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THE CASH CRUNCH: THE FINANCIAL CHALLENGE OF LONG-TERM CARE FOR THE BABY BOOMER GENERATION

HEARING

BEFORE THE

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MONDAY, MARCH 9, 1998

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, DC.

The committee met, pursuant to notice, at 1:02 p.m., in room SD–562, Dirksen Senate Office Building, Hon. Charles Grassley, (chairman of the committee), presiding.

Present: Senators Grassley, Enzi, and Feingold.

OPENING STATEMENT OF SENATOR CHARLES GRASSLEY, CHAIRMAN

The CHAIRMAN. Good afternoon, everybody. I would like to call this meeting of the Special Committee on Aging to order and to give a statement. Then I will call on my colleagues to give a statement, and then we will go immediately to the panel.

A couple of administrative things. We might not have many members attending today because some have not returned to town yet, and others may have conflicts. These members may want to submit questions in writing to the panelists. Those of us who do attend may also wish to submit questions in writing. If that happens, we would like to have those responses returned 2 weeks from today. So, if you get questions in writing, I hope that you will respond accordingly.

The second thing is a kind of generic statement that I feel necessary to make whether it is a town meeting in my State or hearing like this or a hearing of any other committee that deals with Medicare, Medicaid and issues of the aging. And that is that when we talk about trends into the future of people living longer, sometimes we speak as though these create problems that Congress must deal with. I do not consider them problems in the traditional sense that is awful to have to deal with them. As policy makers, we ought to look with pride at the fact that people are living longer and, hopefully, having a quality of life that makes that longer life worth living.

So we are in this particular position in our country where people are living longer. That is a challenge for us as far as public policy is concerned. It is a challenge for the individuals, also, as far as their private sector responsibilities or concern. But for us, they are challenges and not really a problem, although I probably use that word, "problem", as much as anyone. So I want to make clear that

I consider that a challenge and something positive and not something negative.

I appreciate your all being here today. I am especially grateful for the participation of our panelists. Today's witnesses, all experts in their field, will present important perspectives on meeting the public and private financial challenges of long-term care. The goal of today's hearing is to raise public awareness about the challenge to every individual's retirement income security posed by long-term care needs. We will hear firsthand about the realities of providing long-term care and we will review public and private initiatives that will make long-term care services more available and more affordable for older Americans.

Congress is starting to address the many challenges that will be present with the retirement of the baby boom generation. However, more attention needs to be given to understanding the ever-increasing challenges posed by a growing demand for long-term care. Too many seniors and their families already are aware of the emotional hardship and financial devastation that can come with long-term care. It is difficult to pay for long-term care even when one has worked hard and saved for retirement. It is nearly impossible when a family is not so prepared.

The retirement of baby boomers will result in a substantial increase in the number of Americans in retirement as compared to those working, and, of course, as I have already stated, increases in longevity. The charts that we have over here on the side illustrate these two trends, very dramatic increases in the age, the percentage of our population who are over 65. This means the demand for long-term care services will increase considerably. Public budgets are already under pressure from retirement programs and will probably be unable to meet these needs.

In fact, long-term care expenditures for the elderly are projected to more than double between 1994 and the year 2004. Another chart on display illustrates this point, and we will hear more about this from our witnesses today. So we must start now if we are going to meet the needs of our parents and grandparents in a way that sustains their health and independence without destroying their financial well-being.

As policy makers, our job is to develop policies for public programs that can deliver efficient and cost-effective services. Of course, equally important is the role of private long-term care financing. We must inform everyone about the importance of planning for potential long-term care needs and we must provide incentives for the baby boomer generation to prepare financially.

Consider the challenge, then, and it is a considerable challenge. Today's average cost of nursing home care is about $40,000 per year. Most Americans are not able to pay this cost year after year. When individuals are faced with a chronic or disabling condition in retirement, they often quickly exhaust their resources as well as their families' resources. As a result, these individuals turn to Medicaid for help.

The care of nearly 2 out of every 3 nursing home residents is paid by Medicaid. In these Medicaid-covered nursing home patients, more than 25 percent of them were admitted as private-pay residents. More than 50 percent of the nursing home residents who

began as private pay actually spend down their resources, and then in the end, during the last 5 years that they are in a nursing home, rely on Medicaid. Again, we have another chart that very amply demonstrates the high dependence that we have upon Medicaid for people who are in nursing homes.

So today, we will carefully examine the role of public and private financing for long-term care. This hearing will raise public awareness about the financial risk posed by long-term care. Now is not too soon for us to prepare to meet the demands that will come when the baby boomer generation retires.

[The prepared statement of Chairman Grassley follows:]

PREPARED STATEMENT OF SENATOR CHARLES GRASSLEY

Good morning ladies and gentlemen. The Special Committee on Aging of the U.S. Senate will come to order. I appreciate all of you being here today: I am especially grateful for the participation of the panelists. Today's witnesses, all of whom are experts in their fields, will present important perspectives on meeting the public and private financial challenges of long-term care.

The goal of today's hearing is to raise public awareness about the risk to every individual's retirement income security posed by potential long-term care. We will hear first-hand about the realities of needing and providing long-term care. And, we will review public and private initiatives that might make long-term care services more available and more affordable for older Americans.

Congress is starting to address the many challenges that will present themselves with the retirement of the baby boom generation. But, a lot more attention needs to be given to understanding the ever-increasing challenges posed by a growing demand for long-term care.

Too many seniors and their families already are aware of the emotional hardship and financial devastation that can come with long-term care needs. It is difficult to pay for long-term care even when one has worked hard and saved for retirement. It's next to impossible when a family is not prepared.

The retirement of the baby boom generation will result in substantial increases in the number of Americans in retirement as compared to those working. And, experts expect continuing increases in longevity. The charts in front of me illustrate these two trends.

This means the demand for long-term care services will increase considerably. Public budgets are already under pressure from retirement programs. They will probably be unable to meet these needs.

In fact, Medicaid long-term care expenditures for the elderly are projected to more than double between 1994 and 2004. The next chart in front of me illustrates this point. And, we'll hear more about this from the witnesses today.

We must start work now if we are going to meet the needs of our parents and grandparents in a way that sustains their health and independence without destroying their financial well-being.

As policy makers, our job is to concentrate on developing policies for public programs that can deliver efficient and cost-effective services. Equally important is the role of private long-term care financing. We must educate the public about the importance of planning for potential long-term care needs. And, we must provide incentives for the baby boomer generation to prepare financially.

Consider the challenge. Today's average cost of nursing home care is about $40,000 a year. Most Americans are not able to pay this cost year after year. When individuals are faced with chronic or disabling condition in retirement, they often quickly exhaust their resources, as well as their family's. As a result, these individuals turn to Medicaid for help. The care for nearly 2 out of every 3 nursing home residents is paid for by Medicaid. Of these Medicaid covered nursing home patients, more than 25 percent were admitted as private pay residents. What's more, over 50 percent of the nursing home residents who began as private-pay "spend down" their resources and rely on Medicaid after 5 years in a nursing home. The chart in front of me illustrates this point.

Today we will carefully examine the role of public and private financing for long-term care. This hearing will raise public awareness about the financial risk posed by long-term care. Now is the time to prepare to meet the demands that will come when the baby boomer generation retires.

The CHAIRMAN. I will now turn to my colleagues. I will start with Senator Feingold and then Senator Enzi for opening statements.

OPENING STATEMENT OF SENATOR RUSSELL D. FEINGOLD

Senator FEINGOLD. Thank you very much, Mr. Chairman, for convening this hearing and for your leadership of the committee and especially for your strong emphasis on long-term care.

As you know from our conversations, long-term care reform is absolutely one of my highest priorities in the Senate and today's hearing is an excellent opportunity to highlight just how critical it is that we address the problems facing our current long-term care system.

Mr. Chairman, while the underlying problems we will be facing in our long-term care system may be well known among some policy makers, I am afraid that it is not sufficiently appreciated in the Congress to spur adequate action. Yet the problems we face with respect to the long-term care needs of the nation, I think, Mr. Chairman, are just as significant as our problems with regard to Medicare or Social Security and they may even be greater than those problems.

I have spent my entire public career looking at this very issue and it is clear to me that private insurance and Medicaid alone cannot solve this problem. Private long-term care insurance continues to be relatively expensive, affordable only to a fraction of seniors, despite the enactment of a significant tax subsidy, and in many cases, completely unavailable to those seniors and younger individuals who have an existing disability.

Medicaid continues to be an increasing burden on State and Federal budgets, and for those who have no alternative, Medicaid, of course, as you alluded to, Mr. Chairman, requires impoverishment, often forcing seniors to spend down a lifetime of savings. And after all that, all too often, Medicaid forces seniors and younger disabled people to leave their home and family to enter a nursing home in order to receive adequate care.

So the result, Mr. Chairman, is an expensive program for taxpayers and limited, inflexible, unpopular choices for many of those who are in need of the care. Most of our seniors get their care from family members and the people providing the care are often as old as those who are receiving it.

Back home, Mr. Chairman, I hear story after story from people who are trying to provide care, people who face physical, emotional, and financial exhaustion and who only need a little help to keep going. In Wisconsin, we have developed an alternative called the Community Options Program, or COP, which helps people stay in their own home with their family and remain as independent as possible, and it has been an enormous success over the last 18 years or 19 years. By helping people remain at home, we have been able to take advantage of the existing support services that are already provided by those family members and friends and this has helped keep costs down while providing the kind of care that people often prefer.

Mr. Chairman, I just want to make the note that I have introduced legislation, S. 879, which would provide the same kind of reform at the Federal level. The bill is based on Wisconsin's Commu-

nity Options Program, and thanks to the COP program, Wisconsin has not only allowed thousands of elderly and younger disabled to remain in their own home and with their families, but we have also shown that we can save taxpayers hundreds of millions of dollars by reducing expensive nursing home use.

So, Mr. Chairman, I firmly believe that what we have done in Wisconsin can be a significant part of the answer to the challenges we face with long-term care. If we can help families take care of their loved ones in their own home or in the community, perhaps we can delay or in some cases even eliminate the need for expensive nursing home care and we can save taxpayers millions of dollars.

So Mr. Chairman, again, thank you for the opportunity to speak and for holding the hearing. Public education and awareness on this issue are essential if we are going to have any significant reforms, and I really do hope this hearing will assist people in getting a better understanding of just what is at stake on this long-term care issue, and I thank you, Mr. Chairman.

The CHAIRMAN. Yes. In regard to the legislation that you introduced, I remember that we had breakfast a year ago about now in which you and I visited about that and you had stated your activity in that area as a member of the State Senate of Wisconsin, I believe, and now that legislation you have introduced here follows that pattern. You did inform me about that well over a year ago and I thank you. You have gotten it down the road now to get it introduced, evidently.

Senator FEINGOLD. We do have it, and are happy to get any cosponsors that are interested. [Laughter.]

The CHAIRMAN. Before you go, Senator Reid would normally be here but could not be. He is an active participant of this committee. I want to put a statement in for him that he wrote because he cannot be here. I also would have everybody recognize that he held field hearings on long-term care issues in his State during our recess during the month of January.

[The prepared statement of Senator Reid follows:]

PREPARED STATEMENT OF SENATOR HARRY REID

I am pleased to provide my opening statement for this Special Committee on Aging Hearing entitled "The Cash Crunch: The Financial Challenge of Long-Term Care for the Baby Boomer Generation." I welcome all of our distinguished panel of witnesses.

For many years now, I have been interested in the issue of long-term care. In fact, with the approval of this Committee, I recently held two field hearings in Nevada on this topic in January of this year. I am grateful to you Senator Grassley for sending your staff director, Mr. Ted Totman, and to Senator Breaux for sending Mr. Ken Cohen, to participate in these hearings. The support of both of these Committee staff members was instrumental in the overall success of the hearings. Attendance was exceptional, confirming for me the tremendous interest in this topic among all age groups. During these field hearings, our Committee heard from consumers, providers, advocates and policy makers. We addressed many of the long-term care issues we will hear about today by listening to Nevadans who interact with long-term care on a daily basis. I was very pleased with the outcome of our field hearings and am encouraged by the work of our Committee today in holding this hearing. I remain optimistic that we will find acceptable policy solutions to ensure this generation of older Americans, as well as those that follow, will have the means to address their long-term care concerns.

As our population continues to age, my interest in long-term care policy for the future becomes even more apparent. Today, older Americans number 33.9 million

and represent nearly 13 percent of the U.S. population. By 2030, there will be approximately 70 million older persons, more than twice their number in 1996. This group will make up 20 percent of the population, or said another way, 1 in 5 Americans will be over the age of 65 by 2030. Some might say, "who cares, I won't be here in 2030 so why all the fuss?" In my view, that is a somewhat shortsighted position. It is important that we hold a vision for the future and work together to craft the right questions to be asking, and then to orchestrate the much needed solutions. The vital demand for long-term care services in the future cannot be overstated. The need for long-term care will grow right along with the population. It is time we engage with the American people in dialog about our current long-term care system, both its strengths and its weaknesses, and hear from users, providers, advocates and State and Federal officials about the future.

Long-term care is no longer just care provided in nursing homes. Today it includes home health care, assisted living, hospice care as well as institutional care. In my home State of Nevada in 1996, we had 209,000 senior citizens over the age of 65 and this number is projected to grow to 333,000 by the year 2020. The over 85 group in the Silver State which numbered 10,000 in 1993 will reach 34,000 in 2020. It is for this group that long-term care options become such a necessity. Between 1990 and 1996, Nevada's growth in the over 65 population has been the fastest in the nation increasing by 45 percent. In spite of this escalation, as recently as a few months ago it was reported that the state's growing senior population is putting a strain on the long-term care system. While occupancy of available nursing home beds is over 90 percent, it is expected that demand will far exceed availability as the baby boomers retire.

What many may not know is that the face of long-term care is changing. No longer is the nursing home the only option for long-term care. For those that need skilled nursing care, it will continue to be a vital component of the health care delivery system for older Americans. However, home care, assisted living, and hospice care are gaining as acceptable alternatives. Yet while these industries are booming, and providing needed care to many, our public policy in many instances has not kept pace with the growth or the demand. Payment source often dictates the treatment options available rather than the patient's clinical need being viewed as the determining factor. Options such as long-term care insurance are also gaining in public awareness yet, in 1995, private long-term care covered less than 1 percent of total long-term care expenditures. We cannot realistically expect Medicaid expenditures to keep pace with the rapidly growing population. Many erroneously believe that Medicare will pay for their long-term care costs, but this is not the case. We must develop a seamless solution that ensures coverage is available without forcing one into poverty or bouncing the patient from payment system to payment system.

When looking to the future and the growth in the senior population that can already be observed, I am reminded of the old saying, "we ain't seen nothing yet." If our current system cannot accommodate the funding for the growing long-term care needs, how will we be able to do so when the senior population doubles. That is why, Mr. Chairman, I commend you for holding this hearing today. I pledge my willingness to work with you as we strive to find an acceptable solution to providing long-term care for the baby boomers in the 21st century. Our strategy must include both public and private options. Our policies must focus on educating all Americans about long-term care and the many options available. It must also provide incentives for individuals to take personal responsibility to prepare for the future and ensure that for those who need it, a "safety net" is in place should their personal resources not stretch far enough to ensure long-term care protection is available.

The CHAIRMAN. I would also like to include in the record a statement from Senator Breaux.

[The prepared statement of Senator Breaux follows:]

PREPARED STATEMENT OF SENATOR JOHN BREAUX,

Thank you, Mr. Chairman. A key part of our agenda during this entire Congress has been educating the public about the financial strains that will face Medicare and other programs benefitting older Americans when the massive baby boom generation begins to retire.

I just chaired an Aging Committee field hearing in my home State of Louisiana about 3 weeks ago where we focused on this very topic. We had the heads of Social Security, Medicare and Medicaid and the Administration on Aging with us in the Old State Capitol building in Baton Rouge. They were there to help educate the public about the challenges we are facing here as life expectancies continue to in-

crease and more and more of us retire. Demographically, America will look very different in the next century than it does today.

Consequently, programs like Medicare will have to adapt to the new demographic realities if we expect them to be here for future generations. With roughly 77 million members of the baby boom generation beginning to retire as early as 2010—just a dozen short years from now—we will see enormous strains placed on the Medicare program and our overall health care delivery system.

Since the average life-span for men and women is increasing, many baby boomers will require long-term care at some stage in their lives. Since these baby boomers will hopefully be Medicare beneficiaries, this means that millions more Medicare recipients will depend on long-term care than today. And since the program doesn't cover much of the cost of long-term care, the cost will have to come out-of-pocket, through private insurance or through the Medicaid program.

This hearing will attempt to look at the economic implications for baby boomers who will have to turn to long-term care somewhere down the road. While most of our debates and hearings so far have understandably focused on the financial solvency of the Medicare program itself, it is also necessary to look at and evaluate the effects these strains on our health care system will have on individuals' and families' pocketbooks.

A report issued by AARP last week shows that out-of-pocket spending for health care is already a burden for many Medicare beneficiaries 65 and older. In some cases, more than one-third of their yearly income goes for out-of-pocket health care costs, above and beyond what Medicare currently covers.

While the AARP study focuses on those below the poverty line who do not receive Medicaid, the broader implications are clear: If out-of-pocket health care costs are already reaching such high levels in one segment of the population, these costs will only increase as the Medicare-eligible population increases and as the population ages and requires more long-term care services. And since long-term care is so expensive, many baby boomers who are otherwise economically secure now could find themselves in the same situation as this group studied by AARP.

As our Medicare reform commission gets down to serious business—we had our organizational meeting on Friday—the one truth all of us can agree on is this: Medicare, as it is currently structured, cannot absorb 77 million new beneficiaries, much less begin to take care of the costs of the baby boomers' long-term care needs. Even those who are relatively well-off economically will have to plan carefully in order to manage long-term care costs not covered by Medicare.

Our panels today will help us focus on the challenges of financing long-term care, options for private long-term care insurance and ways to reform the way such care is delivered. I look forward to hearing their testimony as the committee starts to take a more detailed look at what the retirement of the baby boomers means for the Medicare and Medicaid programs and our entire health care delivery system.

The CHAIRMAN. I now call on Senator Enzi.

OPENING STATEMENT OF SENATOR MIKE ENZI

Senator ENZI. Thank you, Mr. Chairman. I want to thank you for holding these hearings because I do believe it will be effective in increasing the awareness of yet another financial strain on our nation's retirement system that will result with the retirement of the baby boomers.

My predecessor, Senator Alan Simpson, has traveled around the United States talking particularly to young people's groups about how some changes need to be made or they will be left picking grit with the chickens.

The CHAIRMAN. Those were his words?

Senator ENZI. Those are his words. That is a quote.

What is coming to light, of course, is the fact that it is the baby boomers when it comes to Medicare that will be picking grit with the chickens. So the impending financial problems of Social Security and Medicare have been well documented. However, the increased need for long-term care services that will accompany the retirement of baby boomers has largely been ignored. As the retired population increases and more and more people require long-term

care services, this will certainly pose financing problems that will require the attention of Congress.

I am pleased the Aging Committee is taking the early initiative to begin addressing the problem of financing long-term care in the future. I believe that is very important, to make people aware of the need to plan for the potential long-term care expenses. The traditional social support services will not be able to handle the number of baby boomers that will begin to retire in the next century.

As the size of our retired population increases and as people live longer, there will be a drastic increase in the need for long-term care services. Estimates of the number of people who will require long-term care range from two to four times that of the current level. The average cost of nursing homes, which is the primary component of United States long-term care spending, currently—currently—exceeds $40,000 per year and is increasing at a rate higher than inflation. It would be irresponsible for any of us to expect that the current reliance on personal savings in Medicaid will be able to handle the future costs of long-term care.

We need to increase the private sector options to help individuals prepare for their retirement security. This necessity is already being demonstrated by the increased use and availability of IRA's and 401(k)'s to supplement Social Security income. In addition, medical savings accounts are currently being evaluated as a way to help Medicaid beneficiaries manage their health costs.

Therefore, it seems practical to promote private long-term care insurance as another component of retirement planning. This small, yet growing product has the potential to help many people manage their potential long-term care needs. I am pleased that Congress through the tax initiatives and the Health Insurance Portability and Accountability Act has recognized the need to encourage the purchase of these products. I am confident that private long-term care insurance will continue to develop as an integral component of retirement planning.

The recent initiatives to explore new vehicles to deliver long-term care are also encouraging. The innovative programs that are already underway in some States are showing that long-term care services can be delivered in a more cost-efficient manner. We should continue to provide States with the flexibility to devise their own programs best suited to their own needs.

I commend the third group of panelists for their willingness to explore new options in long-term care and I am hopeful that Congress will continue to promote more State and local-oriented solutions to future long-term care needs.

It is also important to ensure that the existing support networks are there in the future for those that may need them. Medicaid is the third largest Federal entitlement and spending on it has increased rapidly in recent years. The growth of all Federal entitlement programs, including Medicaid, needs to be controlled to prepare for the retirement of the baby boomers. The expansion and promotion of home- and community-based long-term care services can be a useful method to help control future Medicaid expenses for nursing home care. Congress has a responsibility to ensure that the appropriate and necessary care be available in the future to those most in need.

Once again, I thank the chairman for holding this hearing. The financing of future long-term care services is an important matter that warrants Congressional attention. Let us be sure that no one is picking grit with the chickens. This hearing importantly highlights the need to raise awareness of our future long-term care needs. The sooner we act to prepare for our future, the better off we all will be.

Thank you, Mr. Chairman.

[The prepared statement of Senator Enzi follows along with prepared statements of Senator Jeffords and Senator Craig:]

PREPARED STATEMENT OF SENATOR MICHAEL B. ENZI

Thank you, Mr. Chairman. I believe that this hearing will be effective in increasing the awareness of yet another financial strain to our nation's retirement system that will result from the retirement of the Baby Boom generation. The impending financial problems of Social Security and Medicare have been well-documented. However, the increased need for long-term care services that will accompany the retirement of baby boomers has largely been ignored. As the retired population increases and lives longer, more and more people will require long-term care services. This will certainly pose financing problems that require the attention of Congress. I am pleased that the Aging Committee has taken the early initiative to begin addressing the problem of financing long-term care in the future.

I believe that it is very important to make people aware of the need to plan for their potential long-term care expenses. The traditional social support services will not be able to handle the numbers of baby boomers that will begin to retire in the next century. As the size of our retired population increases, and as people live longer, there will be a drastic increase in the need for long-term care services. Estimates of the number of people who will require long-term care range from 2 to 4 times that of current levels. The average cost of nursing home care, which is the primary component of long-term care spending, currently exceeds $40,000 per year and is increasing at a rate higher than inflation. It would be irresponsible for any of us to expect that the current reliance on personal savings and Medicaid will be able to handle the future costs of long-term care.

We need to increase the private sector options to help individuals prepare for their retirement security. This necessity is already being demonstrated by the increased use and availability of IRA's and 401(k)'s to supplement Social Security income. In addition, medical savings accounts (MSA's) are currently being evaluated as a way to help Medicare beneficiaries manage their health costs. Therefore, it seems practical to promote private long-term care insurance as another important component of retirement planning. This small, yet growing product has the potential to help many people manage their potential long-term care needs. I am pleased that Congress, through the tax incentives in the Health Insurance Portability and Accountability Act, has recognized the need to encourage the purchase of these products. I am confident that private long-term care insurance will continue to develop as an integral component of retirement planning.

The recent initiatives to explore new vehicles to deliver long-term care are also encouraging. The innovative programs that are already underway in some states are showing that long-term care services can be delivered in a more cost-efficient manner. We should continue to provide States with the flexibility to devise their own programs best suited to their own needs. I commend the third group of panelists for their willingness to explore new options in long-term care and I am hopeful that congress will continue to promote more state and local oriented solutions to future long-term care needs.

It is also important to ensure that the existing support networks are there in the future for those that may need them. Medicaid is the third largest Federal entitlement and spending on it has increased rapidly in recent years. The growth of all Federal entitlement programs, including Medicaid, needs to be controlled to prepare for the retirement of the baby boomers. The expansion and promotion of home and community-based long-term care services can be a useful method to help control future Medicaid expenditures for nursing home care. Congress has a responsibility to ensure that the appropriate and necessary care will be available in the future to those most in need.

