower incidence of unmet need than states with narrower use.[11] This result is consistent with a large body of research showing that use of paid services eases the burdens of, but does not replace, family caregivers.

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[9] Judith Feder, Harriet L. Komisar, and Robert B. Friedland, *Long-Term Care Financing: Policy Options for the Future* (Washington, DC: Georgetown University Long-Term Care Financing Project, 2007).
[10] Laura Summer, *Choices and Consequences: The Availability of Community-Based Long-Term Care Services to the Low-Income Population* (Washington, DC: Georgetown University Long-Term Care Financing Project, 2003)
[11] Harriet L. Komisar, Judith Feder, and Judith D. Kasper, "Unmet Long-Term Care Needs: An Analysis of Medicare-Medicaid Dual Eligibles," *Inquiry* 42, no. 2 (summer 2005):171-182.

While Medicaid's support for home and community-based care has been growing, nursing homes still absorb the bulk of Medicaid's long-term care spending in most states.[12] Medicaid's emphasis on institutions flies in the face of the desire expressed by people of all ages who need long-term care: they would far prefer to remain at home or in the community. Research also suggests that investing resources in home and community-based care not only can provide services that people prefer but over time actually slow the growth in total long-term care spending by reducing reliance on costly institutional care.

In an analysis of Medicaid long-term care spending from 1995-2005, researchers at the University of California San Francisco found that overall long-term care spending grew more slowly in states with extensive, well-established home and community-based care than in states with few such services—actually reducing total inflation-adjusted "non-MR/DD" long-term care spending over time.[13] While support for home and community-based care initially boosted total spending (and served more people), the researchers argue, over time the availability of care at home and policies to control nursing home use actually reduced reliance on costly nursing home care.

Different approaches would expand the availability of home and community-based services in Medicaid in different ways. For example, the *Community Choice Act*, S. 799, introduced in the 110th Congress, would require all states to make home and community-based personal attendant services available as an option to people eligible for Medicaid nursing home services. States would receive enhanced federal matching rate for attendant care services during an initial period, as they developed these programs.

Another approach, proposed in the *Empowered at Home Act*, S.3327, in the 110th Congress, would allow states to extend income eligibility standards for home and community-based care to nursing home and home and community-based services waiver levels (that is, income up to 300 percent of the supplemental security income, SSI, benefit level) and allow people to retain more assets, so they could actually afford to stay in their homes. States could also extend disability-based eligibility for home and community-based care to people whose conditions have not yet deteriorated to a nursing-home-equivalent level of need so they are actually able to manage in their homes.

These changes would overcome restrictions that have limited states' interest in amending their state Medicaid plans (as allowed under the Deficit Reduction Act of 2005) to broaden long-term care services in the community. For states that choose to expand in these ways, the bill would also eliminate states' ability to cap enrollment and waive state-wideness requirements. If

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[12] Enid Kassner et al., *A Balancing Act: State Long-Term Care Reform* (Washington DC: AARP Public Policy Institute, 2008).

[13] "Non-MR/DD" long-term care spending does not include spending for services specifically aimed at people with mental retardation and other developmental disabilities (MR/DD). In the analysis, "non-MR/DD" spending consists of nursing home, personal care, home health, and non-MR/DD waiver spending. Stephen Kaye, Mitchell P. LaPlante and Charlene Harrington. "Do Noninstitutional Long-Term Care Services Reduce Medicaid Spending?" *Health Affairs* 28, no. 1 (January/February 2009):262-272.

states take up the option, these changes could assure far broader availability of home and community-based care in many states. If made mandatory, or funded more extensively by the federal government, people in need of long-term care could be better and more efficiently served in all states.

Improving Service Delivery for Medicare-Medicaid "Dual Eligibles"

A second proposal, similarly aimed at the population least able to protect themselves, focuses on measures to promote more efficient service delivery for acute as well as long-term care for low income older and disabled people who are beneficiaries not only of the Medicaid but also of the Medicare program.