Once again, I thank the Chairman for holding this hearing. The financing of future long-term care services is an important matter that warrants congressional attention. This hearing importantly highlights the need to raise awareness of our fu-

ture long-term care needs. The sooner we act to prepare for all of our future retirement needs, the better off we all will be.

PREPARED STATEMENT OF SENATOR JAMES M. JEFFORDS

I commend the Chair for convening today's hearing on a topic that is critical to all citizens of the United States not just the elderly. Despite the number of Congressional debates about health care matters, precious little attention has been given to the needs for long term care policy. This is a critical oversight because it is chronic illness and disability, not acute care needs, that will be the major source of health care cost increases in the future. It is imperative that we turn our attention to shifting our health care system from one that is designed around acute care, to a system that is constructed to effectively provide ongoing care.

Several facts are well established. This afternoon we will hear about the shift in demographics, the changing health and wellness patterns of an aging population, and the problems we face in financing long term care. Although the facts are known, we need to transform the list of dry facts into a message that is meaningful to the public. We need to understand how these trends are going to affect the way we live—and how our parents will cope and how our children will fare.

There is no question that the problem of future financing for long term care is going to require a mix of public and private sector initiatives. In recent years the number of long term care policies and options has increased substantially. While the tax incentives provided under HIPAA are just beginning to take hold, the purchase of private long term care policies has surged. Individual or employers who purchase policies, and another 13 states are considering such legislation.

Finally, no matter what mechanisms ultimately finance long term care, we must be sure public and private funds are spent wisely. The types of care offered must reflect the choices and preferences of those who receive the care. The care must be delivered efficiently. Quality is key because quality is not only a matter of ethical and moral responsibility, but it is fiscally necessary to deliver the right care well. I look forward to the testimony of our excellent witnesses and to their observations and suggestions.

PREPARED STATEMENT OF SENATOR LARRY CRAIG

Mr. Chairman, thank you for holding this very important hearing on the future of long-term care for baby boomers. I have a personal interest in this particular issue and can associate with the legislative impact on this generation because I am on the leading edge of the baby boomer generation. As the baby boom population begins to retire, special problems will emerge and it is very important that we address these issues now.

This hearing today will help raise public awareness of the risk to retirement income posed by the potential need for long-term care services. I commend the Chairman and the Ranking Member for gathering such a broad-based and experienced panel of witnesses. I look forward to listening to all of our witnesses here today.

It is clear that the retirement of the baby boomer generation will demand changes in our current long-term care options. There are 76 million baby boomers today. By 2030, baby boomers will make up 20 percent of the population. One in ten of these people will require assistance in daily living.

Currently, long-term care represents a significant portion of the nation's health care spending. Sixty percent of long-term care costs are covered by Medicare and Medicaid. With the enormous numbers of baby boomers beginning to retire, we will see great strains placed on these programs. The current practice of relying upon Medicare and Medicaid for long-term care will fail as America ages. We cannot place the financial burden solely on the nation's taxpayers.

We are not yet prepared for the long-term care needs facing the baby boomers generation. Social Security, Medicare, and Medicaid can't be expected to sustain the whole cost. Our elderly need to retain financial independence, while getting the care they deserve.

I look forward to discussions here today. It is important that we do all we can now, before it's too late, to assure baby boomer health and financial security in the years to come.

The CHAIRMAN. I thank both of my colleagues, and to both of my colleagues and the staff of members who cannot be here, my policy is to accommodate people who are under time constraints, so if

anybody comes in and needs to make a statement, I would be happy to interrupt the panel so that that could be done.

Our first witness, Donna Harvey from Waterloo, IA, is not going to be here because of the blizzard in my State, and I would not have been here except I heard about it coming and I flew out Saturday instead of Sunday. Otherwise, I probably would not be here for another couple of days. But she was going to speak on behalf of an Iowa senior on the case management type work she does for the Hawkeye Valley Area Agency on Aging. We do have her testimony and those of you who are here, you can get that testimony and I am going to submit it for the record. She is Executive Director of the Hawkeye Valley Area Agency on Aging.

[The prepared statement of Ms. Harvey follows:]

PREPARED STATEMENT OF DONNA K. HARVEY

Each day, our agency receives calls from older individuals and their families requesting assistance to stay in their own homes. Many of these older individuals are embarrassed and frustrated that they have to turn to a public agency for assistance. They believed that they had worked hard, paid into a retirement plan, saved some monies, and prepared well for their later years. Fortunately, and unfortunately, persons are living longer than before and exercising their right to remain at home as long as possible. The unfortunate part is that funding for assistance is very limited and very few persons have purchased long term care plans or have adequate resources to purchase all the needed services to facilitate this continued independence.

The Medicaid Waivers available for frail elders in many States have allowed persons meeting all the guidelines to receive assistance with in-home services to provide the necessary assistance to maintain their independence. However, not everyone qualifies for the Waiver. Medicare is also limited, as you know, to persons who are homebound. While this offers limited services to a few more older persons, there is still a great number who do not meet either Medicaid or Medicare criteria.

Few persons purchased any type of private health insurance or long term care insurance that assists with the costs of in-home cares. Older persons attempting to purchase plans find them to be very expensive and limited due to their age at time of purchase.

Today, I would like to share with you about a 69-year-old female who has and is facing challenges to staying in her own home due to lack of planning for the need for long term care services in order to stay in her own home.

Mr. and Mrs. L had planned to retire happily together and to live comfortably on Social Security and Mr. L's retirement from his teaching career. Mrs. L did not work outside the home while raising three children. In 1978, they purchased a small motel in a small community in northern Iowa which was managed by Mrs. L while Mr. L continued to teach in the Waterloo/Cedar Falls area. Mr. L passed away in 1985 before retirement. Mrs. L could not afford to maintain the motel without his income and was forced to sell the establishment and relocate to Waterloo to be near two of her children. Mrs. L was diagnosed with multiple sclerosis in 1978 but was in remission for 12 years and 9 days (1989).

In 1994, Mrs. L's doctor suggested it was time for her to seek assistance with her cares. At that time, she was receiving Beta Seron treatments which cost her approximately $1,000 per month. By this time, Mrs. L was attempting to live on her Social Security income of $593 per month. Mrs. L paid $360 per month for her home which she rents. Her son had purchased a health care plan on her behalf, however, it was limited in its coverage. Her children attempted to assist with her cares and expenses but they had obligations with their own families. Mr. L began placing some of her medical expenses on credit cards in order to maintain her treatments as this seemed to be her only option.

A hospital social worker began working with Mrs. L to identify services needed and funding to provide them. Mrs. L was very reluctant to accept assistance as she believed there were others who might need help more than she did. She also was not prepared to share the need for assistance as she and her husband had felt they were prepared for retirement. She eventually agreed to receive home delivered meals and to have a visit from the Case Management for Frail Elders program administered through Hawkeye Valley Area Agency on Aging. After an assessment and intake process, Mrs. L was enrolled into the Project HOPE for Frail Elders which provided her Section 8 assistance and limited services on a participation basis

(20 percent of her cost). Although Project HOPE assisted Mrs. L with rental costs and some of her services, she could not afford to pay the 20 percent co-pay. It was determined that she did meet the guidelines of the Medicaid Waiver and she began receiving that assistance in December 1994.

Today, Mrs. L's income is $702 per month and she is receiving nursing services, home care aide, chore services, home delivered meals, Section 8 assistance, her home has been modified to be more accessible, and equipment has been purchased to allow her to remain at home. Mrs. L is a wonderful, caring individual and loves to share stories about her husband and is proud of the fact that he served on Admiral Bird's last expedition to Alaska through the U.S. Navy. She has a burial plot in a military cemetery in Minnesota beside her husband. She has no life insurance due to her inability to keep the payments current and is concerned about how she will be buried.

This story is not unique or unusual. With time, we could tell more devastating and emotional stories. While attempting to identify someone to appear and share their stories themselves, there were several underlying issues: embarrassment about their inability to meet all obligations without assistance when they had planned well for their retirement; emotional exhaustion with dealing with all the funding issues involved; and caregivers who were unable to leave their loved ones either due to their own declining health or their inability to locate someone to provide care in their absence.

Local organizations are working hard to locate funding and services to build and maintain a long term care system to allow older persons the ability to remain in their communities and, particularly, in their own homes. It is more apparent every day that education needs to occur with persons aged 20 and over on their responsibility to be aware of their future and what may lie ahead. While we know it is impossible to prepare for every crisis, we believe persons will always want to remain in their own homes and to maintain their independence. When the need arrives for extra assistance, a system to support these cares must be established and funded beyond Medicaid and Medicare. Most importantly, ongoing education of the needs and issues involved must be shared openly and frequently.

The CHAIRMAN. Our first panelists, and would all three of you come up as I read about your background. Our first panelist is Lynda Gormus from Richmond, VA. Lynda has agreed to testify today about her family's experience with long-term care costs and its effect on her parents' retirement income. In addition to being a caregiver for her mother, Lynda and her husband are busy grandparents and we are grateful for your participation, as well.

Then I would call William Scanlon. He frequently comes to testify before our committee. He is Director of Health Financing and Systems Issues for the GAO and he is an expert in the area of health care financing and has testified innumerable times, not only before this committee but also before other Congressional committees, and we are pleased to have his testimony regarding long-term care financing.

Our third panelist is Mathew Greenwald. Dr. Greenwald is President of Mathew Greenwald and Associates, a research and consulting firm in Washington, DC, that specializes in retirement issues. He has given numerous presentations on retirement issues and he has long been interested in the implication of aging of the baby boom generation. Dr. Greenwald has conducted research on retirement-related issues for the National Council on Aging, the AARP, and the National Alliance for Caregiving. Today, we will hear about the results of his work with baby boomers on long-term care and issues related to retirement.

I welcome each of you and we will go Ms. Gormus, Dr. Scanlon, and Dr. Greenwald. Would you proceed, please? Thank you for coming.

STATEMENT OF LYNDA GORMUS, RICHMOND, VA

Ms. GORMUS. Thank you, Mr. Chairman, and thank you, honored members of the committee. I appreciate the opportunity to share our family's experience with long-term care financing.

As you said, I am Lynda Gormus from Richmond, VA, where I live with my husband of almost 36 years. We have three sons, three grandchildren, and another one on the way in June, and we are really excited about that. I have a brother who lives in North Carolina, does a lot of traveling, and comes when he can into town to see Mom.

I have volunteered for many years with the Alzheimer's Association and at one point in time I was part-time staff as Patient and Family Services Coordinator, so I have been dealing not only with our family's issues but a lot of the family issues in our chapter's area. I currently co-facilitate an adult-children's group for those who have a parent with Alzheimer's or a related disorder.

Dad died in 1992 after about 11 years of having Alzheimer's disease, and for the last year and one month of that time, he was in a nursing home and was private pay until his funds were exhausted.

Mom is now 80. She was 11 years younger than Dad, and it was still difficult to caregive for him all that time. She has developed Parkinson's disease, has a brain tumor, left temporal lobe seizures, and some other issues that she deals with and takes multiple medications. She has symptoms of dementia, as well.

We were considered a typical middle-class family. Our mother stayed at home, took care of my brother and me, and Dad went to work; and we lived a modest lifestyle. We had vacations, but there was nothing elaborate about them. We were always happy and comfortable and felt like we had what we needed to be happy. Dad worked for DuPont for over 40 years and retired and I am sure he thought what he had was a sufficient savings to keep my mother and him going and he also had his pension and Social Security.

I am just one of 400,000 family members in Virginia alone who are dealing with a parent with dementia, so the numbers are expansive. It is not just a small issue that we are dealing with, and I am preaching to the choir here. I can tell from things that you said. Mr. Chairman, some of the things you were saying, I was sitting there saying, "been there, done that," type of thing. So I know you understand from what you have said some of the major issues that we as family members are dealing with.

My mom cared for Dad for most of the time of his illness at home. Caregiving takes a great emotional and financial toll and it makes it even tougher when the funds are limited.

One of my sons is a photographer and a few years ago he took a series of pictures of Mom caregiving for Dad. I think something Mom said one time tells it all about what happens to the caregiver. She looked at the slides that he had taken and pointed to an individual in one of those slides and said, "Who is that?" I said, "That is you, Mama." She had gotten to a point where she did not even recognize herself. The stress of caregiving takes a toll that the caregiver cannot even accept. You can tell them, "you need help;" you can try to give them help; but they do not always realize that

they need help. Mom knew she could take care of Dad better than anybody else, and she was right.

The spring or summer before he went into a nursing home, he became bedridden, comatose. He had a rash over a good part of his skin. His stomach, ankles, and feet were swollen; and he was not eating as much as Mom thought he should. Amazingly, even through the whole time of his illness, he was able to swallow. So often, the victims of Alzheimer's forget how to swallow, but Dad could still swallow.

We took him into the hospital and discovered not only did he have some other things going on with infection and so forth and this rash but he also had pneumonia. They kept him in the hospital for a few days but the pneumonia still persisted. We had decided not to treat this at this state that he was in with any antibiotics, so Mom brought him home. Fortunately, having worked for DuPont, the type of insurance that he had paid for 8 hours of hospice care a day; and that gave Mom some relief.

About 9 or 10 o'clock at night, she would get up and make sure that he was set for the night and my husband or I would go over and help her get him settled for the evening. Now remember, she is doing everything for him. He is completely dependent. He is comatose. She would set the alarm in the middle of the night to get up so she could turn him. The pneumonia disappeared.

Once that happened, hospice would no longer provide services and we had to get him placed in a nursing home because her health would not allow her to continue caregiving at home. We began looking too late, I am afraid, into their financial situation. He was in the nursing home less than a year before his funds ran out. With the Spousal Impoverishment Act, Mom was able to keep the house and the car and half of their assets.

I am now looking at a situation with her. She is living in assisted living. She fell this summer and broke her hip. She had had many falls and fortunately had not broken any bones, so we were really lucky. She fell, broke her hip, went into the hospital, had the surgery, went through the physical therapy. After that, we felt like she needed some more assistance until she could get on her own and she went into an assisted living facility at $75 a day. She stayed for a few weeks, seemed to be doing OK; but once she got home, she found that she really could no longer manage like she once could before she fell. So in about three days' time, she decided she needed to go back to the assisted living facility.

We had looked into her finances, oh, I guess a couple of years or so ago to see what might be done regarding expanding her savings and helping it to grow; and we hesitated about doing anything, you know, the bird-in-the-hand theory. When you have real limited funds, you are kind of afraid to let go of anything for a chance that you might lose more. So we did not do anything with the financial plan.

Then after she decided to go back into the facility, we put her house on the market. She had lived there for over 30 years, and it was really hard for her to make that move and decide that she could no longer be there. So we have the house on the market now. My fear is that she is going to run out of her money before her house sells. She will have a fairly decent amount to live on, par-

ticularly if I can invest it appropriately, for quite a while. Hopefully, she will be able to have that meet her needs or otherwise she will have to go onto Medicaid like Daddy did. Anyway, I did check with the facility where she is living and they are allowing us to have a reduced payment until her house sells. So that has relieved me immensely about that responsibility.

I really appreciate the time and the opportunity to come here and share some of the things that we have been dealing with and I thank you for your concern.

The CHAIRMAN. Would you be willing to wait and answer questions for us when the next two are done?

Ms. GORMUS. I would be happy to.

[The prepared statement of Ms. Gormus follows:]

PREPARED STATEMENT OF LYNDA GORMUS

Mr. Chairman, Senator Breaux, Senator Warner, thank you for giving me the opportunity to share my family's experience with long term care costs and its effects on my parents' financial situation. Being able to share our story so that it might help someone else is part of my healing process. My name is Lynda Gormus. I live in Virginia with my husband of nearly 36 years, have three sons and three grandchildren with one more on the way. My only brother lives out of state but visits when his schedule allows. I have volunteered for the Alzheimer's Association for several years and was part time staff for a three-year period. I co-facilitate a support group for the adult children of Alzheimer's and related disorders victims for the Greater Richmond Chapter. I work part time when life allows.

Dad passed away in January 1992 after having Alzheimer's for approximately 11 years. The last year and one month of his life was spent in a nursing home. He was a private-pay patient until his funds were exhausted.

My mother is 80 years old now and has been diagnosed with Parkinson's disease. She also has a brain tumor, coronary artery disease, atrial fibrillation, and left temporal lobe seizures and takes multiple medications. She also exhibits symptoms of dementia which often accompany Parkinson's disease. She currently resides in an assisted living facility.

We were considered to be a typical middle class family. My mother stayed home to take care of my brother and me, while my father worked to take care of our monetary needs. We took family vacations, but nothing extravagant. We always seemed to have what we needed to be comfortable. When Dad retired after more than 40 years of service with DuPont, Mom and Dad had their own home and lived a happy, conservative lifestyle on Dad's pension and Social Security. At one point, Mom worked part time and so did Dad, but I understood that this was more for something to do, not because of financial need.

In Virginia, there are nearly 400,000 family members whose loved ones have a form of dementia. I would say that my parents' financial situation was probably fairly typical of the majority of families. Dad was in his 70's when we began noticing behaviors that were questionable. Mom took care of Dad at home for the major duration of his illness. During that time she became increasingly isolated from friends but was determined that she could take care of him, even when he became completely dependent on her.

Mom was 11 years younger than Dad but had her own physical problems. In the early 80's Mom began having periodic seizures. A brain tumor was discovered near a main vein located just to the left side of the brain. However, this was not considered to be the cause of the seizures, and the search for answers continued. In 1987, it was determined that the seizures were located in the left temporal lobe area and were classified as epileptic.

Caregivers of someone with a long illness know too well the physical and emotional toll it takes on the entire family. The primary caregiver is the second victim of the illness and too often becomes physically unable to continue caregiving for their loved ones. Even when a loved one is placed in a facility, caregiving responsibilities continue.

Mom took care of Dad at home as long as she could. Although expenses were less in caring for him at home, they still exceeded what they would have been if Dad were not sick. The spring or summer before he went into the nursing home, he became bedridden and was basically comatose. My Mom was concerned that he was not eating as much as he should. He was on medication for an infection; his feet,

legs, and stomach were swollen; and a rash covered a good portion of his skin. When finally admitted to the emergency room, we learned that he also had pneumonia.

After being hospitalized for several days, with little or no verbal response, he returned home in what we thought was a close-to-terminal condition. His DuPont insurance covered 8 hours a day of hospice care. This gave my mother a little relief. Several weeks passed. Somewhere around 9 or 10 o'clock every night, Mom would get Dad ready for the next few hours. If the hospice staff was no longer there, my husband or I would go over to help Mom with this bedtime procedure. She set her alarm clock so she could get up in the middle of the night to turn him. The pneumonia disappeared with no treatment other than Mom's established ritual. Services could no longer be provided through hospice because Dad had recovered from the pneumonia. Because of her own health problems Mom's only option was to place him in a nursing home.

As Dad's Alzheimer's progressed, I became more concerned about Mom's health. He was getting the best of care from her, but she was killing herself. One of our sons is a photographer and did a picture story of my Mom caregiving for my Dad. Mom saw slides of these pictures, and asked me the identity of a person in one of the slides. "That is you, Momma," I said.

It is hard to determine which of the many stresses of long term care is the greatest. While the emotional toll is significant, it's even tougher when the money is limited. Mom and Dad had what, I am sure, they considered to be a good savings. Having been born in 1906, he was a young adult during the depression, so his perspective was different than most of us here today. He remembered when $6 was the price of a man's suit.

Shortly before Dad was placed in the nursing home, Mom began looking into their financial situation. We tried to educate ourselves about the complicated Medicaid rules and regulations. We compiled the necessary financial documentation and applied for Medicaid on Dad's behalf. Social services reviewed the application to determine if he were eligible. They informed Mom that he did not qualify, but to reapply when he was closer to having only $2,000 left.

Dad qualified for Medicaid in less than a year after entering the nursing home. The nursing home costs were approximately $3,000 a month. Under spousal impoverishment rules, Mom was allowed to keep their home, car, and half of their assets.

I had hoped that Mom would regain her old stamina once her caregiving responsibilities stopped, but she never has. I began to notice symptoms which were soon diagnosed as Parkinson's disease. A couple of years ago, a financial planner assessed her situation and recommended ideas for investing what was left of her savings so that there would be greater potential for growth. We hesitated. A little over a year ago, she had her house appraised to see what she would be able to realize from its sale. We hesitated, again. She had been in her home for more than 30 years. It was hard to make a move. Her modest savings and her home were all she had left of her more than 50-year marriage, except of course for family and memories. She sold her car when she realized she was no longer able to drive safely. This helped reduce her expenses.

Mom had fallen several times due to the imbalance and instability caused by Parkinson's, and had been fortunate not to have any broken bones. Her luck ran out in June 1997. She fell, broke her hip, had surgery and in-hospital physical therapy. From there she was admitted to an assisted living facility for more rehabilitation. She stayed for several weeks, appearing to be doing OK. In late September she returned home, only to decide after less than a week that she would be better off living in the facility.

We put her home on the market. Her monthly living expenses are more than twice her income and her savings are disappearing rapidly. I'm concerned that her savings will run out before her home sells. She needs a large degree of assistance, and I really don't want her to have to leave where she is. She is safe and has 24-hour assistance. I have thought about the possibility of moving her back home and getting a reverse mortgage to pay for in-home care, but know that situation would not be as secure as where she is now and would be more costly. I have approached the Administrator of the facility to see if temporarily reduced payments would be acceptable until her home is sold. The owner has agreed to write a contract placing a lien on Mom's home, so that they will be the first to get paid when the house is sold. This seems workable.

Once the house is sold, I will investigate her best options for investment and hope and pray that her money can be extended to meet her needs. If not, she will have to turn to Medicaid, like my Dad did. My mom is my best friend, and I miss the person she used to be but thank God that I have memories of two wonderful parents.

Thank you for listening to my story.

The CHAIRMAN. Dr. Scanlon. Thank you very much.

STATEMENT OF WILLIAM J. SCANLON, PH.D., DIRECTOR, HEALTH FINANCING AND SYSTEMS ISSUES, GENERAL ACCOUNTING OFFICE, WASHINGTON, DC

Mr. SCANLON. Thank you very much, Mr. Chairman and members of the committee. I am very pleased to be here today as you discuss the issues of financing long-term care in the future.

Paying for long-term care is already a major burden on the elderly as well as the taxpayer. The question before us today is, how will this care be paid for in the coming years as the baby boomers turn 65 and increasing numbers of those reach ages 85 or 90, times when individuals are more likely to have some disability and need long-term care.

To give you an appreciation of the numerous factors affecting future needs and how we will address them, I would like to focus on four areas, the current burden of long-term care, the impact of the baby boom generation on the needs for long-term care, and expectations regarding the financing of such care from public and private sources.

First, with respect to the current burden of long-term care, in 1995, approximately seven million elderly individuals needed some long-term assistance due to a health-related disability. The elderly themselves or their families paid a big share, almost 40 percent of the nation's 91 billion long-term care health bill. The government, largely through Medicaid and Medicare, paid almost all of the rest.

However, these numbers do not include the hidden costs for the estimated 65 percent of disabled elderly whose families or other unpaid individuals provided all of their care. The story of Mrs. Gormus' mother is a great example of how much care is provided by family members to individuals needing long-term care.

In turning to the future, the first question we ask is, what are going to be the care needs created by the aging baby boom generation? By 2030, 20 percent of the total population will be elderly, compared to 13 percent today, with twice as many persons 85 years and older. Less certain is how these demographic projections will translate into a need for long-term care.

Increased life expectancy and declining death rates due to certain causes among baby boomers could substantially raise the proportion needing long-term care. At the same time, the health care available to them during their lives and their life styles may lead to better health status when they are aged. Such improved health status, combined with improved future treatments for disabling conditions like stroke or arthritis, could perhaps lower the proportion.

With these future unknowns, forecasts of the number of baby boomers needing long-term care are necessarily tentative. Different estimates range from two to four times that of current levels. Even the smaller number represents a significantly increased challenge when compared to today.

How are we going to meet this challenge? The boomers are expected on the whole to be wealthier than their parents, but because they stayed single longer and had fewer children, they will have fewer social resources. And if current trends hold, with more

women working outside the home and families dispersed geographically, the ability to rely on unpaid caregivers could diminish in the future. Consequently, how this challenge will be met depends heavily upon the support available from public programs and private long-term care insurance.

Like our uncertainty about the numbers of persons needing long-term care in the future, there is uncertainty about the contributions of Medicaid, Medicare, and private insurance because each is in a stage of reinvention or development that makes envisioning their futures difficult. Medicaid and Medicare currently finance almost two-thirds of long-term care. While at one time Medicaid's long-term care spending went almost exclusively for nursing home care, today, Medicaid spending for home and community-based care has grown so much that more beneficiaries are now served at home. Substantial growth in Medicaid home services is continuing.

Similarly, Medicare's long-term care role has undergone a dramatic change and may change again. Medicare's home health benefit was at one time used largely to substitute for more costly hospital stays. Today, it also covers home health aides to provide long-term care support for a small but significant proportion of people.

But Medicare's financing role could shift again. In 1999, the program is scheduled to pay for home health services using a prospective payment system as required by the Balanced Budget Act. Home health providers will be expected to deliver care for a fixed payment for a period of time to discourage attempts to profit inappropriately by providing excessive services. As a result, Medicare's role in financing future long-term care may not expand and could even diminish.

Finally, with respect to the potential contribution of private long-term care insurance, to date, private insurance has had almost no role in shouldering the long-term care financing burden. In 1995, private long-term care insurance covered less than 1 percent of total long-term care expenditures. After about 15 years of attention focused on these policies, the number sold and in force remain relatively small. Consumers may be reluctant to buy this insurance because they may not know much about their long-term care risk or about the limits on Medicare and Medicaid long-term care coverage.

They may also be concerned about the affordability of policies. In 1995, an average policy cost over $1,800 for a 65-year-old. Continuing efforts to educate consumers and premium reductions that are associated with competition among insurers may increase demand. To what extent and how soon this may happen is impossible to predict.

In short, what we know today with considerable certainty is that the aging of the baby boom generation will lead to tremendous growth in the elderly population in the next three decades, with an even larger increase in the frailer population of those over 85. What is less certain, however, is the exact number that will need long-term care and the nature and magnitude and funding sources for the services to address the needs of those needing long-term care. Unfortunately, it does seem clear that financing long-term care will be a challenge for the baby boomers, their families, and the Federal and State Governments.

Mr. Chairman, that concludes my statement. I would be happy to answer any questions you or members of the committee have. Thank you.

The CHAIRMAN. Thank you, Dr. Scanlon.

[The prepared statement of Mr. Scanlon follows:]

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LONG-TERM CARE

Baby Boom Generation Presents Financing Challenges

Statement of William J. Scanlon, Director
Health Financing and Systems Issues
Health, Education, and Human Services Division

GAO/T-HEHS-98-107

Mr. Chairman and Members of the Committee:

I am pleased to be here today to discuss the challenges the country will face in financing long-term care for the baby boom generation.[1] Long-term care presents a significant burden for many individuals and for public programs. Long-term care in nursing homes currently costs an individual more than $40,000 per year, with a substantial share of nursing home residents paying that out of their own pockets. In addition to this out-of-pocket spending, Medicaid and Medicare expenditures for long-term care for the elderly–those aged 65 and older–exceeded $51 billion in 1995. More than a million elderly with extensive disabilities live at home, relying heavily on their families for assistance. The aging of the baby boom generation, particularly as members become age 85 and older, will have a dramatic impact on the numbers of people needing long-term care services and will challenge individuals, families, and public programs to finance and furnish that care.

My remarks today focus on four areas: (1) an overview of current spending for long-term care for the elderly, (2) the increased demand that the baby boom generation will likely create for long-term care, (3) recent shifts in Medicaid and Medicare financing of long-term care, and (4) the potential role of private long-term care insurance in helping to finance this care. My comments are based on our previous work and on other published and ongoing research. (See the list of related GAO products at the end of this statement.)

In summary, spending for long-term care for the elderly totaled almost $91 billion in 1995, the most recent year for which expenditures from all sources were available. Almost 40 percent of these dollars were paid for by the elderly and their families and almost 60 percent by Medicaid and Medicare. These amounts, however, do not include many hidden costs of long-term care, since an estimated two-thirds of the disabled elderly living in the community rely exclusively on their families and other unpaid sources for their care.

According to current estimates by the Congressional Research Service (CRS), nearly a quarter of the nation's elderly population–over 7 million elderly people–have some form of disability for which they require assistance, such as help with bathing,

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[1]Long-term care, which includes an array of health, personal care, and social and supportive services, is provided to individuals who are at least partially unable to care for themselves because of a disability or impairment resulting from a chronic illness or condition–such as heart disease or diabetes.

dressing, eating, preparing meals, or taking medicine. As the 76-million-strong baby boom generation ages, so too will its demand for long-term care increase. Long-range predictions of the magnitude of the baby boomers' long-term care needs, however, vary, with estimates of disabled elderly ranging from 2 to 4 times the current disabled elderly. Estimates of cost are even more imprecise due to the uncertain impact of several important factors, including who will be needing care, the types of care they will need, and who will fund it.

Medicaid and Medicare, which currently finance almost two-thirds of long-term care, have undergone some significant changes in recent years. While historically the majority of Medicaid long-term care expenditures were for nursing home care, in recent years there has been a shift toward more financing of home and community-based care. At the same time, Medicare, the largest public payer for home-based care, has been paying for care that more and more resembles long-term care.[2] Both the number of beneficiaries receiving home health care and the number of visits per user more than doubled from 1989 to 1996, with a small but significant proportion of users receiving extensive long-term support from home health aides. Medicare's financing role for this care could, however, again significantly shift as a result of the requirement in the Balanced Budget Act of 1997 to move away from a cost-based per-visit payment system to a case-mix-adjusted per-episode prospective payment system in 1999.

Private long-term care insurance, seen as a means of helping reduce the catastrophic financial risk for people needing long-term care and some of the financing burden that falls to public programs, has contributed little to date. It is a relatively new form of insurance with a growing market. Nevertheless, after 10 years, a very small proportion of elderly or near-elderly have coverage. For example, in 1995, private long-term care insurance covered less than 1 percent of total long-term care expenditures. Consumers' reluctance to purchase long-term care insurance is attributed to their limited knowledge about the risk of needing long-term care and the limitations on Medicare and Medicaid long-term care coverage, as well as concerns about the affordability of policies.

What we know today with some certainty is that the aging of the baby boomers will lead to a tremendous increase in the elderly population in the next 3 decades, with an even larger increase in individuals aged 85 and over, who are more likely to use long-term care services. What is less certain, however, is the nature, magnitude, and funding sources for those services. Financing these services–within the context of evolving service needs and alternatives–will be a challenge for the baby boomers, their families, and federal and state governments.

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[2]Medicare home health includes skilled nursing and therapy services, which are shorter term, and a significant proportion of services that can be used for long-term support.

SPENDING FOR THE ELDERLY'S LONG-TERM CARE EXCEEDED $90 BILLION IN 1995

Spending for the elderly's long-term care was $91 billion, or about $12,000 per disabled elderly person, in 1995, the last year for which data on expenditures from all sources are available. The elderly and their families represent the largest single group of purchasers of long-term care, spending almost $36 billion dollars out of pocket, or almost 40 percent of the total $91 billion expenditures for long-term care. (See table 1 for expenditures and fig. 1 for percentages by funding source.) This spending does not include the substantial unpaid support provided to the elderly by family and friends. Studies have found that about 65 percent of disabled elderly living in the community rely exclusively on unpaid sources for their care. Public funding for long-term care comes primarily from Medicaid, which finances almost one-third of long-term care–$28.5 billion in 1995–and Medicare, which funds one-fourth–$22.7 billion.[3] Long-term care expenditures for the elderly are disproportionately used to purchase nursing home care; about 70 percent of total elderly long-term care expenditures are for nursing homes.

Table 1: 1995 Expenditures for Long-Term Care for the Elderly

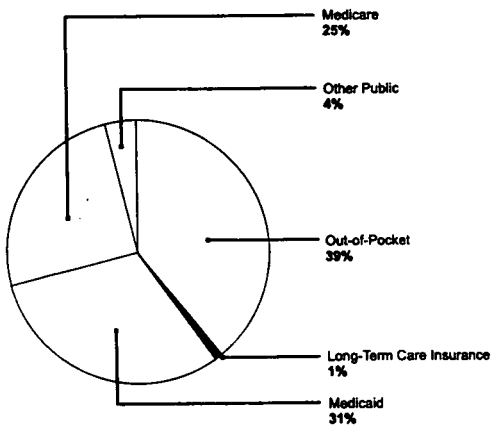
Dollars in billions

Funding source	Nursing home	Home care	Total
Out-of-pocket	$30.0	$5.5	$35.5
Medicaid	24.2	4.3	28.5
Medicare	8.4	14.3	22.7
Other public sources	1.3	2.2	3.5
Private insurance	0.4	0.3	0.7
Total	**$64.3**	**$26.6**	**$90.9**

Source: CRS.

[3]Medicaid, a joint federal-state health financing program for low-income families and blind, disabled, and elderly people, is authorized under title XIX of the Social Security Act and is administered by the states under the general oversight of the Health Care Financing Administration (HCFA). Medicare is a health insurance program that covers virtually all the elderly, authorized by title XVIII of the Social Security Act. The federal share of a state's total Medicaid expenditures can range from 50 to 83 percent; Medicare home health care is almost totally financed by federal funds.

Figure 1: Distribution of 1995 Expenditures for Long-Term Care for the Elderly, by Funding Source



Source: GAO analysis of CRS data.

AGING BABY BOOMERS WILL EXPAND DEMAND FOR LONG-TERM CARE

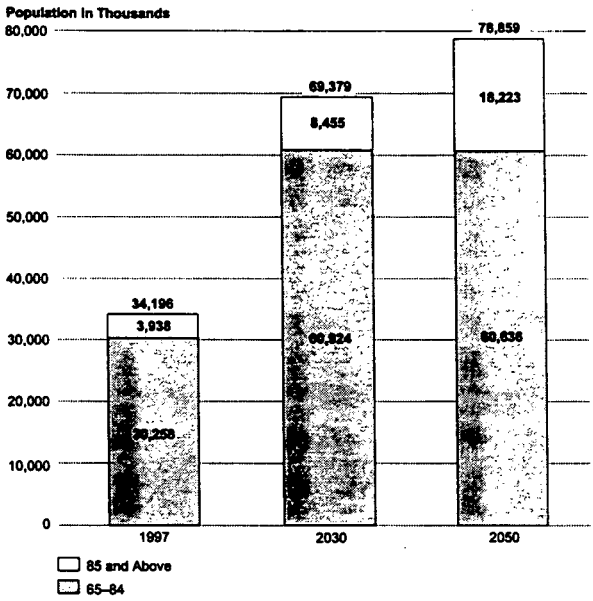
The baby boom generation, about 76 million people born between 1946 and 1964, will contribute to rapid growth in the number of elderly individuals who need long-term care and the resources required to pay for it. Forecasts of the exact number who will need such care are uncertain because of differing conclusions about the effect of better health care and lifestyles on the subpopulation that may eventually need long-term care. Nevertheless, the number will be very large even if the most rosy scenario prevails.

Today's elderly make up about 13 percent of the total population. The number of individuals aged 65 and over will make up about 20 percent of the total population in 2030, when the first of the baby boomers will reach their 85th birthday.[4] From 1997 to 2030, individuals 85 and older, the most rapidly growing age group and the group most likely to require long-term care, will more than double–from about 3.9 million to about 8.5

[4]The prevalence of chronic health conditions increases with age. Disability also increases with age, and the prevalence of disability increases markedly at advanced ages. Those aged 85 and older have almost double the rate of disability of those aged 65 to 74.

million individuals–and by 2050 will more than double again–to about 18 million individuals.[5] (See fig. 2 for the distribution of the elderly in 1997, 2030, and 2050.)

Figure 2: Census Bureau Estimates of Number of Elderly Individuals in 1997, 2030, and 2050



Source: U.S. Bureau of the Census, March 1996 and February 1998.

Nearly a quarter of the nation's elderly population–an estimated 7.3 million in 1994 –require some assistance with either activities of daily living (ADL) or instrumental

[5]U.S. Bureau of the Census, Resident Population of the United States: Estimates, by Age and Sex, Feb. 6, 1998; Bureau of the Census, Resident Population of the United States: Middle Series Projections, 2015 to 2030, by Age and Sex, Mar. 1996; and Bureau of the Census, Resident Population of the United States: Middle Series Projections, 2035 to 2050, by Age and Sex, Mar. 1996.

activities of daily living (IADL), or both.[6] Almost 80 percent of these 7.3 million elderly live at home or in other community-based settings, and about 30 percent of them are severely disabled, requiring assistance with at least three ADLs or needing substantial supervision because of cognitive impairment or other behavioral problems. About 22 percent–or 1.6 million–live in nursing homes. An estimated 1 million individuals live in residential settings that have services available, such as assisted living facilities. Experts agree that population aging will increase the number of disabled elderly needing long-term care over the next several decades, but no consensus exists on the size of that increase. While the sheer number of baby boomers is expected to drive up demand for long-term care services, projections of the number of elderly needing long-term care in the next century vary because of different assumptions about the future prevalence of disability.

Predicting the magnitude and composition of the growth in the elderly needing long-term care services is complicated by several factors. Some researchers argue that medical advances have increased life expectancy but have not changed the onset of illness. They predict that declining death rates may actually increase the need for long-term care if more people live to develop age-related disabling conditions or live longer with existing disabilities. Others argue that disability is becoming increasingly compressed into a shorter portion of the lifespan, decreasing the number of years long-term care is needed. Improved treatments or prevention of common disabling conditions among the elderly, such as strokes and arthritis, could lessen long-term care need, independent of death rates.

Nonetheless, recent forecasts of the number of disabled baby boomers who will need long-term care have been developed but differ widely, ranging from 2 to 4 times the current number of disabled elderly. How this will translate into the need for long-term care services and actual spending will depend on the public and private resources devoted to purchasing long-term care.

SHIFTS IN MEDICAID AND MEDICARE FUNDING OF LONG-TERM CARE COMPLICATE PROJECTIONS

How the increased long-term care needs of the baby boom generation will be met or financed is uncertain. The past 2 decades have seen change in the types of long-term care services used by the elderly and in who paid for these services. The change has

[6]The need for long-term care is frequently measured by assessing limitations in an individual's ability to manage certain functions or activities that are basic for self-care. ADLs include bathing, dressing, toileting, getting in and out of a chair or bed, and eating; IADLs describe difficulty in performing household chores or social tasks and include taking medicine, preparing meals, cleaning, grocery shopping, and money management.

occurred in large part because of shifts in Medicare and Medicaid coverage as well as private purchases of long-term care. We still are experiencing considerable change, which makes it extremely difficult to project what type of services the baby boomers will need and who will pay for them.

Historically, the vast majority of long-term care was supplied in nursing homes or at home by family members and friends. Nursing home care was financed almost equally by residents' own resources and state Medicaid programs. Over the past 15 years, there has been a substantial increase in the number of people receiving paid services at home and relying less on nursing homes. A major contributor to this trend has been increased use of Medicaid-financed home care following passage of home and community-based waiver provisions in 1981. In addition, since 1989, Medicare expenditures for home care have grown rapidly.

Medicaid, Largest Public Funder of Long-Term Care, Continues to Expand Home Care

Medicaid is the largest public funder of long-term care. Most of Medicaid expenditures are for nursing home care, but in the past 15 years there has been a shift to home care. The result is a significant change in the proportion of people with the need for long-term care who are receiving Medicaid-financed services and in the average cost of those services.

State Medicaid programs have, by default, become the major form of insurance for long-term care, but only after individuals have become impoverished by "spending down" their assets. Medicaid long-term care spending for many of the elderly results from Medicaid coverage of people who have become poor as the result of depleting assets to pay for nursing home care, the average costs of which exceed $40,000 per year. In most states, nursing home residents without a spouse cannot have more than $2,000 in countable assets before becoming eligible for Medicaid coverage of their care.[7]

About two-thirds of nursing home residents in 1994 relied on Medicaid to help pay for their care. Slightly more than 25 percent of Medicaid nursing home residents were admitted as private pay residents. Both multiple nursing home stays and lengths of stay affect whether a private pay resident spends down to Medicaid eligibility. For example, more than one-half of residents who entered as private pay residents and who have been in the nursing home 3 to 5 years are on Medicaid.

[7]Countable assets generally refer to liquid assets, excluding such things as a primary residence of any value and an automobile with a market value of $4,500 or less.

Traditionally, states emphasized nursing home care. In attempts to control their long-term costs, states imposed controls on the number of nursing home beds. They required assessment and screening of prospective residents to ensure that Medicaid financed nursing home care for the people who were most disabled. Some states also implemented payment systems to provide these facilities incentives to admit and care for the more disabled and higher cost residents.

States limited eligibility for home care out of concern about the potential cost of covering services for the large number of disabled who were cared for by their families at home. However, as part of the Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35), the Congress established the home and community-based service waiver program: section 1915(c) of the Social Security Act gave states the option of applying for Medicaid waivers to fund home and community-based services for people who meet Medicaid eligibility requirements. These waivers gave states the ability to restrict the number and costs of eligible individuals. As states have become more experienced with the waivers and confident of their ability to manage these programs, they have expanded their financing of home and community-based care. All states now have home and community-based waivers, and over 200 waiver programs serve more than 250,000 individuals nationwide.[8] Medicaid expenditures for home and community-based waivers have increased an average of 32.7 percent per year from 1987 to 1996, reaching a level of $5.8 billion in 1996.

States have used home and community-based waiver services not just to serve additional people at home, but to reduce reliance on nursing homes. In an earlier report, we found that three states we reviewed had restricted construction of new nursing home beds as they financed more home care services.[9] According to the National Academy for State Health Policy, 27 states provide waiver services in assisted living or board and care facilities.[10] Such settings may provide an alternative to nursing homes for someone whose care needs or family resources make it difficult to stay at home.

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[8]Forty-nine of the fifty states have at least one home and community-based waiver. Arizona, the fiftieth state, has a program that functions similarly to such a waiver program.

[9]See Medicaid Long-Term Care: Successful State Efforts to Expand Home Services While Limiting Costs (GAO/HEHS-94-167, Aug. 11, 1994).

[10]Assisted living facilities are similar to other residential facilities, such as board and care facilities, that offer housing, meals, protective oversight, and personal care to people with physical or cognitive disabilities. Unlike nursing homes or many board and care settings, however, assisted living facilities attempt to provide residents with greater autonomy and control over their living and service arrangements.

As they address the challenges identified with providing long-term care, states are expected to increasingly focus on Medicaid-funded care provided in the beneficiary's home or a community-based setting rather than expanding long-term care in nursing homes. Spending on home care in 1996 increased about 24 percent in comparison to the 3-percent increase in the overall program. According to the National Academy for State Health Policy, seven more states plan to expand home care to community-based residential settings, such as assisted living or board and care facilities. In the last 5 years, a number of states also have created forums to consider the direction and financing of long-term care--the National Conference of State Legislatures reports that at least 23 states have formed task forces or study commissions on this issue.

New Payment System May Reduce Medicare's De Facto Long-Term Care Financing

Since 1989, Medicare has become the largest funder of long-term home care, financing $14.3 billion in care--or more than half of the home care purchased for the elderly in 1995. A new home health payment system, mandated by the Balanced Budget Act of 1997, however, may reduce the amount of long-term home care financed by Medicare.

Medicare traditionally had focused on acute care and consequently paid very little for long-term care. However, legislative and court decisions and consequent changes in guidelines have essentially transformed the home health benefit from one focused on patients needing short-term care after hospitalization to one that serves chronic, long-term care patients as well.[11] As a result, Medicare, on a de facto basis, has financed an increasing amount of long-term care through its home health care benefit.

The increase in Medicare home health care use has been dramatic. Emerging trends in home health use suggest that Medicare is covering long-term care for increasing numbers of beneficiaries, rather than just skilled home health care. Both the number of beneficiaries receiving home health care and the number of visits per user more than

[11]To qualify for Medicare home health care, a beneficiary must be confined to his or her residence (that is, "homebound"); require intermittent skilled care from a qualifying service--skilled nursing, physical therapy, or speech therapy; and be under the care of a physician, with the services furnished under a plan of care prescribed and periodically reviewed by a physician. If these conditions are met, Medicare will pay for additional qualifying services and home health aide, occupational therapy, and medical social service visits. Beneficiaries are not liable for any coinsurance or deductibles for home health services, and there is no limit on the number of visits for which Medicare will pay.

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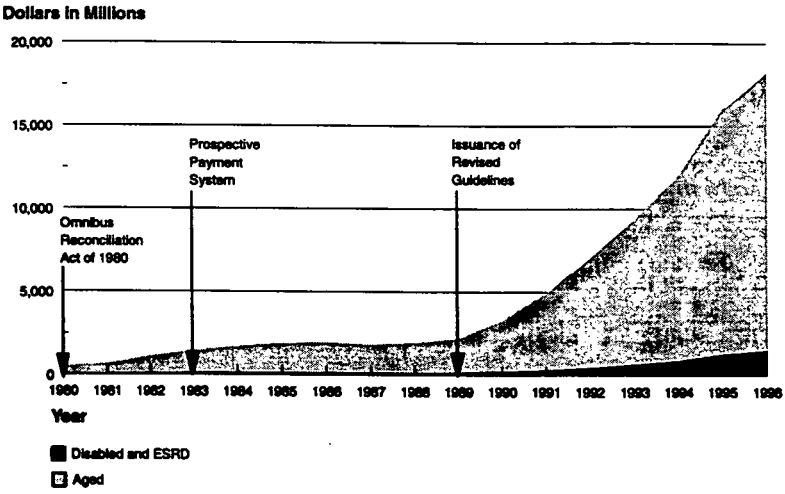
doubled from 1989 to 1996.[12] A small but significant proportion of users receive extensive long-term support primarily from home health aides. The share of visits supplied by home health aides increased from about 25 percent of all home health visits in 1988 to almost 50 percent in 1995. At the same time, home health users without a prior hospitalization accounted for about one-third of all users in 1993. Figure 3 shows the growth of Medicare home health care expenditures and highlights major policy changes.

Figure 3: Medicare Home Health Expenditures, 1980-96



Notes: ESRD = end-stage renal disease.

The Omnibus Budget Reconciliation Act of 1980 removed both the requirement that a beneficiary be hospitalized for 3 days in the year prior to receiving home health care and the 100-visits-per-year limitation.

Source: HCFA's Office of the Actuary.

[12]Medicare: Home Health Utilization Expands While Program Controls Deteriorate (GAO/HEHS-96-16, Mar. 27, 1996).

Medicare's role could shift significantly as a result of the Balanced Budget Act. The Balanced Budget Act will change the way that Medicare home health care is reimbursed from a cost-based per-visit payment system to a case-mix-adjusted per-episode prospective payment system in 1999. How this system will be designed to reflect differences in home health care needed by individuals with various disabilities and what incentives the system creates will have major implications for the amount of future Medicare funding for long-term care.

SLOW GROWTH OF LONG-TERM CARE INSURANCE RAISES QUESTIONS ABOUT THE EXTENT OF PRIVATE SUPPORT

The baby boomers, in general, are expected to be wealthier in retirement than their parents.[13] Those who are single or less educated, or who do not own homes, however, may not do as well. At the same time that many baby boomers will have greater financial resources, they will have fewer social resources, since this generation has remained single longer and had fewer children. As a result, a smaller proportion of this generation will have a spouse or adult children to provide unpaid caregiving. Geographic dispersion of families and the large percentage of women who work outside the home also may reduce the number of unpaid caregivers available to elderly baby boomers, creating more need for purchased services.