Approximately 8.8 million Medicare beneficiaries, poor enough to qualify for Medicaid, have their acute care services financed by Medicare.14 Medicaid pays the cost-sharing associated with their Medicare benefits and, if they need long-term care, it is Medicaid that pays for their services. Although together the two programs provide a broad set of benefits, except for some state demonstration programs, neither program bears responsibility for coordinating services within or across programs. Neither program, for example, assumes responsibility for assuring support services following a Medicare-financed hospitalization that might prevent a Medicaid-financed admission to the nursing home. And, if Medicaid were to invest in such support and prevent a hospital admission, its administrators often point out it is Medicare and the federal government that would reap the savings from lower hospital spending, while Medicaid and the state would bear the expense for in-home care.

Coordination of acute and long-term care services for dual eligibles has the potential to promote both more efficient use of resources and better quality care. Some models currently exist that use a single delivery system to provide the full range of Medicare and Medicare-covered services, in return for payment from both programs.[15]

For example, in Wisconsin, The Family Care Partnership Program is a voluntary program, available in some regions of the state, for dual eligibles who have a nursing home level of long-term care need. Participants receive integrated care from a health plan that has contracts with both Medicaid and Medicare. The plan receives monthly per-person payments from Medicaid and Medicare for each participant to pay for all services its enrollees receive.[16]

Payment based on capitation, rather than fee-for-service, can encourage efficiency and enable a delivery system to use savings from reduced hospitalizations or other acute-care services to offset costs of coordination and long-term care. However, capitation also can reward an organization that delivers too little service—delivering less but not better care and simply

[14] Kaiser Commission on Medicaid and the Uninsured, *Dual Eligibles: Medicaid's Role for Low-Income Medicare Beneficiaries,* Fact Sheet (Washington, DC: Kaiser Family Foundation, February 2009).
[15] Center for Health Care Strategies, Inc., "States with Fully-Integrated Care Programs for Dual Eligibles," http://www.chcs.org/usr_doc/ICP_State-by-State_Dashboard.pdf; and David C. Grabowski, "Special Needs Plans and the Coordination of Benefits and Services for Dual Eligibles," *Health Affairs* 28, no.1 (2009): 136-146.
[16] Wisconsin Department of Health Services, "Program Overview," Family Care Partnership Program, http://dhs.wisconsin.gov/wipartnership/2pgsum.HTM.

reaping greater profits. Use of capitation rates on the assumption that the result will be greater efficiency can risk harming the very disabled patients coordination is aiming to help.

Efforts to encourage coordinated care must therefore begin with the development and assurance of effective delivery arrangements—not with payment of a capitation rate. Providers and plans can be encouraged to develop those mechanisms through demonstrations and rewarded for reducing unnecessary services with mechanisms that pose less risk than full capitation—for example, the opportunity to share in and reallocate "savings" from lower than projected use of hospital care. Even for a sophisticated organization, payment based on fixed budgets, which depend on the actually delivery of services (of whatever mix), may be preferable to payment of capitation payments, which are made whether or not services are delivered. Finally, quality monitoring and beneficiary choice can help assure that delivery systems are actually delivering better value, not simply lower costs.

PUBLIC CORE OF INSURANCE FOR LONG-TERM CARE

Adding a Long-term Care Benefit to Medicare

Medicare's health insurance protection is of enormous value to the seniors and people with disabilities who are its beneficiaries. But Medicare's gaps—especially in financing for long-term care—leave even its beneficiaries at risk of financial catastrophe and inadequate care when their illnesses or impairments create the need for long-term care services and supports.

As we look at reforming our entitlement programs—Social Security, Medicare, and Medicaid—in the face of an aging population, it is essential that we look at the full range of people's financial and health care needs and equitable, efficient ways to support them. Adding a long-term care benefit to Medicare—with a financing stream to support it—is therefore worthy of our attention.

One such proposal was developed for our Robert Wood Johnson-funded Long-Term Care Project by Leonard E. Burman and Richard W. Johnson.[17] The proposal would provide long-term care benefits alongside health benefits through a pre-funded, phased-in, progressively-financed program—in which resources are accumulated in advance of service needs and individuals who earn more, contribute more. The proposal is aimed at the working-aged population, should they become disabled and eligible for Medicare, and the future older population when they become eligible for Medicare.