While many baby boomers will have more financial resources in retirement than their parents, what might be more important is whether they have insurance. Private long-term care insurance has been seen as a means of reducing the catastrophic financial risk for people needing long-term care, and relieving some of the financing burden currently falling on public programs. Some observers also believe private long-term care insurance could provide individuals greater choice in selecting services to satisfy their long-term care needs. Nevertheless, a very small proportion of the elderly or near-elderly have purchased long-term care insurance during the past 10 years. Concern exists that consumers are not knowledgeable about their risk for needing long-term care and about the limitations on Medicare and Medicaid long-term care coverage, and that this lack of awareness decreases demand for long-term care insurance. Questions also remain about the affordability of policies for the majority of elderly people and the value of the coverage relative to the premiums being charged.

Private long-term care insurance is a relatively new product with a growing market. In 1986, approximately 30 insurers were selling long-term care insurance policies of some type, and an estimated 200,000 people had purchased these policies. The Health Insurance Association of America (HIAA) has found that by 1995 125 insurers were

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[13]This prediction depends on the assumption that real wages will continue to grow and that Social Security, private pensions, and health expenditures will remain stable.

offering long-term care insurance policies, and more than 4 million policies had been sold. Many fewer individuals had coverage, since many policies sold did not remain in force as individuals stopped paying premiums or dropped one policy to purchase another.[14] Long-term care insurance financed less than 1 percent of long-term care in 1995.

Long-term care insurance is still struggling to gain a greater market share. A recent survey of the elderly and near-elderly found that only about 40 percent believe that they or their family will be responsible for paying for their long-term care.[15] HIAA reports that the industry expects continued growth, however, and that the "tax deductibility" of qualified policies will help accelerate that growth.[16]

The affordability of long-term care insurance will have a large impact on its market share. Assessments of the ability of private long-term care insurance to provide coverage to a majority of people who will need long-term care are pessimistic. HIAA reports that in 1995 policies paying $100 a day for nursing home care and $50 a day for home health care averaged annual premiums of $1,881 when purchased at the age of 65 and $5,889 when purchased at the age of 79.[17] Long-term care insurance, then, is most affordable for

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[14]We found that insurance companies we reviewed expected about 20 percent of long-term care insurance policies to lapse during the first year of ownership and about half of all policies to lapse within 5 years. See Health Care Reform: Supplemental and Long-Term Care Insurance (GAO/T-HRD-94-58, Nov. 9, 1993).

[15]M.A. Cohen and A.K. Nanda Kumar, "The Changing Face of Long-Term Care Insurance in 1994: Profiles and Innovations in a Dynamic Market," Inquiry, Vol. 34 (spring 1997), pp. 50-61.

[16]Section 321 of the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, 110 Stat. 2054, amends the tax code to treat private long-term care policy and long-term care expenses the way health insurance policy and other health care expenses are treated under the code. The portion of such expenses that exceeds 7.5 percent of adjusted gross income is deductible. Private long-term care policy and long-term care expenses can now be included in calculating the amount of this deduction. However, aged-based limitations were established on the amount of these policy premiums that may be included in calculating this deduction. For example, individuals aged 51 to 60 are limited to including no more than $750 of these premiums.

[17]These policies have lifetime 5-percent compounded inflation protection and a 20-day deductible period; adding nonforfeiture benefits increases average annual premiums to $2,560 for 65-year-olds and $8,146 for 79-year-olds.

middle- and upper-income individuals. One recent study estimates that the proportion of elderly who can afford long-term care insurance ranges from 10 to 20 percent.[18]

Not only is the cost of long-term care insurance a problem for the elderly and near-elderly, but questions also remain about the value of the coverage relative to the premiums being charged. Individuals who consider and decide against purchasing long-term care insurance indicate skepticism about the policies' providing adequate coverage.[19] Also, as insurers have better understood their risks and competition has increased, premiums have decreased. Some potential purchasers may defer purchase of long-term care insurance because they expect a "better buy" in the future–that is, improved coverage at less cost.

We have reported on a number of problems in the long-term care insurance market–including disclosure standards, inflation protection options, clear and uniform definitions of services, eligibility criteria, grievance procedures, nonforfeiture of benefits, options for upgrading coverage, and sales commission structures that reduce incentives for marketing abuses.[20] By the end of 1996, all 50 states had adopted laws and regulations pertaining to long-term care insurance, and 38 states had adopted at least one-half of the provisions of the 1996 National Association of Insurance Commissioners (NAIC) Long-Term Care Insurance Model Act. The Health Insurance Portability and Accountability Act requires that long-term care insurance policies written after December 1996 meet requirements of NAIC Long-Term Care Insurance Model Act to qualify as tax-deductible. This requirement adds to consumers' protection.

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In conclusion, even though we cannot know the exact numbers of the baby boom generation who will require long-term care services, we do know that the aging of the baby boomers will lead to a tremendous increase in the elderly population in the next 3 decades and an even larger increase in the 85-and-over population who are more likely to use long-term care services. Financing these services will be a challenge for the baby boomers, their families, and federal and state governments.

Mr. Chairman, this concludes my statement. I would be happy to answer any questions you or Members of the Committee might have at this time.

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[18]"Long-Term Care Insurance Special Report: How Will You Pay for Your Old Age?" Consumer Reports (Oct. 1997), pp. 35-50.

[19]Cohen and Kumar, "The Changing Face of Long-Term Care Insurance in 1994," 1997.

[20]GAO/T-HRD-94-58, Nov. 9, 1993.

RELATED GAO PRODUCTS

Long-Term Care: Consumer Protection and Quality-of-Care Issues in Assisted Living (GAO/HEHS-97-93, May 15, 1997).

Medicare Post-Acute Care: Home Health and Skilled Nursing Facility Cost Growth and Proposals for Prospective Payment (GAO/T-HEHS-97-90, Mar. 4, 1997).

Medicare: Home Health Utilization Expands While Program Controls Deteriorate (GAO/HEHS-96-16, Mar. 27, 1996).

Long-Term Care: Current Issues and Future Directions (GAO/HEHS-95-109, Apr. 13, 1995).

Long-Term Care: Diverse, Growing Population Includes Millions of Americans of All Ages (GAO/HEHS-95-26, Nov. 7, 1994).

Medicaid Long-Term Care: Successful State Efforts to Expand Home Services While Limiting Costs (GAO/HEHS-94-167, Aug. 11, 1994).

Health Care Reform: Supplemental and Long-Term Care Insurance (GAO/T-HRD-94-58, Nov. 9, 1993).

Long-Term Care Insurance: High Percentage of Policyholders Drop Policies (GAO/T-HRD-93-129, Aug. 25, 1993).

Long-Term Care Insurance: Risks to Consumers Should Be Reduced (GAO/T-HRD-91-14, Dec. 26, 1991).

Long-Term Care Insurance: Consumers Lack Protection in a Developing Market (GAO/T-HRD-92-5, Oct. 24, 1991).

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The CHAIRMAN. Dr. Greenwald.

STATEMENT OF MATHEW GREENWALD, PH.D., MATHEW GREENWALD AND ASSOCIATES, WASHINGTON, DC

Mr. GREENWALD. Thank you very much. I am pleased to be here to talk about a subject that I have studied and been interested in for over a quarter of a century.

I would like to spend my time with you talking very briefly about three issues. First, what financial future awaits the baby boom as it ages, especially in the area of long-term care. Second, what financial problems are intrinsic to retirement; that are intrinsic to retirees now and will be for the baby boom later, and what are the best ways of dealing with these problems. Third, what are people's viewpoints, right now, as they work through the issues of increasing life expectancy and increasing financial risk in retirement?

First of all, what financial future awaits the boomers? I think boomers might be under more financial pressure than is often anticipated. Life expectancy is clearly rising, especially at age 65. Further, I think it is likely to rise a great deal more for the boomers, for a number of reasons.

We are making a great deal of progress, not only in understanding the aging process itself, but also in terms of medical technology that can keep people alive much longer. Right now, scientists are very encouraged about artificial lungs, livers, hearts, pancreases, and other organs that can keep people alive.

Second, as has been noticed, boomers took better care of themselves throughout their lives, than prior generations. As a matter of fact, their mothers took better care of boomers when they were in the womb than any other generation.

The entitlement programs will be under pressure. Samuel Preston, a leading demographer at the University of Pennsylvania, stated that life expectancy in Japan was 79.7 years in 1994. Social Security assumes that we will reach that stage in 2050, a lag of 56 years. But many demographers expect us to be 5 years ahead at that time, and those 5 years are very expensive.

Long life is a great gift, but unlike other gifts, it comes with a price tag, and with the boomers, the price tag will be very high. Boomers will live longer in retirement because they will live longer and because there are no signs that they want to retire earlier. In fact, there is more competition for jobs than ever and the boomers will face that, making it harder for them to stay in the work force as they age.

Medical technology is now very expensive, and with new artificial organs and limbs coming into place it will be more expensive still, but boomers will demand it. I do not know if you saw a story in yesterday's New York Times about financial aid for college students. It stated that boomers were more militant about getting financial aid than previous generations. Just think how militant they will be in wanting a new artificial liver that will keep them alive.

Dr. Scanlon stated that a lot of long-term care is now provided to people by family members, unpaid care. The provision of unpaid care is less likely to be given to boomers because they did not produce a boom of children. They produced a baby bust. People are

living further away from elderly parents and are less available to provide care. Further, record numbers of boomers did not have any kids at all. It is the children that are providing unpaid long-term care. Boomers will be more likely to have to pay for their long term care.

Also, boomers have higher life style needs. They are less likely to accept second-class health care or third-class nursing care than the current generation of retirees, who remember gas rationing and the great depression.

Second point, what problems are there financially in retirement? I think retirement is a time of great financial uncertainty and a time where people cannot recover financially from setbacks because they cannot work longer if they have a setback. They have no opportunity for financial recovery.

To illustrate the problem, I would like to refer to a mythical couple retiring today. Imagine they are both 65, they are attending this hearing as their last work responsibility. Their life expectancy could be 2 hours if they die on the way home from this hearing. It is possible. Their life expectancy could be a combined 80 years if they both live to 105. It is possible. The range is 80 years, and that is a very expensive range.

Their time in a nursing home could be zero, or they both could develop Alzheimer's and each spend 8 years in a nursing home, a combined 16 years. Either is possible. They do not know. They might have no medication costs and no hospital costs or health care costs or those costs could be astronomical.

The statement is often made that you need 1 million to retire. This statement is not accurate. People do not know how much they need in retirement. The costs could be very significant or zero.

Three things can be done. Save as much as possible for every exigency, which is impossible; save less and take a risk, which could lead to terrible circumstances; or use risk-protection products that protect people efficiently at an affordable cost for boomers right now, that protects against almost every exigency, like long-term care insurance and life annuities.

I think people can use their money much more efficiently. That, I think, is in some ways the only way out; to change financial strategies in retirement. It is something that can be done.

Where are people now on this issue? I did a survey for the American Council of Life Insurance last August, surveying 1,000 people age 42 and above. The key findings are: people are aware of how long they are going to live. They are aware of how long their life expectancy will be increased. Twenty-five percent expect to live to age 90. Fifteen percent expect to live to age 95.

They are aware of the need to predict certain key facts. Ninety-four percent say it is important to predict your health in retirement if you are trying to decide how much you need to save for retirement. High numbers feel it is very important to predict how long you will live and if you need nursing care.

So people know the importance of anticipating key factors. But 82 percent say that it is very hard to predict these things. They are right. Not only is it very hard, it is impossible by individuals. But it is possible through risk protection products, because for groups

of people, we can predict how many will need nursing care, and how many will live past 85 or 90.

Boomers are very concerned about these issues. They are concerned about the future of Social Security. They are concerned about the need for nursing care. They are concerned about outliving their resources, especially women. When it comes to retirement, it is, to a considerable extent, a women's issue because women are the ones who live considerably longer than men. Women are the ones who experience the poverty, and women are the ones who are concerned about it right now.

But there still is a lot of denial, especially among baby boomers. Only 12 percent think they or their spouse will wind up in a nursing home. It will be higher. Two in five plan to work after retirement to supplement their income. But, we know from prior experience that, fewer will be able to.

In fact, we know that a significant proportion of people must retire before they plan to. In the survey we did for the American Council of Life Insurance, 41 percent of retired people retired before they wanted to, usually because of downsizing, poor health, or disability. People who wait too long to prepare for retirement financially often find that their preparation period is curtailed.

Now, part of the denial is thinking and preparing for possible long-term care needs. Only 9 percent of the older boomers, ages 42 to 51, have thought a great deal about preparing financially for the possibility of needing care. We asked the others how come they had not thought much about it and these are the main reasons. They did not want to think about it, they do not have the money for it, they do not think they will need it, they anticipate insurance will pay for it. But for almost all the insurance they have will not pay for it.

Now, I want to address the issue of affordability, if I can, for a moment. My company did a survey in 1995 and asked people what they would have to do to save an additional $25 a week. That is $1,300 a year. Ten percent said they could not afford to save an additional $25 a week. The rest, 90 percent, said they could. What would they have to give up? They would spend less on eating out. They would buy less expensive food in the supermarket, and probably more nutritional foods, I might add. They would go out less, and a small proportion would not subscribe to cable TV. That is the hardest thing to give up.

These are not terrible things to sacrifice. Thirteen-hundred dollars a year, for baby boomers, at their age, will pay for good, long-term care insurance for a couple. So it is affordable for the boomers now.

Boomers want to use long-term care. We asked them, what is the best way of paying for long-term care needs. Fifty-two percent said, buy long-term care insurance, twice the proportion, 23 percent, who said Medicaid. Even a free good is not that good.

So I think that we need to educate people on risk protection products. It is more efficient use of the money. The baby boomers who use it now, they can have all the protection they need at an affordable price. The alternatives are not workable.

Thank you very much for your time and for the extra time, and I also would be pleased to answer any questions.

[The prepared statement of Mr. Greenwald follows:]

MATHEW GREENWALD'S TESTIMONY TO SENATE SPECIAL COMMITTEE ON AGING
March 9, 1998

I am Mathew Greenwald, President of Mathew Greenwald & Associates, a non-partisan market and social research firm located in Washington, D.C. I am delighted to have this opportunity to testify before you for two reasons in particular. First, the implications of aging on the Baby Boom generation has been a special interest of mine since my graduate work in sociology more than a quarter century ago. I was fortunate to study under Dr. Matilda Riley, a pioneer in the sociology of age and now a Scientist Emeritus at the National Institutes of Health. Second, for the last quarter century I have conducted hundreds of focus groups and in-depth interviews with Baby Boomers on long term care and related issues and have implemented surveys of over half a million Baby Boomers on issues related to aging, retirement and long term care. I will refer to a number of these studies today.

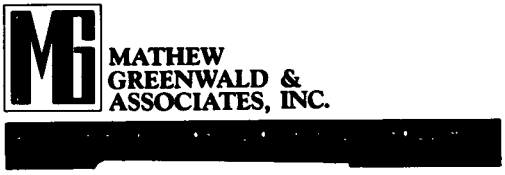
There are four major issues I wish to address.

First, what future awaits the Baby Boom as it ages, particularly in the area of long term care? There is a lot we can anticipate, and if we take a comprehensive view we can discern things that are not apparent if we look at one issue at a time.

Second, what problems do the retired now have, and what problems will Baby Boomers have, with the financial aspects of retirement? A proper understanding of these problems will provide a useful insight into how to overcome these problems and how you can be most helpful to the Baby Boom generation.

Third, what are people's viewpoints on these issues now? Do Baby Boomers understand the issues that are before them; are they adequately preparing for the financial stresses of the possibility of needing long term care in general and retirement in particular?

And fourth, what should Congress do to most effectively help the Baby Boom population achieve financial security in old age; especially when it comes to funding long term care?



I. The Baby Boom in Retirement

The first issue is the financial future awaiting the Baby Boomers. A lot is apparent, even though the first Baby Boomer will not become 65 for another 13 years. Perhaps the most significant trend is the increase in life expectancy. Life expectancy at age 65 has been rising quickly since the late 1960s and there is reason to believe that the life spans of Baby Boomers will be especially long; much longer than the current generation of older people.

There are several reasons to expect longer lives for Baby Boomers: the dramatic increases in medical technology and significant gains in the understanding of the aging process itself, the fact that Baby Boomers had much better care than older generations from the time of conception (in the post World War II era) through infancy and until now, and improvements in lifestlye factors, such as reduced rates of smoking.

Even if these facts are ignored, the trend in life expectancy is clearly up and government life expectancy projections have a track record of considerably underestimating life expectancy increases, with implications for the financial projections that are made about Social Security in particular.

Samuel Preston a leading demographer from the University of Pennsylvania stated that life expectancy in Japan was 79.7 in 1994 but that Social Security assumes we will not reach that figure until 2050, 56 years later than Japan. Many demographers think that Americans will live five years longer than Social Security now assumes.

Long life is a great gift. It is a gift we all want and are grateful to receive. This is the first time in the long history of the human species that most people reach old age and that is a very significant accomplishment that certainly has not received as much notice as justified.

However, unlike other gifts, the gift of long life has a financial cost, and for the Baby Boomers the financial cost will be high indeed. There are many reasons for this.

First, longer life has already significantly lengthened the retirement period. Currently, it is not unusual for a person to be retired for over 30 years. Even if the average age of retirement goes up, and there are many reasons to expect that it will not go up much, it will be difficult for the average age of retirement to go up faster than life expectancy at age 60 or 65. And each year of life has very significant cost, even if lived in good health.

Second, as life expectancy increases, more people live into the high incidence years for needing nursing care. The need for nursing care goes up significantly after age 85, and many more of us will reach that age. Further, although we are making great progress in dealing with the killers of older people, such as cancer, heart attack and stroke, we are making far less progress against some of the cripplers of older people, such as Alzheimer's, osteoporosis and arthritis, which put people into nursing homes. There are reasons to expect that the gap between the onset of ill health and the time of death will widen, meaning that the need for nursing care and the term in nursing homes may rise substantially.

Further, the cost of nursing care is likely to rise especially fast. As we all know, the huge size of the Baby Boom population will push up the overall need for nursing care no matter what. But what is less focused on is that if the laws of supply and demand continue in force, as they have for centuries, the cost of nursing home care will be pushed up because the huge numbers of Boomers, especially as they succeed the much smaller population just before them, will represent an enormous increase in demand for these services.

Currently, a great deal of nursing care is provided free of charge by the grown children of the elderly, especially daughters. But the Baby Boomers are not likely to be as fortunate. They have fewer children: remember they produced a Baby Bust, not Boom, and record numbers of Boomers have no children at all. Further, more daughters are working and unavailable to assist. And the geographic distance between grown children and their parents has widened. Fewer grown children live in the same neighborhood as their elderly parents. I conducted a study of long-distance care-giving for the Pew Foundation and discovered that even people who live in the same metropolitan area as their frail parents often cannot take adequate care of them if it takes more than 30 minutes to reach these parents. Many frail elderly need daily care and few working people have the energy and ability to commute an extra one hour each day to help a parent in need (that is 30 minutes of travel each way).

As less long term care is provided free of charge, more will be provided at a cost. And the cost for Baby Boomers will be very high.

The third reason why the gift of long life will carry a very expensive price tag is the tremendous advances in medical technology that will clearly continue, if not accelerate.

Right now hip and knee replacements are commonplace. So are replacements of heart valves, eye lenses and other parts. But scientists are perfecting many other replaceable parts, including combining natural cells with artificial materials to make replacement organs. Human parts tend to wear out with age. When they do wear out, people will want replacements, if available. If

you lost your eyesight and could get it restored, would you want to? The cost of replacement parts is a cost that will be staggering for our society when the Baby Boomers age; it will be a cost there will be great pressure to pay.

I wish to make two further points about the cost of longer life expectancy for the Baby Boomers. The first point is that the Baby Boomers have significantly higher life style needs than prior generations. Today, most retirees lived through at least most of the Great Depression. They remember privation, doing with less and sacrifice. Just about all retirees clearly remember World War II and gas rationing, meat rationing and victory gardens. The current generation of retirees can do with less. I recently completed a series of focus groups for MetLife among middle-class retirees. Their average age is 68. Almost all are homeowners. All made a good living; they were teachers, store owners, government managers, chemists, television cameramen and others. None had long periods of unemployment; all had good jobs.

Since retiring, almost all have cut back on their life style. They eat out less, travel less, buy fewer clothes. Most feel they will have to cutback more in their lifestyle in the future. They feel they can do with less, feel perfectly comfortable with that, are resigned to that.

After hundreds of focus groups with Baby Boomers and surveying thousands of Baby Boomers I can assure you that Boomers will not be as easily resigned to a very diminished lifestyle at the end of their lives, They will not be as accepting of second-class health care or third-class nursing care as the current generation of retirees.

The other point I wish to make is one I am sure you are well aware of, so I will make just a brief comment. It will be just about impossible for government programs to expand to pay for increased Baby Boomer needs in retirement. Right now the Social Security system takes in far more than it pays out, significantly reducing the need for government borrowing. Soon after the Boomers start retiring, the Social Security system will have to pay out first more and then a great deal more than it takes in. This will put an enormous burden on other government programs. The Medicare program is projected to be bankrupt far before the first Boomer is eligible for benefits. The rising, ever more sophisticated, ever more expensive, medical technologies will put an even greater strain on the system.

Furthermore, the Boomer population is of such disproportionate size, compared to other generations, that its impact on entitlement programs will also be disproportionate. Overall, entitlement programs will be under great strain to even attempt to keep cut-backs in protection modest. This makes it essential to help the Boomers themselves pre-fund.

II. Organizing Finances in Retirement

The second major issue I would like to address is the financial problems that retirees inevitably have, why these problems are especially serious and what can be done about them.

Retirement is a time of maximum financial uncertainty, compounded by the fact that most retirees cannot recover from a financial set back or miscalculation. A working person can work overtime, seek a second job, invest more aggressively, or put off retirement if he or she makes a financial miscalculation. For most retirees, there is no chance to earn more money and investing more aggressively can be dangerous.

To illustrate the uncertainty inherent in retirement, I would like you to imagine a married couple both age 65 retiring today. Let's imagine they are attending this hearing as their last work responsibility and will then go home to start their retirement. It is possible that they will get into an automobile accident on their way home and both die. It is also possible that they will each live to age 105. Thus their combined life expectancy (and I use combined life expectancy because a married couple's finances are, of course, combined) can range from two hours (if they both die on their way home today) or 80 years, if they both live to the age of 105. The difference in cost of funding two hours or eighty years of life is, to understate it, huge. But people are stuck with this uncertainty because they cannot predict how long they will live.

This couple has equal uncertainty in the area of needing long term care. It is possible that neither will need long term care. It is also possible that both will develop Alzheimer's' and each spend eight years in a nursing home. Thus, the possible cost of their nursing care ranges from zero to over one million dollars. And they cannot accurately predict what it will be.

The cost of medication for older people is very high. Again the cost for this illustrative couple can range from zero to an astronomical amount.

In other areas the uncertainty is just as large, especially in the area of health care costs.

A number of financial planners have stated that a person retiring today needs one million dollars. That statement reminds me of a Dilbert comic strip. In the first panel a researcher is standing before a business group and states that he did a survey of 1,000 people and the average respondent had an income of $25,690. In the next panel a member of the audience asks how many of the respondents actually had an income of $25,690. Of course the answer could be none. The odds of any retiree needing one million dollars is very low. Many

retirees will need far less for a life time of financial security, but some will need far more.

The problem a couple retiring today has is that they have to answer three key questions if they want to know how they should organize their finances. They will have to know 1) how long they will live in retirement, with a realistic possible range of two hours to a combined 80 years, 2) if they will need nursing care, with a realistic range of zero to a combined 16 years at a realistic expense of at least one million dollars and 3) what will their combined health and drug costs be, with a realistic range of nothing to well over one million dollars.

The problem with these questions is that they are not answerable by individuals. Those who underestimate how much they will need risk ending their lives in want and deprivation, or in a substandard nursing home. But these questions are answerable through risk protection insurance products.

One other point about this. The risk of miscalculation is predominantly a women's issue. Women are the ones who significantly outlive men. Women are more likely than men to end their lives in poverty. And women are more concerned about the financial uncertainty of old age than men. I clearly recall focus groups I conducted for the American Council of Life Insurance in which fairly affluent women in their 50s talked about being afraid of ending their lives as "bag ladies," sorting through garbage cans and dining on ketchup and warm water.

There are three ways that people can deal with the financial uncertainty of retirement. First, they can save up enough money to meet every exigency. But there are two problems with this. One is that very few can afford this; for most this is not an option. Second, most will not require the maximum amount of money in retirement. Few couples will live to 105 and spend a combined 16 years in a nursing home. Thus, those that save the maximum will be safe and secure, but most will have saved too much and, thus, sacrificed too much.

A second approach is to save less than is necessary to meet every exigency and hope for the best. This is what most do, and it is risky. The risk is ending life in deprivation. Doing research on this subject I have heard plenty of heartbreaking stories. The man who could not afford Christmas presents for his grandchildren and was too embarrassed to attend his children's Christmas parties. The woman I interviewed, in an assignment for the Institute of Medicine, who were in a nursing home that did not have a private place to be examined by a doctor. When a medical examination required them to disrobe they had to do so in front of other people. And there are, of course, problems far worse than those created by people who took the risk of not saving all that was necessary for them.

But there is another way; a much more efficient way that protects people against all of the risks, at a cost affordable for most Baby Boomers. This more efficient way is through the use of insurance products that can give people the money they need for key risks at a fraction of the cost. Thus, rather than having to save up hundreds of thousands to pay for the potential cost of nursing care, a Baby Boomer can buy long term care insurance for a very affordable amount of money and be protected if the need arises. Rather than saving up enough to pay for a life than could last until 105 or more, a person can buy a life annuity and get a guaranteed income for life. Those who do not live that long in a sense subsidize those that do live a long time. But, all who buy a life annuity get a guaranteed income for life.

Most retired people improperly organize their finances. Besides Social Security and a pension, if they have one, they invest conservatively and live on the interest on their principle. This could work with a retirement that lasts five or ten years. But it cannot work with a retirement that lasts 20 or 30 years. Further, there is a great deal of evidence that a primary financial goal of most older people is to be financially independent. Leaving money behind to children is important to most, but of secondary importance. The strategy of trying to live on the interest generated by their savings means that people are very reluctant to spend any of their principal. After all, it is the principal that is producing their income and reducing the principal means that their income will go down. Additionally, since almost no one knows how long they will live, almost no older person knows how long their income must last. Thus, those that follow the strategy of living on the earnings of their principal tend to die with their principal intact and passed on to the next generation. As stated, these estates are not caused by the desire to leave an estate as much as they are the product of not knowing how long one's money must last.

The people who follow this strategy do not use the money they spent a lifetime accumulating on their primary financial goal. They often suffer a good deal of privation to preserve this principal intact.

The key point is to recognize the financial uncertainty inherent in the retirement period and come up with an effective strategy for dealing with this uncertainty. If this is followed, older people will have more financial security and better lifestyles. The reason is they will be using their money more efficiently by engaging in a type of risk sharing that protects all who participate, at a fraction of the cost. Long term care insurance is a good example of this.

There is another reason why this is important. It might be referred to as the de-annuitization of old age. Most people are used to living on a paycheck. They budget from week to week, from fortnight to fortnight or from month to month. And after decades of that, most learn to do this fairly well.

In earlier times, the retirement period was similar. Most people lived primarily off Social Security and if they had a pension it was likely to be a defined benefit plan. Both Social Security and defined benefit plans are basically annuities and act as a paycheck. They provide a "paycheck" on a regular basis that people live off. The same budgeting techniques that people employed when they were employed could be used in retirement.

However, recently, people have been encouraged to take on more financial responsibility for their retirement. Individual Retirement Accounts, 401(k) plans, defined contribution plans and other plans have been developed in response. One result of that is that people are no longer "put on a paycheck" when they retire. Rather, they have access to a sum of money (for the Baby Boomers it will typically be a larger amount of money than they have ever dealt with before) and told to manage that money to last an indeterminate period of time that could be two hours and could be over 40 years. This is a task that requires new skills and strategies. Without that, many will fail.

Developing retirement financing vehicles, such as IRAs and 401(k)s was a wonderful idea that has worked; these vehicles have encouraged people to prepare financially for retirement. But the implications of providing many people with a large sum of money that must be managed must also be thought through.

In no area is the risk sharing strategy more important than in preparing for long term care needs. The incidence of needing long term care is high, and for the Baby Boomers there is reason to expect it to get higher. The cost can be staggering to those who do not prepare properly and reasonable to people who do.

Most older people cannot afford a long stay in a nursing home. But almost all Baby Boomers can afford the cost of long term care insurance that will enable them to afford a long nursing home stay. My company, along with the Employee Benefit Research Institute and the American Savings Education Council, organize an annual survey of Americans, called the Retirement Confidence Survey. In 1995 we asked a representative sample of 1,000 Americans in the Retirement Confidence Survey what they would have to give up to. Less than 10 percent said they were unable to cut-back. What they would cut-back on was interesting. Eating out less topped the list. Second, was getting less expensive food at the supermarket (and I am willing to bet the food they would buy would be better nutritionally). Third was going out less. A few said they would have to give up cable television. Twenty-five dollars a week is sufficient to buy a good long term care insurance policy with infliction protection for even the oldest Baby Boomer couple, and the price goes down significantly for those younger.

Thus it is clear that almost all Baby Boomers can provide for their long term care needs, at little sacrifice, if they choose an efficient means for doing so.

III. The Public Works Through Long Term Care and Retirement Issues

I now want to address the third issue on my list, what are people's viewpoints on these issues at this point. For this purpose I will depend upon the Longevity and Retirement Survey, a study my company conducted in 1997 for the American Council of Life Insurance. A representative sample of 1,000 Americans, ages 42 and over were interviewed by telephone for this study. A complete report of the survey is available from the American Council of Life Insurance, in Washington, D.C.

Based on the Longevity and Retirement Survey I feel that people's viewpoints can be summarized by four key words: Awareness, Concern, Denial and Desire for Self-Responsibility. I will address each in turn.

Awareness

In the area of awareness, Americans ages 42 and over have a good sense of the longevity they are likely to achieve. Almost two out of three people (61%) we surveyed feel it is at least somewhat likely that they will live to age 80 and almost half (44%) feel it is at least somewhat likely that they will live to age 85. A quarter believe it is at least somewhat likely that they will reach age 90 and 15% feel it is at least somewhat likely that they will reach age 95. Women are more likely than men to think they will live into their 80s.

There is also awareness of the need to predict future situations in order to determine how much money to accumulate for retirement. For example, 77% feel it is very important and 17% somewhat important to predict general health in retirement to determine how much money to save for retirement. Fifty-nine percent think it is very important and 30% somewhat important to know how many years you will spend in retirement. Finally, 53% feel it is very important and 35% somewhat important to predict if you will need nursing care.

But there is also awareness and realism that these things are difficult to predict. Indeed, more than four in five (82%) agree "It is difficult to know how much money to save when you don't know how long you will live."

Further, people have given a good deal of thought to how to support a potentially long retirement. Among the youngest people in this survey, the Baby Boomers born in 1946 to 1955, 41% have given a great deal of thought to how

they will support themselves if they live a long time in retirement and 39% have given this some thought.

Concerns

This thought may be why there are high levels of concern about many aspects of retirement. Two-thirds of the working people surveyed are extremely or very concerned about cutbacks in Social Security and Medicare, 54% are extremely or very concerned about having to pay for nursing care for self or spouse and just about half (49%) are extremely or very concerned about outliving their resources.

Denial

Even with these concerns most non-retired Americans ages 42 and over have a fairly rosy view of their future in retirement. Most think they will remain independent and active when they retire; indeed, only one in eight feel it is very likely that they or their spouses "will require nursing care"(12%) or "will require assistance with everyday activities such as bathing, getting dressed and getting out of bed (11%)." Actually, we know that many more than that will need long term care. Almost two in five of the Baby Boomers in our sample say it is very likely that they will work during their retirement. But if the experience of the retired of today is any indication, this is wishful thinking. Indeed, it is extremely likely that even the age that Baby Boomers predict they will retire is wishful thinking.

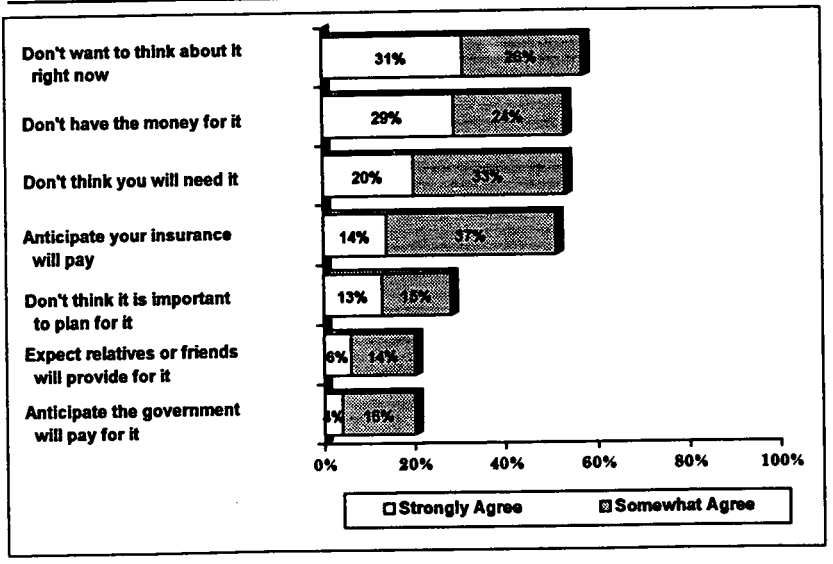
Among the non-retired people in our survey, 16% plan to retire before age 60, 27% plan to retire between 60 and 64, 30% plan to retire from 65 to 69 and 8% plan to retire at age 70 or after. Eight percent do not plan to retire and 11% could not answer the question. The average age planned for retirement is 62. We examined the planned retirement ages of those who expect to live into their late 80s and 90s with those who expect to live a shorter time. Interestingly there are no real differences. This means that expectations of living longer do not translate into expectations of working longer. These two things - long life and age of retirement - are disconnected in Americans' minds. But this is wishful thinking at best and denial at worst. Because if the age of retirement does not go up, and there are reasons to think it will not, then retirement becomes longer (and more costly) and thus requires more accumulation to fund it. We have evidence that Americans have yet to think this through.

There is another often overlooked problem probably awaiting the Baby Boom generation as they prepare for retirement. Forty-one percent of the retired people in our survey state that they retired before they planned. This confirms

the findings of other surveys, including the Retirement Confidence Survey. The most frequent reason for retiring before one planned is poor health and disability. Plant closing and downsizing are other frequent reasons. This likelihood of retiring before one planned is important because many people delay preparing financially for retirement until the time of retirement looms. Retiring early means significantly curtailing the preparation period. We know that people who retire before they planned are likely to be in financial hardship during retirement.

Only 9% of the older Baby Boomers, now ages 43 to 52 have thought a great deal about preparing financially for the possibility of needing nursing care. (Of course not all of these have taken any action.) We asked those who have not thought a great deal about preparing financially for the possibility of nursing care costs why not. The four main reasons, given by hale the Boomers: 1) don't want to think about it right now, 2) don't have the money for it, 3) don't think will need it, and 4) anticipate insurance will pay for it,.

Reasons for Not Preparing for Nursing Care Needs -- Baby Boomers



Some of these reasons are likely misconceptions or wishful thinking. Health insurance does not pay for nursing care, yet many who have health insurance think it will cover nursing care expenses. Similarly, many believe Medicare covers nursing care, but Medicare does not cover most nursing care,

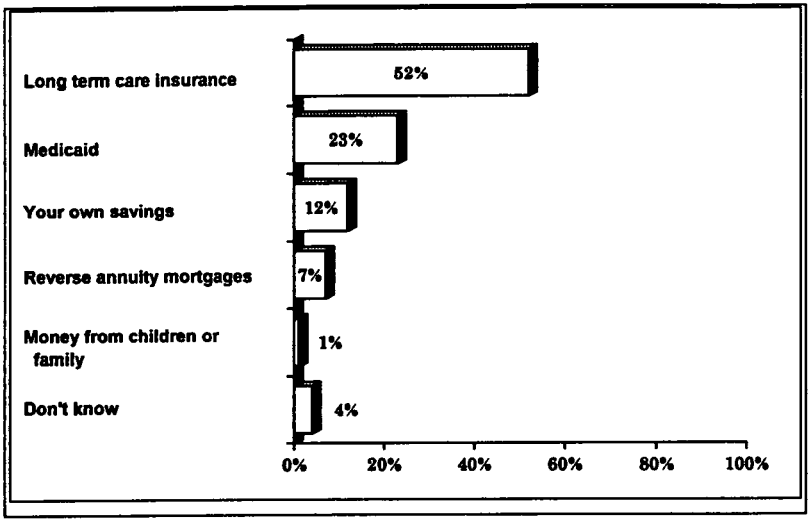
although it does cover some. Those who feel they do not have the money for it most often can afford it. As for those who do not want to think about it now, this is a problem that must be addressed. The sooner Baby Boomers start preparing for the possibility of nursing care costs, the less expensive it will be for them, the better the care they will receive and the lower the costs that society will have to endure (probably through the Medicaid system).

Currently, many Baby Boomers are not familiar with long term care insurance. Indeed, even among Baby Boomers there is less familiarity with long term care insurance as an option for paying for long term care than there is with Medicaid as a way of paying for long term care.

DESIRE FOR SELF-RESPONSIBILITY

However, for most people, especially the Baby Boomers, long term care insurance is the most desirable option for paying for nursing care. Among Baby Boomers, twice as many people feel long term care insurance is the best way to pay for nursing care than feel this way about Medicaid, which is next most chosen as the best option. Four times as many Boomers feel long term care insurance is the best way to pay for nursing care than feel this way about using savings.

Most Desirable Options for Paying the Cost of Nursing Care -- Baby Boomers



What does this all mean? I think it means that people in general, and Baby Boomers especially, are working through the problem of how to deal with finances in retirement and the risks and uncertainties in the retirement period. There is a natural tendency to put these considerations off, because they are complex and because some of the problems that often beset people in old age, such as disability, ill-health and of course the uncertain timing of death, are unpleasant and therefore hard to think about.

The central issue remains the increasing cost of the retirement period, especially for the Baby Boomers, and the increasing cost of a large retired population for our society, especially as the Baby Boom increases the proportion of all Americans who are retired. Because of these cost pressures, it is useful to have more efficient ways for Americans to use the money they have accumulated. But this requires a different way of thinking about retirement finances and the use of different financial strategies for dealing with the uncertainties intrinsic to the retirement period.

This brings me to suggestions for Congress. A key issue is the tremendous financial strain that the gift of longer life will create. The impact of the aging Baby Boom on Social Security and Medicare is clear. As government

tries to assure the financial security of these programs it must help people find the most efficient ways to use their resources to protect themselves financially against the uncertainties they will encounter in retirement. There are four steps that I feel will most effectively do that:

1. Educate people, especially Baby Boomers, about the uncertainties they will face in retiremen, and the financial strategies, especially that can help them most effectively deal with the financial aspects of these uncertainties.

2. Develop new tax policy that encourages people to prepare early for retirement through the most effective vehicles that are affordable for most people. In the area of preparing for possible nursing care needs, long term care insurance is the most effective approach, it is affordable by most people and is the approach that people find most desirable.

3. Further encourage employers to offer employees long term care insurance and education and information on other risk protection vehicles and approaches.

The CHAIRMAN. I perceive from the mail that I get about this type of insurance that the industry is spending more of their time trying to sell the insurance to those that are in their 60's or close to retirement than they are to the people that you named. I think your group was age——

Mr. GREENWALD. Forty-two and over.

The CHAIRMAN [continuing]. 42 to 50, is that right?

Mr. GREENWALD. Yes. I think that is true.

The CHAIRMAN. I will start my questioning with Lynda. First of all, I think you ought to be thanked not only for sharing your family experiences for us but for the demonstration of love that you have shown in your commitment to your mother and your mother in turn for father. It should not go unsaid, and it has been said by the other two panelists here, that family caregivers play a very vital role in our health care system. Three-fourths of it is by people outside of nursing homes, probably most often by relatives like you are.

It is the goal of our hearing today to raise public awareness about the risk of long-term care needs, so my question is, what do you think can be done to better inform the public about the financial risk associated with long-term care, either your general opinion or what you have learned from just your experience in your family?

Ms. GORMUS. I think one of the best ways to educate the public is with those of us who have been through the situations. I found when I worked the Helpline at the Alzheimer's office, that once people find out that you have personally dealt with something, they are much more willing to listen to what you have to say.

So I think if, somehow, folks can get beyond their personal pride and just say it like it is and let people know that it has been tough and that they need to look at their own situations a lot sooner than they probably are and make them aware from our personal experiences what it is all about, then perhaps that will begin to help the public take a look at things a whole lot sooner than they do.

The CHAIRMAN. Thank you for that experience.

Dr. Scanlon, without a doubt, I think we have had the point pretty well made here that public programs are not going to be able to sustain the added long-term costs associated with the retirement of the baby boomers. Based on your testimony, we can expect an increase between two and four times the current number of individuals needing long-term care when baby boomers retire. What is the likelihood that the current public programs can sustain the costs associated with increased demand for long-term care services?

Mr. SCANLON. I would hate to say that it is impossible, but the challenge is really, as one envisions it, overwhelming. When you think about the numbers of people increasing to two to four times the current level, that is a huge increase by itself, but we also need to deal with the reality of the costs of services per individual in the future. The fact is that as we talked about the diminishing social resources, we are going to be providing more formal paid care and the cost per individual is likely to grow.

One of the challenges the public programs face is to try and find the most efficient way to deliver long-term care. As we have heard today, there is much less reliance on nursing homes than there was in the past. We are starting to understand that home care, com-

plemented by family care, can provide adequate services to many individuals. We need to find out more about that, as well as to find out more about the use of alternative residential settings that may be very efficient in terms of serving the needs of some at lower cost than nursing homes.

I know that when the challenge occurs, that we will come through in terms of meeting the challenge, but it is hard to imagine how we are going to do it, given the magnitude of it.

The CHAIRMAN. To what extent does longevity by itself affect the projected long-term care expenditures?

Mr. SCANLON. Longevity probably by itself could account for the lower sort of estimate of twice as many individuals needing long-term care. Even with some improvements in the health status of individuals, there are going to be so many individuals that are over 65, and even more important, over 85, in the period 2030 and beyond that we can expect at least twice as many people needing long-term care.

The CHAIRMAN. Both you, Dr. Scanlon, and Dr. Greenwald suggested that long-term care of family caregivers is likely to decrease for baby boomers compared to the level provided by today's family caregivers. In other words, things like Lynda and her family are doing, for the next generation, there is going to be less of that.

So I would like to have both of you—well, first of all, Mr. Scanlon, you said in your statement that as much as 65 percent of the disabled elderly living in the community rely on unpaid family and friends for their care, and since baby boomers have fewer children and particularly because they are not living so close, one generation geographically close to the other generation, that is another problem.

With this in mind, are you able to make some sort of a guesstimate of how much this might increase the demand for public services and what does this mean for the role of the family caregiver? I would ask both Dr. Greenwald and Dr. Scanlon that.

Mr. SCANLON. As you can tell from our statement, we have shied away from being very precise in forecasting the future, in part because the delivery of long-term care is changing so dramatically. While we can expect that there will not be the family members, it will not be a question of willingness but it is a question of availability, I think, primarily in terms of family members able to provide care.

We are also experiencing at this time changes in the nature of services that are being provided to persons needing long-term care. We have more home care. We also have more care, as I indicated, in alternative residential settings. Those things can dramatically affect the burden on public programs.

If we looked in 1985 forward to 1995 and made a projection about the number of nursing home beds that we would need to serve people needing long-term care, we would have been 10 percent off. We have 10 percent fewer people in nursing homes today than we thought we would have in 1985. Where we are going to be in 2005 or 2015 is hard to know, given the dynamics of the way in which we deliver services.

The CHAIRMAN. Dr. Greenwald.

Mr. GREENWALD. I think it is clear that the incidence of needing long-term care will go up because as people live longer, they enter the high incidence years for needing long-term care. For example, Alzheimer's rates go up significantly past 85 and more and more people will live to 85.

Second, as older and older people need care, their children are also older. It is one thing to ask a 40-year-old to take care of a 70-year-old. It is another thing to ask a 70-year-old to take care of a 100-year-old, but that is where we will be.

Caregiving is hard. We did a survey for the National Association of Caregivers funded by the Equitable Foundation that found that over half of caregivers are spending over 11 hours a week providing care. That is going to be harder in the future as geographically diverse as people will be.

So the population will be older. I think there will be more people needing care. I think unpaid care will be far less likely. The goal of public policy, I think, is to encourage as much self-care as possible, and with the pressures on Medicare and Social Security I do not think there will be any choice. So we do not want to lose what we have in terms of unpaid care, but we are going to lose a lot of it anyway.

The other thing is, if the laws of supply and demand stay in force as they have for the past 500 years or so, the demand for nursing care services should raise the cost significantly for the boomers. So they are not only facing higher incidence but I think the cost will go up from the $40,000 it is now.

The CHAIRMAN. Did you have something you wanted to add, because if you did, I do not want to cut you out of responding to our questions, as well.

Ms. GORMUS. No. I was just sitting here thinking about my husband's grandmother, who will be 106 in August and is now in a nursing home. She has been there since a year ago last December 5 because her 64-year-old baby passed away with cancer and she was the caregiver for her. So people do live a long time sometimes.

The CHAIRMAN. Senator Enzi.

Senator ENZI. Thank you, Mr. Chairman.

I have got to say, of all the committees that I sit on, this one is always the most unsettling. I mean, I know I am aging even while I sit here. [Laughter.]

I think we could have called this "lowering the boom on the baby boomers," really. It is creating some awareness out there that is drastically needed. The baby boomers have been paying into this system for their whole lives and they really think that since it has provided fairly adequately for those who have gone before that it will also provide for them, and what we are hearing is that it will not. It is not just those young folks that are just coming into the system. It is the baby boomers, the heart and backbone of the whole payment system through all of these years. So I appreciate all three of you helping to bring this to light and I want to ask a couple of questions.

Ms. Gormus, I really appreciate your taking the time and relating the experiences that you have had. There is a lot to be learned from that and I am going to encourage all the members of the committee to be looking at all of the testimony that is being presented.

today. But have you considered or would you encourage others to consider the long-term care insurance? Is that a way to go? What are your feelings on that?

Ms. GORMUS. Yes. I have recently checked with someone that I know who sells that and just asked her to give me some figures on that. I really do not see that the public funds are going to be able to substantially take care of the needs of the population. I think for those of us who are used to paying our way, it is kind of difficult and painful to have to go onto what we consider public assistance. Even though Dad put into it for years, if he had known that he would have to accept funding from the government, I think that would have just devastated him. So I think long-term care insurance is a very good possibility for seeing that we can take care of ourselves financially.

Senator ENZI. Has that ever actually been presented in any kind of a presentation as a viable alternative? Has anybody come forward to talk to you about that kind of insurance?

Ms. GORMUS. Yes. I am a member of the Optimists Club and we had as one of our speakers long-term care insurance. The woman who presented, I would say is in her early 50s, and her husband passed away from dementia after several years. They had been financially devastated because of his illness, and she knew firsthand what the needs were. So to hear it from, as I said, somebody who has been there, it really makes a difference and an impact as to its importance.

Senator ENZI. That is truly the only way to get it out, I think, when it is personal experiences to people that you trust.