The proposed Medicare benefit would cover nursing home services and up to 100 hours per month of home care for persons meeting specified disability criteria. Cost-sharing and deductibles would be required, up to a maximum out-of-pocket ceiling and would be subsidized for low-income beneficiaries. In order to allow revenues to accumulate to support the benefit, the new Medicare benefit would not apply to current Medicare beneficiaries aged 60 or older. All

[17] Leonard E. Burman and Richard W. Johnson, "A Proposal to Finance Long-Term Care Services Through Medicare with an Income Tax Surcharge," working paper no. 8, Georgetown University Long-Term Care Financing Project, 2007, http://ltc.georgetown.edu/forum/8burmanjohnson061107.pdf.

individuals under the age of 55 would participate, with individuals aged 55-59 given the option of participating by paying an additional lifetime surcharge. Five years after the program begins, participating Medicare enrollees would be eligible for benefits, and Medicaid would cover the cost-sharing and deductibles for low-income beneficiaries.

The proposal's financing would be designed to replicate the current distribution of long-term care financing across income groups, but to spread it across the full population, rather than concentrate it on users. General revenues currently support Medicaid; the new Medicare benefit would replace most of Medicaid and rely on equivalent general revenues for part of its financing. Current private long-term care spending, the authors show, increases with income, whether through Medicaid spend-down for people with low and modest incomes or through self-financing for the better-off. The new Medicare benefit, which would replace the bulk of that spending, would be financed with a surtax on the income tax that similarly varies with income.

The financing mechanisms used to support the proposal stand out in their attention to pre-funding and progressivity. To assure pre-funding, dedicated revenues would be placed in a trust fund, as currently in Medicare. But unlike Medicare, contribution rates would be designed and the trust fund structured to pre-fund future expenses by investing in nongovernmental securities, "so that", in the authors words, "revenues raised would be exactly offset by outlays and could thus not be used to mask budget deficits." The financing mechanism is not only promoted as a mechanism for more equitably and adequately supporting long-term care but also as a means to raise national savings—or to pre-fund future expenses. By establishing and investing the trust fund, it is designed to "improve the nation's ability to cope with the long-run fiscal imbalances that will start with the retirement of the baby boom generation." Essentially, this proposal allows future generations to finance their own benefits—paying now to support future needs.

Adding a long-term care benefit to Medicare builds on and strengthens our existing universal public program for health insurance, and is therefore designed to accommodate an American system. But it is interesting to note that other industrialized nations are moving toward universal public protection for long-term care financing. According to analysis of 19 Organization for Economic Cooperation and Development (OECD) countries this movement does not imply the absence of private obligations (cost-sharing and other out-of-pocket spending) nor does it imply unlimited service or exploding costs.[18] Rather, in general, it reflects an effort to balance public and private financing in a way that relates personal contributions to ability-to-pay and targets benefits to the population with the greatest need for care. Because so many of these nations already have the larger elderly populations that the U.S. is moving toward, their experience can provide important lessons for our design of a more effective long-term care system.

Establishing a Voluntary Public Long-term Care Insurance Program

Another option for broad public insurance protection for long-term care is to create a new program, specifically designed for this purpose. One such proposal is the *Community Living*

[18] Organization for Economic Cooperation and Development (OECD), *Long-Term Care for Older People*, OECD Health Project, 2005.

Assistance Services and Supports Act (*CLASS Act*), S. 1758 introduced by Senator Kennedy in the 110th Congress. This proposal is similar to the proposal for a new Medicare benefit in promoting a broad (if not universal) spreading of risk and in phasing in coverage as its participants age, rather than covering those who are currently elderly or disabled. It differs from the Medicare proposal not simply in creating a new administrative mechanism but in its financing structure and in its offer of a specified cash benefit, rather than the coverage of a defined set of services.

As introduced in 2007**,** the *CLASS Act* would provide an initial cash benefit of $50 or $100 per day, depending on disability level, for people to use on non-medical services and supports. Dollar amounts would increase with inflation.