Dr. Scanlon, when we did the Balanced Budget Act, we put some provisions in to help control the rapid increase in health care expenditures. Some things were things like prospective payment system and provisions to combat fraud and abuse. Do you think that these modifications to Medicare's coverage of home health care services will help to solve any of the problem or is that just a small stretch on a big problem?

Mr. SCANLON. I think there are two different problems that we need to consider. One is the issue of costs in the Medicare program, and with prospective payment, one can easily bring costs under better control.

However, I think that the more important issue with respect to long-term care is to identify what we wish to purchase in the way of home care services and to ensure that the system is going to encourage their delivery.

One of the challenges that the Health Care Financing Administration faces over the next year is to design this prospective payment system for home health. Our provision of home care, while growing, is not really well understood in terms of the impact that it has on the beneficiaries receiving it and what level of investment we wish to make. So it is that second problem that I think that we really have to try to address over the next year.

Senator ENZI. Thank you.

Dr. Greenwald, you mentioned this wide spread, the two hours to 80 years. Can we have confidence in the stability of the companies that are selling long-term care insurance in light of that wide range? Is there any actuarial experience?

Mr. GREENWALD. Well, I think so. I think that the insurance companies that sell this product are regulated and have, I think, a great track record, including through the great depression, which was difficult for all financial institutions.

But to some extent, having a baby boom that will live a long time requires a massive amount of investment to pay for 30 or 40 years of living without earning money. To handle these investments we must, depend upon financial institutions. I think part of the solution is to change the viewpoint of financial preparation for retirement being an accumulation issue, because with people living this much longer, accumulation alone will not work. We must transform it to a risk management issue.

If we do that, not only with long-term care insurance but with life annuities, with systems where people can design their own plans, depending upon their other resources, the people who do not live a long time or who do not need care, will in a sense pay for the people who do live longer and will deliver that money most efficiently. That is, I think, the way out.

So I think the financial institutions have proven their viability for an extended period of time, and if we just teach people to choose the right risk management strategies, then I think we can, help the baby boom meet the financial risks and costs they will face in retirement. We just have to think through what longer life means. Most of what it means is great. All we have to do is pay for it.

Senator ENZI. Thank you, and my time is expired.

The CHAIRMAN. I am going to quit with one more question to Dr. Greenwald and then I will call the next panel. This is the fact that you brought up, well, maybe each panelist did, about women living longer than men and they are at a greater risk of living in poverty if they are financially unprepared for long term. In your work, do you find that women are aware of the added risks that they face due to the fact that they are expected to live longer?

Mr. GREENWALD. Yes. Interestingly, women were much more likely than men to think they will live into their 80's but not more likely to think they will live into their 90's. Women expressed a great deal more concern without living resources and a great deal more interest in all the different financial vehicles and education that might help them. So I think they are more aware and more concerned and, in some ways, more fearful.

The CHAIRMAN. Thank you. I am just going to say thank you once again for taking time out of your busy schedule to come and testify and to answer our questions and your contribution to the legislative process. I appreciate it very much.

Ms. GORMUS. Thank you.

Mr. SCANLON. Thank you very much.

Mr. GREENWALD. Thank you.

The CHAIRMAN. Thank you.

I would like to now call our second panel, and again, would you come as I am calling your names, or all of you can come right now. This panel will discuss the importance of private financing of long-term care. Private long-term care insurance is one way by which a growing number of Americans prepare for and finance their long-term care. This panel of witnesses will provide a review of private

long-term care insurance and address its significance to public programs.

First is Sam Morgante. He is Vice President of Product Development and Government Relations for GE Capital Assurance Long-Term Care Division. Mr. Morgante is currently Chairman of the Long-Term Care Committee of the Health Insurance Association of America. He is an expert in the area of private long-term care and we are pleased to have his participation in this meeting.

Next we have two people representing the American Council for Life Insurance, Dr. Janemarie Mulvey and Dr. Barbara Stucki. They are coauthors of a new study projecting the impact of long-term care needs of the baby boomers and the Medicaid program. Dr. Mulvey is Director of Economic Research at her association and her areas of expertise include taxation and retirement security issues. Dr. Stucki is a senior policy analyst for the Council and she specializes in long-term care issues, and prior to joining the ACLI, Dr. Stucki was a policy analyst for the American Association of Retired Persons, where she worked on long-term care issues.

Following their testimony, we will hear from Dr. Joshua Wiener. He is a principal research associate in health policy at the Urban Institute. His areas of expertise are Medicaid, health care for the elderly, and long-term care. He has more than 25 years' experience as a health care researcher and government official.

Mr. Morgante, would you start, please?

SAMUEL MORGANTE, VICE PRESIDENT, PRODUCT DEVELOPMENT AND GOVERNMENT RELATIONS, GE CAPITAL ASSURANCE COMPANY, AND CHAIR, HEALTH INSURANCE ASSOCIATION OF AMERICA LONG-TERM CARE COMMITTEE, SAN RAFAEL, CA

Mr. MORGANTE. Thank you, Mr. Chairman. Good afternoon. I am Sam Morgante. I am Chairman of the Long-Term Care Committee of the Health Insurance Association of America. HIAA's 250 member companies provide health, long-term care, and disability coverage to more than 65 million Americans. I am also Vice President of Product Development and Government Relations for GE Capital Assurance Company. On behalf of HIAA, I appreciate the opportunity to talk to you today about our role in helping baby boomers plan for their future retirement and long-term care needs.

Today's baby boomers face a looming crisis in their retirement years, the need for and lack of adequate planning for long-term care. While the current system is flawed, financing of long-term care is complicated and requires a thoughtful solution. Fiscal realities and national priorities make it imperative that individuals, policy makers, employers, and insurers play a vital role in solving our nation's long-term care dilemma.

Long-term care is the single major catastrophic health care expense faced by the elderly today and will definitely remain so for our retiring baby boomers. As we have heard previously, with average nursing home costs of around $41,000 annually and increasing to about $100,000 in 1996 dollars by the year 2030, such expenses can indeed cause financial ruin. Instead of pooling risks, the current system places each household on its own, and when household

resources have been depleted, Medicaid becomes the payer of last resort.

The financial well-being of the retiring baby boomers is cause for great concern. The first reason is sheer volume. The number of elderly people, defined as those of 65, is expected to double, from 35 million to 70 million, by 2030, when the last of the baby boomers retire.

Second, the future financial status of social support programs, such as Social Security, Medicare, and Medicaid, cannot be expected to sustain the retirement and long-term care demands of the baby boomers.

Finally and most importantly, although many baby boomers may have saved enough for their own retirement, it is clear that they have not yet sufficiently prepared for their future long-term care needs.

There is a critical role for private insurance to provide a better means for financing long-term care for the vast majority of Americans who can afford to protect themselves. The long-term care insurance market is growing and the products that are available today are affordable and of high quality. These policies have changed dramatically since they were first introduced. Today, they provide extended benefits and cover virtually all sites and types of long-term care, including nursing homes, assisted living facilities, adult day care, respite care, hospice, and home health care.

By December 31, 1996, close to 5 million long-term care insurance policies had been sold. The market grew at an annual rate of 22 percent in the period from 1997 through 1996 [sic]. By the end of 1996, approximately 80 percent of the 4.96 million long-term care insurance policies sold had been marketed in the individual market.

The employer-sponsored market has enhanced this growth by contributing about 14 percent of all policies sold. Today, more than 650,000 policies have been sold through over 1,500 employers. The growth in the employer-sponsored plans is particularly promising. These employer plans offer the opportunity to reach a large number of people efficiently during their working years, when premiums are more affordable. Enrollment experience shows that the average age of the employee electing this coverage is 43.

There is strong evidence that with education and availability, younger people can and will purchase long-term care protection. Major incentives for the purchase of long-term care insurance were included in the passage of the Health Insurance Portability and Accountability Act of 1996. HIPAA's provisions have improved the climate for private long-term care insurance. Nonetheless, HIPAA is not a panacea and will not by itself achieve the optimum public-private partnership for long-term care financing.

HIAA believes other equally important tax-related changes could make long-term care insurance more affordable to a greater number of people. Some examples of these actions that could be taken are part of our written testimony, and in summary, these are to enhance the deduction for long-term care insurance premium such that premium dollars are not subject to a percentage of income; to permit the tax-free use of IRA and 401(k) funds for purchases of long-term care insurance; to permit premiums to be paid through

cafeteria plans and flexible spending accounts; and to encourage State tax incentives for the purchase of long-term care insurance.

Finally, the importance of consumer education about financing long-term care cannot be overstated. It is a shared responsibility of both the public and private sectors. Over time, the HIAA believes that private long-term care insurance will give millions of people an opportunity to be financially independent throughout their retirement years. Recognition of the private long-term care insurance market in this hearing is a solid step in this direction.

Thank you, Mr. Chairman. We look forward to working with you to provide further assistance in this area and I will be pleased to answer any questions you might have.

The CHAIRMAN. Normally, I would not ask a question at this point, but it just came to my mind. I was referring to the direct mail that we receive for this type of insurance. I do not notice much advertising for this kind of insurance. Is it a highly advertised product and I am just missing it, or is it not advertised?

Mr. MORGANTE. It has not been advertised as other insurance products. It has been a targeted marketplace towards seniors, and part of the reason of this hearing today is to talk about how this could be more directed towards baby boomers, which is a good question to be asked at this point.

[The prepared statement of Mr. Morgante follows:]

Statement

of the

Heath Insurance Association of America

on

THE IMPORTANCE OF LONG-TERM CARE INSURANCE IN PLANNING THE RETIREMENT OF BABY BOOMERS

Presented by

Samuel Morgante
Chair, HIAA Long-Term Care Committee
Vice President, Product Development & Government Relations
GE Capital Assurance Company

Before the

Senate Special Committee on Aging

of the

UNITED STATES SENATE

March 9, 1998

Good afternoon, Mr. Chairman and Members of the Committee. I am Samuel Morgante, the chairman of the Long-Term Care Committee of the Health Insurance Association of America (HIAA). As the nation's preeminent health insurance trade association, HIAA, based in Washington, D.C., is the industry's most influential advocate for the private, market-based health care system. HIAA's more than 250 member companies provide medical expense and supplemental insurance, as well as long-term care insurance and disability income protection, to more than 65 million Americans. HIAA develops and advocates federal and state policies which would build upon our health care system's quality, affordability, accessibility and responsiveness. I am also Vice President for Product Development and Government Relations of GE Capital Assurance Company.

On behalf of HIAA, I appreciate the opportunity to talk to you today about our role in helping baby boomers plan for their future retirement and long-term care needs. Currently, more than 100 companies provide long-term care insurance to over 5 million people. Quality private insurance coverage is offered through a variety of mechanisms, including individual and employer-sponsored arrangements and riders to life insurance plans.

Let me begin by summarizing the most important points of my testimony:

- Today's baby boomers face a looming crisis in their retirement years – the need for and lack of adequate planning for long-term care. While the current system is flawed, the financing of long-term care is complicated and requires a thoughtful solution, not a rush to judgment.

- Fiscal realities and national priorities make it irresponsible to place the financing burden primarily on the nation's taxpayers. All elements of society – individuals, policymakers, employers, and insurers must play a vital role.

- There is a growing and critical role for private insurance to provide a better means of financing long-term care for the vast majority of Americans who can afford to protect themselves. Continued growth of the market will alleviate reliance on scarce public dollars, enhance choice of long-term care services for those who may need them in the future and promote quality among providers of long-term care.

- The long-term care insurance market is growing and the products that are available today are affordable and of high quality.

- There is a continued role that the government can play in financing long-term care for those without adequate resources to protect themselves.

- There continues to be a critical government role, independent of financing care – in education and research – to further our collective knowledge about who needs long-term care, what services should be provided and what the total costs to society will be.

To address these concerns, HIAA believes the following steps must be taken:

1. Encourage personal responsibility for financing long-term care through the expansion of the private long-term care insurance market;

2. Educate the public and policymakers about the risks and costs of long-term care. Without understanding the problem, the public cannot be expected to understand the appropriate solutions. It is critically important for the public and private sectors to do more in this area.

3. Improve the government's ability to target assistance to those most in need. The government must take full responsibility for providing care to those without the resources to do so.

4. Stimulate the private insurance market through enhancement of the tax status of long-term care insurance.

5. Encourage the delivery of adequate reimbursement for quality long-term care services; and

6. Support research and demonstrations related to the need for long-term care services and private and public sector partnerships in paying for long-term care.

This hearing is a very positive first step in accomplishing these objectives. The public and private sectors must take the time to make the necessary investment today in designing a financing arrangement that our elderly can live with today, our future retirees can live with tomorrow and our children can depend on in the next generation. Long-term care is an especially critical issue that today's baby-boomers face. We commend the Committee for bringing this issue to the forefront and recognizing the important role that the private long-term care insurance market can play in solving our nation's long-term care dilemma.

Nature of the Problem

When we speak of "long-term care," we are describing a wide range of health and personal care services provided to individuals who have lost some or all capacity to function independently due to a chronic illness or condition and who are expected to require these services for an extended period of time. About 70 percent of the non-institutionalized elderly with long-term care needs receive all their help from family members and friends. However, 30 percent receive additional paid home care services and about 40 percent of all elderly will spend some time in a nursing home.

Long-term care is the major catastrophic health care expense faced by the elderly today and will definitely remain so for our retiring baby boomers. For the elderly who have out-of-pocket health care expenses of over $2,000 a year, an average of 80 percent is spent on nursing home care. With annual nursing home costs averaging $41,000 (increasing to about $100,000 in 1996 dollars by 2030), and easily double that amount in high cost areas, such expenses can indeed cause financial ruin. Instead of pooling risks, the current system places

each household on its own and when household resources have been depleted, Medicaid becomes the payer of last resort. This approach combining out-of-pocket outlays and welfare features remediation and relief when prevention and planning should be the preferable approaches.

Today's situation, a population of approximately 8 million people, increasing to about 13 million in 2030, needing long-term care services and lack of preparation for this catastrophic event; calls for a thoughtful and deliberate approach. Today is not a time to consider a quick plunge into national broader solutions that fail to recognize how these financing and delivery issues affect costs and access to long-term care. HIAA supports a comprehensive approach to financing long-term care that utilizes the inherent strengths of both the private and public sectors in a more efficient and equitable manner than the essentially unintended system created today.

The Long-Term Care Dilemma for Baby Boomers

The baby boomers, roughly 76 million people born from 1946 through1964, have demonstrated an increased awareness of health care, social and financial issues at every stage of their lives. They put pressure on the school system during the 1950s and 60s. Their adolescence and entry into the workforce have slowed increases in the growth of wages in the 1970s and 80s. They became the "sandwich generation" when their parents aged and they began having children in the 1980s and 90s. When they retire in the 21st century, their huge numbers certainly will create a surge in the concern for adequate retirement and long-term care savings. And, as they become the "older elderly," most of them will experience chronic illness and need long-term care and the call for choice and

quality long-term care services will be heightened. All these factors will increase the need for a solution to the nation's long-term care dilemma, which will likely be the most critical issue for the nation.

The financial well being of the retiring baby-boomers is cause for great concern. This concern is mainly due to three factors. The first factor is their sheer volume. The number of elderly people is expected to double from 35 million to 70 million by 2030, when the last of the baby boomers retire. When this happens, one in five Americans will be aged 65 or over. In addition, these elderly will have longer life expectancies and our society will witness the largest proportion of older elderly, those aged 85 and over. Secondly, the future financial status of social support programs, Social Security, Medicare and Medicaid, cannot be expected to sustain the retirement and long-term care demands of the baby boomers. Finally and most importantly, although many baby boomers are viewed to have saved enough for their retirement, it is clear that they have not yet sufficiently prepared financially for their future long-term care needs. The long-term care burden cannot be expected to remain in the hands of individuals, through out-of-pocket payments, depletion of retirement savings, and reliance on government programs.

The Private Long-Term Care Insurance Market Today

The insurance industry is justifiably proud of the role it has played in the evolution of the largest private insurance system in the world. Now, we are entering the next logical phase of this evolution. Advances in medical technology and general health are increasing the life span of the elderly, but

they are also increasing the number of people who will need treatment for chronic illness. At the same time, rising income, particularly among the current elderly and future baby boomer retirees, makes insurance against the costs of long-term care more affordable. Long-term care insurance must now be folded into this country's extensive private health insurance system.

The market is developing rapidly, as evidenced by the number of companies developing long-term care insurance products, the number of individuals covered and the variety of products available to the public today. By December 31, 1996, over 100 companies have sold close to 5 million long-term care insurance policies. The number of policies purchased increased by more than 600,000 in 1996 alone, and the market has grown an average of 22 percent between 1987 and 1996. These insurance policies include individual, group association, employer-sponsored and riders to life insurance policies that accelerate the death benefit for long-term care.

The majority of long-term care insurers continue to sell policies in the individual market. As of the end of 1996, approximately 80 percent of the 4.96 million long-term care insurance policies had been sold through the individual and group association markets. However, about one-third of the 1996 long-term care insurance carriers sold policies in either the employer-sponsored or life insurance markets, up from 14 percent in 1988. These two markets also represented 20 percent of all long-term care policies sold as of 1996, up from less than 3 percent in 1988.

Although all three markets experienced growth in 1996, the majority of growth, about 79 percent, can be attributed to the individual and group association

markets. The total premium volume for the individual and group association policies sold in 1996 alone was about $750 million. The employer-sponsored market enhanced this growth by contributing close to 20 percent of the sales in 1996. At the close of 1996, over 650,000 policies had been sold through 1,532 employers. Although the growth in the long-term care life insurance rider market was minimal in 1996, it continues to account for about 7 percent of the entire long-term care insurance market, with over 340,000 policies sold cumulatively as of the end of 1996.

As in previous years, the long-term care insurance market remained highly concentrated among a relatively small number of sellers. Twelve sellers represent approximately 80 percent of all individual and group association policies sold in 1996. HIAA conducted an in-depth look at the top sellers' latest policies and found that insurers offer policies with a wide range of benefit options and design flexibility at moderately priced premiums. Key findings follow:

- All companies offer plans which cover nursing home, home health care, adult day care, respite care and alternate care services. Hospice care was specifically covered by 10 insurers and a separate assisted living facility benefit was offered by 10 of the top sellers.
- Other common benefits include: care coordination or case management services, homemaker or chore services, restoration of benefits, bed reservation reimbursements, medical equipment coverage, spousal discounts, survivorship benefits and caregiver training.
- Benefit eligibility criteria used are deficiency in performing Activities of Daily Living (ADLs) and determination of cognitive impairment.
- All plans are guaranteed renewable, have a 30-day free look period, cover Alzheimer's disease, have a waiver of premium provision, offer unlimited or lifetime nursing home maximum periods.

- Whereas in previous years, most companies used a 6-month preexisting condition limitation, 9 of the 12 sellers now waive their preexisting condition limitation as long as pertinent medical conditions are disclosed at the time of application.
- Age limits for purchasing are also expanding. Companies now offer individual policies to people as young as 18 and as old as 99 years.
- All plans offer the NAIC Model Act and Regulation inflation protection requirement of benefits increasing at an annual 5 percent compounded rate, funded with a level premium.
- All companies offer plans that have a nonforfeiture benefit, with a shortened benefit period or a return of premium, as the most common types.

In addition to examining each top seller's policy provisions and marketing materials, we also reviewed the premiums they offered for their most recent policy. Premiums for long-term care insurance policies varied widely depending on multiple factors, including entry-age of the policyholder and benefit designs chosen. HIAA analysis reveals that the average premiums reported by the leading sellers have been decreasing over time. The average premiums in 1996 decreased an average of 5 percent when compared to the average premiums for the leading sellers in 1995. This is a strong indication that market competition and insurers' increasing confidence with their pricing and anticipated claims experience have kept premiums stable, if not more affordable. In addition, given the tremendous changes in long-term care insurance policy design (i.e., elimination of prior hospitalization requirements, expansion of available benefits, coverage of additional sites and levels of long-term care), buyers are now clearly receiving more benefits for their premium dollar.

The Employer-Sponsored Long-Term Care Insurance Market

The growth in employer-sponsored plans is particularly promising. Employer plans offer the opportunity to reach a large number of people efficiently during their working years when premiums are more affordable. Coverage in the workplace offers the additional advantage of employers selecting the best plan at the best price for their employees. Enrollment experience shows that the average age of the employee electing this coverage is 43. This is strong evidence that with education and availability, younger people can and will purchase long-term care protection. Most of these plans offer coverage to the elderly as well by including retired employees and their spouses and parents of the employee or employee's spouse.

By the end of 1996, 1,532 employers were offering a long-term care insurance plan to their employees and retirees. There were over 500 employer-sponsored plans introduced in 1995 and 1996. Most of these plans were employee pay-all plans. However, at least 432 of these employers paid part or the entire employee premium for long-term care insurance. The majority of these employers were very small firms (under 100 employees), and were insured by one insurance company. Among the employee pay-all plans, employee participation rates varied widely by insurer and employer. The average percent of active employees participating in this coverage per employer group is about 6 percent.

Since June 1990, many small employers (1-500 employees) have started offering long-term care insurance to their employees. This number has increased from 58 in 1990 to over 600 in 1996. This group represents over 60

percent of all employers offering long-term care coverage to their employees and/or retirees. There have also been substantial increases in the number of medium-sized and large-sized employers who offer long-term care coverage.

Challenges to the Long-Term Care Insurance Market

Incentives for the purchase of long-term care insurance were included in the recent passage of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). A new federal focus on streamlining public expenditures and encouraging individual responsibility has emerged. HIPAA's long-term care provisions have improved the political climate for private long-term care insurance. Nevertheless, HIPAA is not a panacea and will not, by itself, achieve the optimum public-private partnership for long-term care financing. HIAA believes that several factors could hasten the development of private long-term care insurance and strengthen its ability to respond to the baby boomer's demand and need for long-term care protection.

Educating the Public is Essential – The need for better consumer education is the responsibility of both the private and public sectors. It is virtually impossible to sell a product to someone who already believes they have it or they will never need it. However, this is where we often find ourselves with long-term care insurance. Education should begin early, so that working age people understand their risks for long-term care and can plan for their potential long-term care needs while they have the income to do so.

Over the last several years, the insurance industry has made an extensive effort to inform the public about long-term care and its potential costs. Since 1987,

when the HIAA long-term care consumer guide was first published, over two million copies have been distributed. (A copy of the most recent *HIAA Guide to Long-Term Care Insurance* is attached.) It is clear the public wants information on this subject. HIAA remains willing to work with all levels of government to further similar consumer communication and education efforts.

A dilemma, just as critical, is the lack of knowledge of the policymakers themselves. There is also a need for continuing education in this area.

Public Expenditures Should be Targeted – HIAA also recognizes that the private sector alone cannot realistically meet society's entire need. There will always be a significant need for public sector involvement. For those unable to finance their own long-term care services, a "safety net" program of public assistance must continue to be provided. This is true especially for the current generation of elderly and disabled individuals, who have not had the time, product availability or financial resources to provide effectively for themselves. In this regard, HIAA supports initiatives to improve the current long-term care public assistance programs and research and demonstrations on innovative needs-based public long-term care programs.

We recognize that such innovations could be costly. However, we believe that their benefits are significant and that it is the responsibility of the public sector to target its assistance to those most in need. Funding of these improvements could be partially offset through mandatory estate recoveries of recipients after their death and the death of a surviving spouse. Additional revenues could also be generated from further strengthening and strictly enforcing the transfer of assets rules so that individuals could not give away property in order to qualify for Medicaid.

Expansion of Long-Term Care Insurance Coverage Should be Encouraged - While several tax clarifications passed in HIPAA, we believe that other equally important tax-related changes, at both the federal and state levels, could make long-term care insurance more affordable to a greater number of people. The expansion of this market will have the parallel effect of reducing future costs to the federal and state governments by reducing Medicaid outlays.

Federal and state governments have an important role in encouraging the growth of private long-term care insurance market. This could be achieved by enhancing tax provisions for long-term care insurance. Encouraging additional tax provisions for these products would reduce the cost of long-term care insurance for many Americans, would increase their appeal to employees and employers, and would increase public confidence in this relatively new private insurance coverage. Further, enhancement of tax incentives for the purchase of long-term care insurance would demonstrate the government's support for and its commitment to the private long-term care insurance industry as a major means of helping Americans fund for future long-term care needs. It also reinforces the message to the public about individual responsibility.

These efforts will lead to an increase in the portion of the population who seek to protect themselves against catastrophic long-term care expenses. Some examples of specific actions that could be taken are to:

- Enhance the deduction for long-term care insurance premiums, such that premium dollars are not subject to a percentage of income;
- Permit the tax-free use of IRA and 401(k) funds for purchases of long-term care insurance;

- Permit the premiums to be paid through cafeteria plans and flexible spending accounts;
- Provide a tax subsidy for the purchase of long-term care insurance; and
- Encourage state tax incentives for the purchase of long-term care insurance.

These tax incentives would largely benefit two groups: those who did not have the opportunity to purchase such coverage when they were younger and the premiums were lower and as a result, now face the greatest affordability problems because of their age; and those younger adults, our current baby boomers, who need incentives or mechanisms to fit providing for their own long-term care protection into their current multiple priorities (e.g., mortgage and children's college tuition) and financial and retirement planning. Further, the educational effects of such tax incentives could far outweigh its monetary value by educating consumers about an important issue and as a result, would help to change attitudes as well.

Encouragement of Delivering Quality Long-Term Care Services and Focus on Research Affecting Long-Term Care Use and Costs is Critical – Rather than spend tax dollars to provide long-term care to those who can afford to protect themselves, HIAA believes it is a higher priority to devote public expenditures toward encouraging the delivery of quality long-term care services. Reimbursement policy under public programs must be adequate to ensure high quality patient care and deter cost-shifting to private paying patients.

Public expenditures should also focus on research affecting long-term care use and costs, and support of budget-neutral demonstrations involving public-private

financing partnerships. In addition, more resources are needed in basic and applied biomedical aging research to facilitate the management of chronic disease and disability. Treatments which ameliorate or control conditions such as Alzheimer's disease, incontinence, and osteoporosis will greatly enhance the quality of an older person's life and significantly reduce or delay the need for costly long-term care services.

Another priority for additional public spending on long-term care would be the monitoring of genetic studies. These studies could help in learning more about the aging process and how to reduce or delay the impact of aging on service delivery. Applying lessons learned from these efforts could improve the ability of future long-term care insurance products to meet the needs of consumers. However, it is essential that such studies not impede development and growth of the market and that insurers continue to have access to and consider any relevant medical information for insurance purposes. Like all insurance, long-term care insurance will only remain affordable if adverse selection can be minimized.

The federal government must also continue its important function of collecting and organizing data through national surveys and share this information with the public in a useful and timely manner. Financial support of such research and demonstration efforts is fairly minimal when compared to the tremendous benefits they will reap over the long haul.

Summary and Conclusions

We all agree that solving the nation's long-term care problem is vitally important. The flexibility and versatility that private long-term care insurance offers baby boomers and their families make it the preferred approach to pre-funding the catastrophic long-term care costs many Americans. In addition, private insurance also provides maximum flexibility to present and future informal caregivers. Many of us have experienced or will soon experience, either needing or providing long-term care for our loved ones. Over time, HIAA fully believes that private long-term care insurance will give millions of people an opportunity to be financially independent throughout their retirement years. Recognition of the private long-term care insurance market in this hearing is a solid step in this direction.

Given this promising start, HIAA believes its would be a mistake to minimize the role of private insurance in designing a comprehensive national policy for long-term care. Instead, the public and private sectors must combine their efforts and knowledge to create a solution that will benefit most Americans today and in the future. This investment will pay off many times over as you and I grow older and it will help us avoid placing an insupportable tax burden on our children.

Thank you Mr. Chairman and Members of the Committee. We look forward to working with you to provide further assistance in this area.

The CHAIRMAN. Dr. Mulvey.

STATEMENT OF JANEMARIE MULVEY, PH.D., DIRECTOR, ECONOMIC RESEARCH, AMERICAN COUNCIL OF LIFE INSURANCE, WASHINGTON, DC

Ms. MULVEY. Good afternoon, Mr. Chairman and members of the committee. I am Janemarie Mulvey, Director of Economic Research for the American Council of Life Insurance. The ACLI is a major trade association of the life insurance industry, representing 532 life companies. Our members also comprise over 85 percent of the private long-term care insurance market. I appreciate this opportunity to testify today.

I would like to share with you the results of a study we recently completed. Our study measured the impact of long-term care insurance on both Medicaid and out-of-pocket costs for individuals in the year 2030.

First, I would like to provide some perspective on how large the problem will be. By the year 2030, the last of the baby boomers will reach retirement. Although there are many uncertainties about the future disability rates among the baby boomers, the unprecedented growth in the elderly population alone will place additional burdens on the long-term care system.

Despite people's preferences for services to help them stay in the home and community, government spending predominately pays for institutional care. Nearly 80 percent of Medicaid long-term care expenditures are for nursing home care. In the absence of major changes and given this institutional bias in how long-term care services are financed, it is likely that nursing home use will continue to dominate long-term care expenditures over the next 30 years.

As you heard from earlier panelists, the number of nursing home residents is expected to double by 2030. Not only will the total number of nursing home residents increase, but so will the cost per resident. Since 1990, the costs per stay have increased at an annual average rate of 3 percent above the overall rate of inflation. Assuming this trend continues, the annual cost of a nursing home stay will increase from $40,000 today to nearly $97,000 by 2030, after adjustments for inflation.

As a result of these trends, by 2030, nursing home expenditures will likely quadruple to 330 billion in inflation adjustments. To put this number in perspective, it is equivalent to the size of the entire Social Security system today.

Without a marked increase in ownership of long-term care insurance among the baby boomers, these costs will largely be financed by Medicaid and by individuals and their families. We project by 2030 that Medicaid expenditures will likely increase 360 percent, and out-of-pocket expenditures will increase 380 percent.

We believe these trends are unsustainable for two reasons. First, growth in Medicaid nursing home expenditures are expected to outpace growth in tax revenues. Second, growth in out-of-pocket expenditures for nursing home care will far exceed the expected growth in baby boomers' future incomes.

Is private long-term care insurance a potential solution to this crisis? We believe so. Our simulations show that long-term care in-

surance help protect baby boomers from financial hardship and reduce their reliance on Medicaid. We simulated long-term care expenditures, assuming that baby boomers who could afford a long-term care policy purchased one. We had inflation protection in our policy and the benefits covered from 2 to 5 years. Under this analysis, nearly two-thirds of baby boomers could afford a long-term care policy.

Our results show that private insurance can be an important source of funding for long-term care services in the future. We found that Medicaid expenditures will likely fall 21 percent, or 28 billion after adjustments for inflation. The number of individuals who rely on Medicaid could be reduced by 19 percent.

Individuals would also experience significant out-of-pocket savings through the ownership of long-term care insurance. Long-term care insurance could reduce the number of nursing home residents who impoverish themselves by 44 percent. Total out-of-pocket expenditures could decline by 40 percent, or 63 billion.

Looking at the big picture, the share of nursing home expenditures paid for long-term care insurance would increase from 3 percent under current financing trends to nearly 30 percent. As a result, Medicaid's share of nursing home expenditures would likely decline, from 41 percent to 32 percent. Similarly, the share of nursing home expenditures paid directly out-of-pocket would decline from 48 percent to 31 percent.

The cost estimates presented today are only the tip of the iceberg. In 2030, the baby boomers have not yet reached age 85. By 2050, all of the baby boomers will have reached that age and their probability of needing long-term care will be greater. The costs will be even higher, and the impact of long-term care insurance could be greater, as well.

These are achievable goals. My coauthor and colleague, Barbara Stucki, will briefly discuss what we believe needs to be done to realize the full potential of long-term care insurance.

The CHAIRMAN. Dr. Stucki.

STATEMENT OF BARBARA STUCKI, PH.D., SENIOR RESEARCH ANALYST, AMERICAN COUNCIL OF LIFE INSURANCE, WASHINGTON, DC

Ms. STUCKI. Thank you, Mr. Chairman. My name is Barbara Stucki and I am a senior policy analyst with the American Council of Life Insurance.

As discussed by my colleague, Dr. Mulvey, our study indicates that long-term care insurance could have a significant impact on financing for long-term care. However, the potential of this product has not yet been fully realized. At this time, about 6 percent of elderly people and a very small number of baby boomers have purchased long-term care insurance. Since many who have a policy have not yet begun to use long-term care services, private insurance currently pays for about 3 percent of the nation's long-term care expenditures. So what are the keys to realizing the potential of private long-term care insurance?

First, as we have heard, there continues to be a great need to educate the public about the risks of needing long-term care. In addition, people have to understand the limitations of Medicaid and

Medicare programs for long-term care. Americans tend to underestimate the risk of needing assistance due to disability. In a recent survey, more than two-thirds of the respondents found it difficult to admit that they would ever need some long-term care during their lives.

In reality, today, about 1 in 5 Americans older than age 65 and almost half of Americans age 85 and older who live in the community require assistance with their everyday activities. The risks of using nursing home care are also substantial. More than half of women and one-third of men age 65 and older will need a nursing home stay sometimes during their lives.

Americans also have misconceptions about who will pay for long-term care. Many believe that Medicare will pay to help with daily activities. In reality, the Medicare home health benefit is medically oriented and is targeted to people who need skilled nursing care and rehabilitative therapy at home. In addition, the nursing home benefit under Medicare only covers short stays. Many middle-income baby boomers are also unaware that the Medicaid program requires them to impoverish themselves before they are eligible for public assistance.

So in addition to education, a second part of the solution lies in raising the awareness that rapid increases in long-term care expenditures projected for the 21st century can have serious implications for baby boomers' retirement security. The fact is, baby boomers need to look at retirement security in different terms from their parents. As life expectancy and the associated risk of disability increase, retirement is becoming a less predictable event. An unanticipated nursing home stay can deplete hard-earned savings and threaten a family's financial future. In the year 2030, a nursing home stay costing $97,000 a year will likely equal more than 2½ times the projected median income of elderly households, at about $35,000.

Looking into the future, there are two key goals of retirement security, first, saving enough money for retirement, and second, protecting against life's uncertainties, including the uncertainty associated with future long-term care costs. While both goals require planning, the calculations are very different. Saving for retirement is largely a matter of accumulating enough assets to last a lengthy retirement period. Protecting against the risk of needing long-term care requires a much different approach. This is because long-term care costs are extremely expensive and would require a large amount of savings.

For example, a 45-year-old would have to save almost half-a-million dollars to pay for 2 years of a nursing home stay at age 85. To reach this goal, she would have to save $3,500 annually.

Another alternative is private insurance. Long-term care insurance, like other insurance, spreads the risks across many individuals and this lowers costs to any one individual in the event that they would need long-term care. Based on our study, a 45-year-old would pay in the neighborhood of about $400 a year for a policy covering 2 years in a nursing home. Compared to the $3,500 needed in savings, long-term care insurance could save her over $3,100 a year.

Is it OK to continue?

The CHAIRMAN. Please, go ahead. Kind of wind it up, but finish your thoughts.

Ms. STUCKI. In terms of lifetime savings, these numbers are even more substantial. After paying long-term care premiums, the 45-year-old could protect over $430,000 of her savings if she buys a long-term care policy instead of paying for nursing home care on her own.

Some policy makers emphasize the high cost of private long-term care insurance. In reality, the cost of a long-term care policy is tied to the age of purchase. Therefore, a third key to realizing the potential of private insurance is to encourage baby boomers to purchase insurance at younger ages. Generally, premiums are much lower when purchased before age 65. For example, compared to a 65-year-old, premiums are more than 50 percent lower for a 55-year-old and 70 percent lower for a 5-year-old.

Purchasing at earlier ages also increases the likelihood that baby boomers will be able to buy policies with comprehensive benefits. A recent survey found that purchasers under the age of 65 had policies with almost 7 years of coverage on average, in contrast to about 4 years for those age 75 and older. In addition, roughly two-thirds of younger purchasers were likely to choose inflation protection as a policy feature, in contrast to less than one-third of older purchasers.

In conclusion, there is still time to seek out private sector solutions to the looming long-term care crisis. However, whether private insurance will pay a greater role in financing the costs of long-term care in the next century depends in large part on the extent to which baby boomers' plans for their retirement include long-term care.

The results of this study indicate that if a large proportion of baby boomers purchased long-term care insurance, total nursing home expenditures paid by Medicaid could decline from the current 41 percent to 32 percent. The study also shows that private long-term care insurance is affordable for most Americans.

However, it is important to one's financial security to plan ahead and purchase long-term care insurance as early as possible. This will present a significant challenge to baby boomers, since many are preoccupied with more immediate concerns. There is thus an important role for government to help encourage individuals to plan for their long-term care needs. This can be accomplished through education and by ensuring that long-term care insurance is an essential part of any public policy debate on retirement security. In addition, expansion of tax incentives for long-term care insurance premiums could help middle-income baby boomers who face multiple demands on their resources.

Thank you, Mr. Chairman.

The CHAIRMAN. Ms. Stucki, thank you.

[The prepared statement of Ms. Mulvey and Ms. Stucki follows:]

American Council of Life Insurance®

Who Will Pay for the Baby Boomers' Long-Term Care Needs? Expanding the Role of Private Long-Term Care Insurance

Testimony Before the U.S. Senate
Special Committee on Aging

March 9, 1998

Presented by:

Janemarie Mulvey, Ph.D.
Director, Economic Research
American Council of Life Insurance
and
Barbara Stucki, Ph.D.
Senior Policy Analyst
American Council of Life Insurance

Who Will Pay for the Baby Boomers' Long-Term Care Needs? Expanding The Role of Private Long-Term Care Insurance

Study Overview

The aging of the baby boomers and increases in life expectancy are expected to boost demand for long term care services over the next 30 years. The objective of this study is to project the long term care needs of retirees in 2030 and the subsequent financial impact on the Medicaid program and individual's out-of-pocket costs. Most importantly, this study will measure the extent to which the increased ownership of long term care insurance can help to finance these costs in the future.

The study finds that private long term care insurance can play an important role in financing long term care needs of the baby boomers. Specifically, increased ownership of long term care insurance can:

- reduce Medicaid nursing home expenditures by 21 percent
- reduce out-of-pocket expenditures for nursing home care by 40 percent

The potential of long-term care insurance to finance future long-term care costs will depend on the extent to which baby boomers plan ahead for their long- term care needs. The government can help in this effort by educating baby boomers in the following areas:

- the limitations of government programs in paying for long-term care services,
- the potential risk of needing long-term care services,
- the impact of unplanned long-term care expenditures on their financial security,
- the need to incorporate long-term care insurance as an essential part of their retirement planning process, and
- the importance of purchasing long-term care insurance at younger ages.

The Looming Crisis: Aging Baby Boomers

One of the biggest challenges facing America in the 21st century will be the aging of the "baby boomers"- individuals born between 1946 and 1964. Due to the large size of this segment of the population, baby boomers have dramatically affected societal trends and the demand for services at each stage of their lives. In their formative years, they crowded the school systems. As they reached adulthood, they dominated the housing and labor markets. Now as baby boomers are beginning to save for their retirement, the stock market is reaching record highs.

The impact of baby boomers will continue to be felt as members of this large and influential group ages. The first baby boomers have already turned 50. As the 21st century approaches, over 70 million baby boomers will face the prospect of retirement and the needs associated with an aging population. These demographic trends will present new challenges to families and society.

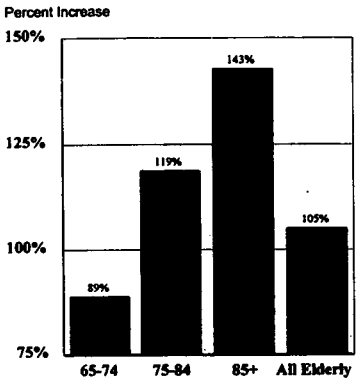
By the year 2030, when the last of the baby boomers reach retirement, it is estimated that the number of elderly individuals will double from 35 million to nearly 70 million. Over 20 percent

of the population will be over 65 in 2030,[1] compared with 13 percent in 1990. This means that in about thirty years, 32 states will resemble Florida's population today.

Life expectancy is also expected to improve into the 21st century. As a result, individuals ages 85 and older are expected to be the fastest growing segment of the elderly population, increasing 143 percent between 1990 and 2030 (Figure 1).

Figure 1

Percent Increase in Elderly Age Groups From 1990 to 2030



Source: Social Security Administration Intermediate Projections

What will happen as the baby boomers enter retirement? How will the cost of health care, particularly long-term care be affected? Although there are still many uncertainties regarding the future of this diverse group, it is clear that the boomers will play an increasingly important role in our long-term care system.

Long-Term Care Expenditures Are Likely to Increase Dramatically

It is not clear whether increased longevity will be accompanied by more healthy years or whether aging baby boomers face additional years limited by chronic conditions. Currently, people age 85 and older are almost six times more likely to need long-term care than people in their 60's.[2] As we look to the future, some researchers suggest that the incidence of disability will decline as a result of medical breakthroughs. Others maintain that raising life expectancy may increase the likelihood of developing age-related disabilities such as Alzheimer's disease. Although there are still many uncertainties regarding the likelihood of becoming disabled in the

future, unprecedented growth in the elderly population by 2030 alone will place additional burdens on the long-term care system.

Long-term care consists of many different services aimed at helping people with chronic conditions. Those who need help at home with everyday activities may rely on personal assistance services or a homemaker. Care in the community includes adult day services and assisted living facilities. Individuals who need skilled care or constant supervision often receive care in a nursing home.

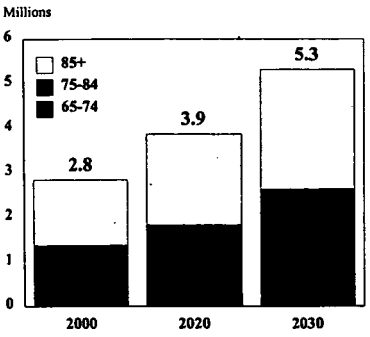
Long-term care can be expensive. For example, a person with a severe disability who lives at home may pay over $36,000 per year for the help of a home care aide.[3] Assisted living facilities charge $26,000 on average. A nursing home can cost $40,000 per year.[4] All of these figures are averages and can vary widely depending on geographic location.

Increasing numbers of baby boomers are becoming aware of long-term care as they provide care to their own aging parents. Many of these caregivers are beginning to think, who is going to take care of me? Baby boomers emphasize that they do not want to end up in a nursing home. However, despite people's preference for services to help them stay in the home and community, government spending predominantly pays for institutional care. Medicaid is the largest government payer of long-term care, but only 19 percent of Medicaid long-term care expenditures cover home and community-based services.[5] Less than half of states (22) have programs that pay for long-term care services in assisted living facilities.[6] As a result, those who impoverish themselves paying for long-term because they lack private insurance or substantial funds could spend their remaining days as a Medicaid recipient in a nursing home.

Given the current institutional bias in how long-term care services are financed and in the absence of a major change, nursing home use will continue to dominate long-term care expenditures over the next 30 years. Under this scenario, by 2030 we can expect the number of people receiving institutional care to increase to 5.3 million individuals, almost double the current nursing home population (Figure 2).

Figure 2

Projected Nursing Home Residents, 2000 - 2030 By Age

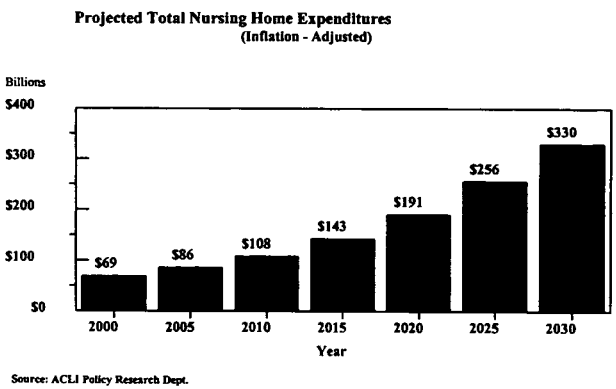


Source: Forecast by American Council of Life Insurance

Not only will the total number of nursing home residents increase but so will the costs per resident. Since 1990, the costs per stay have increased at an annual average rate of 3 percent above the overall rate of inflation. Assuming this trend continues, the annual cost of a nursing home stay is expected to increase from $40,000 today to $97,000 (in 1996 dollars) by 2030.

Increasing numbers of nursing home residents combined with a higher cost per stay will lead to a quadrupling of nursing home expenditures by the year 2030 (see Figure 3). As the baby boomers age into the 21st century, total expenditures for nursing home care could reach $330 billion (in 1996 dollars). To put this number into perspective, nursing home expenditures in 2030 will equal the size of the entire Social Security system today.

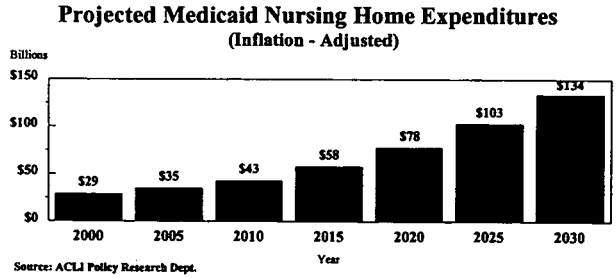
Figure 3



The Impact of Rising LTC Expenditures on Government and Individuals

Rising numbers of nursing home residents by 2030 will place increased financial burdens on the Medicaid program. Currently, Medicaid pays for about 41 percent of total nursing home expenditures[7]. Assuming Medicaid's share of total expenditures remains constant in the future, the simple fact that the population is aging will lead to a doubling of nursing home residents receiving Medicaid assistance. As a result, total nursing home expenditures paid for by Medicaid are expected to increase 360 percent by 2030 to $134 billion (in 1996 dollars) (see Figure 4).

Figure 4

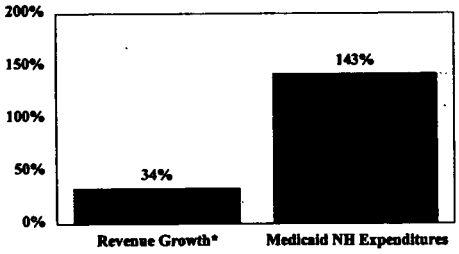


These trends in Medicaid expenditures for nursing home care will be unsustainable at current tax rates. Legislation to dramatically increase taxes to fund the expected increases in Medicaid is politically unlikely in an era of balanced budgets and fiscal conservatism. Yet, without explicit increases in tax rates the future growth in tax revenues to fund Medicaid will be limited by growth in overall wages. As a result, growth in Medicaid nursing home spending is expected to outpace growth in tax revenues over the next 30 years (see Figure 5). Without additional tax revenues, Congress would be forced to reduce Medicaid nursing home expenditures either by reducing benefit levels or further restricting eligibility requirements. These actions could threaten the Medicaid safety net for low-income individuals who have no alternative but to rely on public programs.

In order to control Medicaid expenditures, some states are trying to reduce nursing home use by emphasizing care in the home and community. While home and community-based care is less costly per person than institutional care, many studies suggest that any savings could be more than offset by increased demand for services. Other strategies involve limiting provider fees and growth in nursing home beds, and using care management. It is still unclear whether these approaches will be adequate to contain future long-term care costs.

Figure 5

Medicaid Revenue vs. Expenditure Growth (Inflation - Adjusted)
Years 2000-2030



*** Based on growth in wages.**
Source: American Council of Life Insurance calculations.

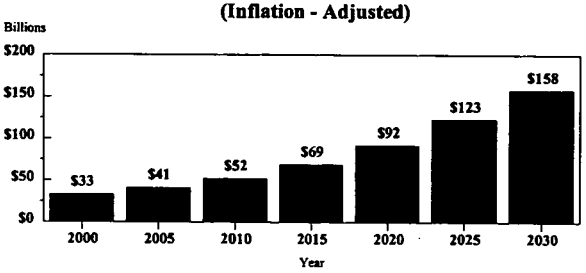
Though government pays for a large portion of long-term care costs, if baby boomers fail to plan ahead and purchase private insurance, much of the burden of rising nursing home costs will continue to fall on individuals and their families. Currently, about 48 percent of nursing home costs are paid for by individuals in the form of out-of-pocket costs. If current trends continue, projected out-of-pocket expenditures for nursing home care are expected to increase to $158 billion (in 1996 dollars) in 2030 from an estimate of $33 billion in 2000 (see Figure 6). This represents a 378 percent increase in total out-of-pocket costs for nursing home care by 2030.