The primary focus of a cash benefit is on people with long-term needs living at home or in the community. This population was also the primary focus of the Pepper Commission's social insurance recommendations. A cash benefit has been advocated—particularly by the working aged disability community—as providing greater flexibility for beneficiaries to tailor services and other purchases to suit their particular needs—including the ability to pay family caregivers, make home modifications, or make other eligible expenditures on non-medical services and supports that make life easier in ways that a pre-specified benefit package might not accommodate. Demonstrations using cash or vouchers within Medicaid suggest the importance of accompanying a cash benefit with information and counseling to help people identify and arrange their hiring or purchases, as well as with arrangements to assure that workers are both qualified and paid adequate benefits.

All employed individuals and their spouses would be eligible to participate in the new benefit, contingent on the payment of a monthly premium (subsidized for low-income participants)—and people who had previously joined could continue to participate if no longer employed. The goal would be to have a person's premium remain constant over time. But the commitment to self-funding would allow premiums to rise if necessary to assure program solvency.

Participants would first become eligible for benefits ("vested") after 5 years of payment. Premiums would be voluntary but deducted from workers' paychecks—with workers' of participating employers automatically enrolled—unless they explicitly opted out. This "opt out" approach has also been applied to employment-based savings programs, and produced substantial, albeit not universal, participation rates.[19]

The cash benefit and voluntary participation of the *CLASS Act*, illustrate the potential for creating an optional, self-funded, phased in, limited long-term care benefit—starting with the working aged population among whom the need for long-term care is relatively rare. Over time the benefit would apply to the very old, who are most likely to need long-term care. Providing a substantial portion of the population, younger and ultimately older, a core of financial protection against long-term care needs, this approach has the potential to spread the risk of long-term needs and assure better access to care.

[19] The Retirement Security Project, *Automatic IRAs: Extending Savings Opportunities to 75 Million More Workers* (Washington, DC: The Retirement Security Project, February 2007).

THE IMPORTANCE OF ACTING NOW

At this time of economic hardship and fiscal stress, many will argue that improving our long-term care financing system is a low priority—that we cannot afford to address financing for long-term care. Indeed, Mr. Chairman, in 1990, when the Pepper Commission issued its report, you observed that "For some, it has become far easier to bemoan our inability to act than to tackle the problems we all face." You rejected that approach, arguing

> The President and the Congress have a choice. We can continue to duck our heads and hope this issue will not bring the nation to its knees, or we can use the Commission's recommendations as the rallying point for building the political consensus that can make universal coverage for health and long-term care a reality. I opt for the latter course – not just because it can work, but because it is the only responsible means to take action we know is imperative.[20]

The facts are that long-term care costs, like health care costs, undermine families' financial security, and that the costs of dual eligibles—especially those who need long-term care—are driving up federal and state expenditures for existing entitlement programs, Medicare and Medicaid. Assuring efficient, adequate, and equitable long-term care financing is part and parcel of building our nation's economic future.

The need to address this problem will only grow as our nation ages. In the next forty years, the population over age 65 will roughly double—growing from 39 million and 13 percent of the population to 80 million and 21 percent of the population. The proportion aged 85 or over, who are most likely to need long-term care, will more than double—from 2 percent to 5 percent—and from 6 million to 21 million people. At the same time, people under age 65 who need long-term care are living longer, with their numbers expected to grow from 4 million to 13 million over the same period. [21]

This is not bad news—having more people living longer is a major accomplishment for our society. We must match that accomplishment with policies that enhance the quality as well as the duration of life. And, given the scope of the demographic changes before us, we do not have to consider ourselves stuck with the inadequate long-term care system we have; we should consider ourselves on the ground floor of the long-term care system we want to build.

Now is the time—with new leadership, a powerful necessity to invest in rebuilding our nation's prosperity, and a new excitement about our nation's and our government's potential to build a better future—to confront the policy, political, and fiscal challenges of building a better long-term care system. I look forward to continuing to work with you to do just that.

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[20] Senator John D. Rockefeller IV, "The Pepper Commission Report on Comprehensive Health Care," *New England Journal of Medicine*, Vol. 323, No. 14, October 4, 1990, p. 1005.

[21] Judith Feder, Harriet L. Komisar, and Robert B. Friedland, Long-*Term Care Financing: Policy Options for the Future* (Washington, DC: Georgetown University Long-Term Care Financing Project, 2007).