Out-of-pocket payments for long-term care services are substantial, but these expenditures do not capture the full cost of caring for older people with physical and mental limitations. About

57 percent of frail elders who live in the community rely solely on family and friends to provide care. In fact, a recent survey found that there are 22 million American households with at least one member providing some unpaid assistance to a spouse, relative, or other person over age 50.[8] Whether family caregivers will be able to continue to provide this level of help to numerous very old relatives in the 21st century remains to be seen.

Figure 6

Projected Out-of-Pocket Costs For Nursing Home Services (Inflation - Adjusted)



Source: ACLI Policy Research Dept.

Rising life expectancy increases the likelihood that baby boomers will rely more on their children to help them with their long-term care needs. As elderly boomers live longer, they are also more likely to face multiple chronic conditions that require complex and physically demanding care. At the same time, the pool of potential family caregivers is shrinking due to smaller family sizes and greater geographic dispersion of families. Caregiving in the 21st century will be further complicated by the fact that the burden of providing assistance will increasingly fall on family members who are employed. In 1960, only one-third of married women worked outside the home. By 1990 almost three-fifths of women were in the labor force. About 25 percent of working Americans currently provide some unpaid care to elderly relatives and friends living in the community. As the physical stress of caregiving increases, many of these families may face additional financial burdens if they have to rely more on paid long-term care.

Equally troublesome is the growing number of Americans who may lack family support to help them if they become disabled. About 26 percent of baby boomers were childless in 1990. These trends may increase the percent of baby boomers over age 85 that may be living alone in 2030. Individuals without children available to provide long-term care often require institutionalization at earlier ages than those with family support.

Private Insurance Offers a Solution to the Looming Long-Term Care Crisis

By the time the baby boomers retire, entitlement spending on Social Security and Medicare could consume the entire federal budget, leaving little room for other discretionary spending. Thus, attempts to increase public spending to expand long term care coverage for baby boomers seem highly unlikely. As a result, the policy debate is shifting from discussions of a national health care program that includes long-term care toward greater support for private-sector solutions to financing long-term care.

The willingness of policymakers to support private sector initiatives is most evident in the recent enactment of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). HIPAA improved financial incentives for long term care purchasers in a number of areas. First, HIPAA excludes benefit payments from qualified long term care policies from taxable income. Second, HIPAA allows individuals to deduct as medical expenses the cost of premiums for tax-qualified long-term care insurance from federal taxes. While these tax incentives are limited to those taxpayers who itemize medical expenses, they still represent a positive step towards expanding tax incentives for purchasers of private long term care insurance. Most importantly, the enactment of HIPAA signals that policymakers expect consumers to assume greater responsibility for their long-term care needs.

Private long-term care insurance consists of a wide variety of products that help protect people if they become disabled and need long-term care services. Unlike government programs that focus on institutional care, long-term care insurance policies cover a wide range of services to help people with disabilities live at home, participate in community life, as well as receive skilled care in a nursing home. Policies may also include respite care, coverage for home modifications, or payment for family caregivers. Most policies pay for services such as assisted living that are not covered under many state Medicaid programs. These options enable frail, elderly baby boomers to retain their independence.

Can long-term care insurance help protect baby boomers from financial hardship and reduce their reliance on Medicaid? In this study, we simulated long-term care expenditures under two alternative financing scenarios:

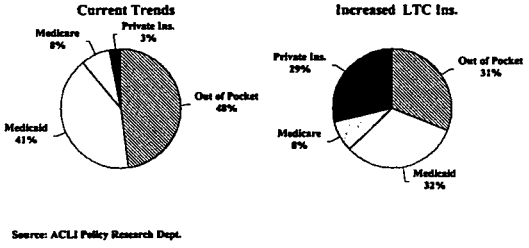
Scenario I: Current Financing Trends Continue

Scenario II: Increased Purchase of Long-term Care Insurance

In the case of increased purchase of long-term care insurance, we assumed that everyone age 35 and older in the year 2000 who could afford a policy purchased a policy.[9] Long-term care insurance policies incorporated coverage for either two or five years of benefits and included compound inflation protection of 5 percent a year. Individuals purchased the policy they were most able to afford.

Figure 7

Nursing Home Financing in 2030



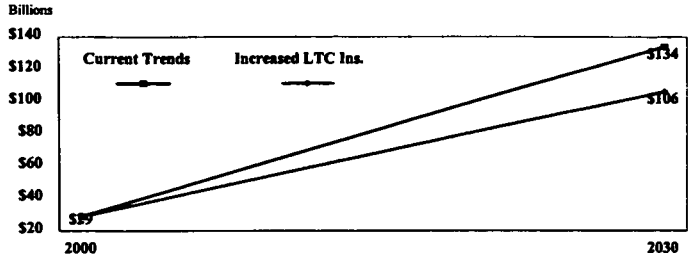
Source: ACLI Policy Research Dept.

The results of this study indicate that private insurance can be an important source of funding for long-term care in the future and can substantially reduce nursing home expenditures for both Medicaid and individuals. Assuming three-fourths of purchasers retain their policy to the year 2030, the share of nursing home expenditures paid for by private insurance would increase from 3 percent today to 29 percent in 2030. At the same time, Medicaid's share of nursing home expenditures could decline from 41 percent to 32 percent and those paid directly out-of-pocket by individuals could decline from 48 percent to 31 percent of the total. Under this scenario, the proportion of national expenditures for nursing home care paid by private insurance (29 percent) would almost equal that of the Medicaid program (31 percent) and private out-of-pocket payments (30 percent).

The Medicaid program could save $28 billion (in 1996 dollars) or 21 percent of total Medicaid nursing home expenditures as a result of increased ownership of long term care insurance. This amount represents more than one out of every five dollars that Medicaid would have had to spend on nursing home care in the year 2030. These savings translate into 19 percent fewer nursing home residents who would need to rely on Medicaid in 2030 or about 490,000 individuals.

Figure 8

Impact on Medicaid NH Expenditures (2030)
(Inflation - Adjusted)



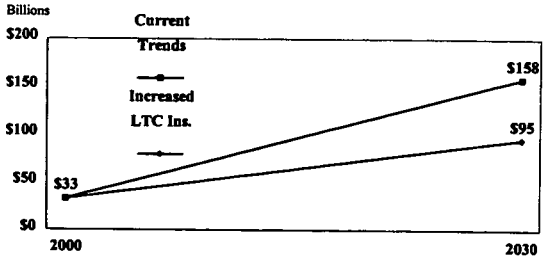
Source: ACLI Policy Research Dept.

The loss of financial independence due to impoverishment is a big concern to individuals who need long-term care. The projections suggest that 385,000 of the 863,000 nursing home residents at risk of impoverishment in 2030 could avoid reliance on Medicaid through private insurance. This means that ***long-term care insurance could reduce the number of nursing home residents who "spend-down" by 44 percent.*** In addition, many people who impoverish themselves paying for care have little choice but to enter a nursing home. A significant portion of these individuals may avoid institutionalization since it is likely that their long term care policy included home care.

Out-of-pocket expenditures borne by nursing home residents and their families could be substantially reduced due to the increased ownership of long term care insurance. ***About 40 percent of out- of-pocket costs could likely be saved by the increased ownership of long term care insurance.*** As shown in Figure 9, total out-of-pocket expenditures could be reduced by $63 billion to $95 billion (in 1996 dollars) in 2030.

Figure 9

Impact on Out-of-Pocket Expenditures
(Inflation - Adjusted)



Source: ACLI Policy Research Dept.

Keys to Realizing the Potential of Private Long-Term Care Insurance

Private insurance currently pays for only a small portion of the nation's long-term care expenditures. This in part reflects a small, but growing market for long-term care insurance. Over 4.3 million policies had been sold as of 1995.[10] Payments by private insurance for long-term care are also limited by the fact that many who have purchased a policy have not yet begun to utilize long-term care services.

About 6 percent of elderly people and a very small number of baby boomers have purchased long-term care insurance. Part of the reason for limited sales among baby boomers may stem from the fact there is still widespread denial about the risk of needing long-term care. Having largely invented youth culture during the 1960's, many of the baby boomers are still concerned with sustaining their youth and vitality. In addition, a large proportion of Americans continue to have numerous misconceptions about long-term care.

Whether private insurance will play a greater role financing the cost of long-term care in the next century depends in large part on the extent to which baby boomers plan ahead for their retirement. There is an important role for government to help encourage individuals to plan for their long-term care needs by:

- educating baby boomers about the limitations of government programs that pay for long-term care,
- educating Americans about the risk of needing long-term care and the impact of unplanned long-term care expenditures on their financial security,
- incorporating long-term care insurance as an essential part of any public policy debate on retirement security, and
- encouraging purchase at younger ages when premiums are less expensive.

We need to educate baby boomers about the limitations of government programs that pay for long-term care.

Many Americans believe that Medicare will pay for their long-term care needs. In reality, this program primarily focuses on acute care needs (hospital stays and physician visits). The Medicare home health benefit is also medically-oriented, and is targeted to people who need skilled nursing care and rehabilitative therapy at home. Medicare does not pay for help with daily activities unless provided with home health care. In addition, the nursing home benefit under Medicare only covers short stays (up to 100 days).

Those who are poor can turn to Medicaid. In fact, unless the way long-term care is financed changes when baby boomers grow old, 38 percent of residents will be eligible for Medicaid when they enter the nursing home.[11] Some of these will be individuals who are poor, while others will have experienced a drop in income, possibly due to the loss of their spouse's pension. In addition, without adequate private insurance, a significant number are likely to become poor paying for medical costs and for long-term care in the community.

Many baby boomers are unaware that the Medicaid program requires people with disabilities to impoverish themselves before they are eligible for public assistance. As a result, middle income families have few options but to use their own income and assets to pay for their long-term care needs. In 2030, a nursing home stay will cost $97,000 a year (in 1996 dollars). This will likely equal more than two and a half times the projected median income of elderly households in 2030 of $35,000 (in 1996 dollars).[12] These resources will be inadequate to pay for a single year of nursing home care.

We need to educate baby boomers about the risk that they will need long-term care and the impact of unplanned long-term care expenditures on their financial security.

Because it seems so far off in the future, few members of this generation have begun to prepare for their own long-term care needs. Part of this stems from the fact that Americans tend to underestimate the risk of needing assistance due to disability. A recent survey conducted by the National Council on Aging and John Hancock reported that more than two-thirds of the survey respondents found it difficult to admit that they would ever need some long-term care during their lives.

In reality, today about 1 in 10 Americans older than 65 and almost half of Americans age 85 and older who live in the community require assistance with their everyday activities.[13] The risks of needing nursing home care are also substantial. Nearly half of women and one-third of men age 65 and older will need a nursing home stay sometime during their lifetime.

Many baby boomers are not planning for the future because they are preoccupied with more immediate concerns. Boomers currently represent more than half of all workers, and are parents of 75 percent of the nation's children under age 18. The baby boomers are now in their high-expense years, between the ages of 32 and 50, when child care and housing expenses tend to dominate their budgets. In addition to their immediate needs, baby boomers are also trying to save enough for their children's college education.

Looking into the future, many people are worried about the financial well-being of baby boomers when they retire. It is highly possible that some baby boomers could spend one-third of their lives in retirement. Many fail to realize that rapid increases in long-term care expenditures projected for the 21st century have serious implications for their retirement security.

Equally importantly, baby-boomers need to look at retirement security in different terms from their parents. As life expectancy and the risk of disability increases, retirement is becoming a less predictable event. An unanticipated nursing home stay can deplete hard-earned savings and threaten a family's financial future. At the same time, the 21st century could see an erosion of the social safety net for aging baby boomers. If expenditures for long-term care continue to rise dramatically, government may try to control costs by limiting Medicaid benefits and tightening eligibility requirements for middle-income individuals. At the same time, it will become increasingly challenging for children of baby boomers to serve as their parents' and other relatives' caregivers.

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We need to make long-term care insurance an essential part of any debate on retirement security.

Looking into the future, there are two key goals of retirement security: 1) saving enough money for retirement, and 2) protecting against life's uncertainties including the uncertainty associated with future long-term care costs.

While both goals require planning, the calculations are very different. Saving for retirement is largely a matter of accumulating enough assets to last a lengthy retirement period. There has been much debate on whether the baby boomers are saving enough. Some believe they are saving enough and others believe most boomers savings will fall short of their needs. While the answer to this question is beyond the scope of this paper, ultimately the answer arrived at will affect the baby boomers standard of living in retirement.

An equally important issue is the need for baby boomers to protect against life's uncertainties, specifically the risk of needing long-term care. This second issue requires a much different approach. This is because long-term care costs are extremely expensive and would require a large amount of savings. For example, the 45-year old who needs nursing home care when she is 85 years old would have to save a total of $489,000 for a two year stay. To reach this goal she would have to save $3,500 annually. Considering the multiple demands on boomers today, relying on savings to pay for long-term care needs is not a financially feasible option for most middle income Americans.

A more affordable alternative is long-term care insurance. Long-term care insurance makes it possible for middle income families to manage the risk that they may become disabled without having to save large amounts of money each year. Long-term care insurance, like other insurance, is intended to spread the risk across many individuals and thus lower costs to any one individual in the event they would need long-term care services.

Figure 10

Alternative Ways to Pay for Future Long-Term Care Needs

	Age Today	
	45 year old	**60 year old**
Option 1: Asset Accumulation		
Annual Savings Needed	$3,557	$4,481
Lifetime Assets Needed at Age 85 To Pay for 2 Years of Nursing Home Care	$489,446	$235,432
Option 2: Purchase Private LTC Insurance		
Annual Premium Contributions	$417	$824
Lifetime Value of Premiums	$57,907	$52,097
Potential Savings From LTC Insurance:		
Annual Savings From LTC Insurance	$3,140	$3,657
Lifetime Savings From LTC Insurance	$431,539	$183,335

Source: Author's calculations based on a 2-year LTC policy with inflation protection of 5 percent.

The 45 year old women in the illustration above would only have to pay about $417 a year for a long-term care premium covering two years in a nursing home. This policy would include inflation protection of 5 percent a year. Long-term care insurance could thus save her $3,140 a year in savings that could be used for many of her more pressing needs including accumulating assets for retirement. In terms of lifetime savings, these numbers are even more staggering. After paying her long term care premiums, the 45 year woman could protect $431,539 of her savings if she buys a long-term care policy instead of trying to pay for nursing home care on her own (see Figure 10).

We need to educate baby boomers about the importance of purchasing insurance at younger ages, when it is more affordable.

Many policymakers have emphasized that the high cost of private long-term care insurance is unaffordable for most Americans. In reality, the cost of a long-term care insurance policy is tied to the age of purchase. Variations in premiums by age reflect the increased risk of needing long-term care as people grow older (see Figure 11). Insurance companies are only able to financially assume the risk presented at older ages if they charge higher premiums.

Consequently, the earlier policies are purchased the lower the premiums. Generally, premiums are much lower when purchased before age 65. For example, premiums are 70 percent lower for a 45 year old as compared to a 65 year old ($702 per year at age 45 for a five-year policy with inflation protection). Similarly, premiums are 54 percent lower for a 55 year old as compared to a 65 year old ($1,068 per year at age 45 for a five year policy with inflation protection).

Figure 11

Long-Term Care Insurance

Average Annual Premiums

By Age

Ages	2 Year Policy*	5 Year Policy*
35 to 39	$358	$507
40 to 44	$403	$605
45 to 49	$500	$734
50 to 54	$645	$905
55 to 59	$892	$1,204
60 to 64	$1,265	$1,709
65 to 69	$1,849	$2,432
70 to 74	$2,638	$3,610
75+	$3,851	$5,274

*Policies include: coverage for $100/50 per day for nursing home/home care, 90 day elimination period, and 5% compounded inflation protection.

Source: American Council of Life Insurance

Purchasing at an earlier age has other benefits. Since this product involves medical underwriting, those who purchase insurance at an early age are more likely to qualify for coverage. In addition, lower premiums also increase the likelihood that baby boomers will be able to purchase policies with very comprehensive benefits. A 1994 survey by the Health Insurance Association of America found that purchasers age 55-64 had policies with more coverage (almost 7 years) than older purchasers (about 5 years for those age 65 to 74 and 4 years for those age 75+).

Figure 12

Percent Who Can Afford LTC Insurance by Age

Ages	Percent Who Can Afford
35 - 39 Years Old	73
40 - 44 Years Old	71
45 - 49 Years Old	81
50 - 54 Years Old	72
55 - 59 Years Old	63
60 - 64 Years Old	47
65 +	31
Total	62%

The implications of this are very significant for the future potential of long-term care insurance. We need to educate baby boomers that it is important to purchase insurance at younger ages when it is more affordable . The results of this study indicate that about three-quarters of individuals ages 35 to 44 could afford a policy if they spend 2 percent or less of their income on private insurance (see Figure 12). Under this criteria, 46 percent of those ages 35 to 44 would be able to afford a 5 year policy, while the rest would purchase a 2 year policy. Similarly, 58 percent of individuals ages 45 to 49 years old could afford a 5-year policy.

According to a 1994 survey by Health Insurance Association of America, purchasers age 55 to 64 were far more likely to choose inflation protection (61 percent) as a policy feature in contrast to older purchasers (38 percent of those 65-69, 27 percent of those 70-74).

Conclusions

Projections about long-term care needs 30 years into the future may seem too distant for consumers and policymakers faced with more immediate concerns. Nonetheless, this study provides an important framework within which to examine options to help Americans plan for their long-term care needs. The results of this study indicate that long-term care insurance has the potential to significantly reduce future out-of-pocket and Medicaid expenditures for long-term care. If a large proportion of baby boomers purchased long-term care insurance, total nursing home expenditures paid by Medicaid could decline from the current 41 percent to 32 percent. In addition, the proportion of total nursing home expenditures paid for by individuals out-of-pocket could decline from the current 48 percent to 31 percent.

The cost estimates presented in this study reflect only the tip of the iceberg. In 2030, the baby boomers are concentrated between ages 65 and 84. By 2050, however, all of the baby boomers will have reached age 85 years and beyond, an age when the probability of needing long- term care services increases markedly. So both total long-term care costs and the potential savings from long-term care insurance could be considerably higher by that time.

In addition, our analysis assumes that spend-down rates under Medicaid in 2030 would be similar to today's and that the share of nursing home costs paid for by Medicaid (under our current financing trends scenario) would remain constant through 2030. In reality, as nursing home costs rise faster than overall inflation and incomes, many more middle income baby boomers could become impoverished by nursing home costs and thus become eligible for Medicaid. In this case, increased purchase of long-term care insurance could provide greater costs savings to Medicaid than our projections suggest.

There is still time to seek out private sector solutions to the looming long-term care crisis. Baby boomers need to be encouraged to make plans to ensure that disability does not destroy their future financial security. The study also shows that private long-term care insurance is affordable for most Americans. However, it is important to one's financial security to plan ahead and purchase long-term care insurance as early as possible. This means incorporating long-term care insurance as an essential part of retirement planning.

The insurance industry is constantly evolving to meet these new challenges. Companies are making a significant effort to add features and design policies that will appeal to consumers. Greater flexibility and increased choice in benefits also provide some new options for people with modest incomes to purchase long-term care insurance. In addition to traditional long-term care insurance policies, individuals can also obtain a rider to their life insurance policy that will accelerate benefits to finance long-term care. With this type of product, the insurer pays a portion of a life insurance benefit to the policyholder instead of paying the beneficiary at the policyholder's death. Employer participation in the long-term care insurance market is also increasing, allowing earlier and more affordable planning for employees seeking coverage for long-term care.

If the government is serious about encouraging people to purchase private insurance then it has got to do more. There continues to be a great need to educate the public about the risks of needing long-term care. In addition, people have to understand the limitations of Medicaid and Medicare programs for long-term care. As part of this educational effort, there is a need to encourage purchase at younger ages when premiums are less expensive. Finally, expansion of tax incentives for long-term care insurance premiums could promote greater affordability especially among older individuals and those with modest incomes.

Finally, while this study focused primarily on the role of long-term care insurance in offsetting future nursing home costs, it is important to note, that we also believe that private long-term care insurance can change much of the bias towards institutional care in the current system and thus the very nature of the how long-term care services are delivered in the next century. Baby boomers will demand more services and different options than presently exist in long-term institutional and home care.

About the Authors

Janemarie Mulvey, Ph.D. is **Director of Economic Research** at the American Council of Life Insurance (ACLI). Her areas of expertise include cost forecasting, Social Security and pension issues. Prior to joining ACLI, she was an economist at the Urban Institute where she developed their State Legislative Impact Model (SLIM). The SLIM model was used to evaluate health care reform proposals in various states. She also co-authored a book with Marilyn Moon entitled Entitlements and the Elderly: Protecting Promises and Recognizing Realities. Prior to the Urban Institute, Dr. Mulvey was a Senior Analyst in the Public Policy Institute of the American Association of Retired Persons (AARP). At AARP, her research included measuring the tax burdens of the elderly, the extent of the elderly's out-of-pocket health care costs, and the macroeconomic impacts of health care reform. She has a Ph.D. in Economics from George Mason University and an M.A. in Economics from the University of Maryland.

Barbara R. Stucki, Ph.D. is a **Senior Policy Analyst** at the American Council of Life Insurance working on long-term care and disability issues. Prior to joining ACLI, Dr. Stucki was a Policy Analyst for the American Association of Retired Persons, where she worked on long-term care issues including private-sector financing options, aging with a disability, and informal caregiving. Dr. Stucki has also conducted field research on the impact of urbanization on rural elders in West Africa. She has a Ph.D. in anthropology with emphasis on gerontology from Northwestern University in Chicago.

Endnotes

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2. Hobbs, FB and Damon, BL (1996). 65+ in the United States. Current Population Reports P23-190. Washington, D.C. Bureau of the Census.

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The CHAIRMAN. Dr. Wiener.

STATEMENT OF JOSHUA M. WIENER, PH.D., PRINCIPAL RESEARCH ASSOCIATE, THE URBAN INSTITUTE, WASHINGTON, DC

Dr. WIENER. Thank you, Mr. Chairman. I am Joshua Wiener, a principal research associate at The Urban Institute. The Special Committee on Aging is to be commended for holding this hearing on long-term care, an extremely important topic that has been neglected by Congress in recent years.

My role in this hearing is to be the skunk at the picnic. My overriding conclusion after 10 years of looking at private long-term care insurance is this: Private long-term care insurance is unlikely to ever play a major role in financing nursing home and home care for the elderly.

In my brief time, I would like to make four points. First, good quality private long-term care insurance sold to the elderly costs about $2,500 per year. Any way you cut it, that is a lot of money, and so it is not surprising that most studies, including those that I have done, suggest that only 10 to 20 percent of older people are likely to be able to afford private long-term care insurance. Long-term care insurance is affordable mostly to people who do not end up on Medicaid, so Medicaid savings are likely to be small.

The tax deductions for purchase of individual private long-term care insurance that were in the Health Insurance Portability and Accountability Act of 1996 primarily benefit the well-to-do and are a highly inefficient way to encourage the purchase of private long-term care insurance. Most of the tax loss will be spent on people who would have bought private long-term care insurance without the tax deduction.

Second, although I could quibble with the estimates, I agree with the American Council of Life Insurance that purchase of private long-term care insurance at younger ages can make private long-term care insurance much more affordable, but it is important to remember that their estimates, as well as those presented in my testimony, are upper bounds of what is potentially possible and not predictions of what will happen into the future.

Moreover, most baby boomers have competing demands for their money, including mortgage payments, child care, college education for their children, and general retirement. When private long-term care insurance has been offered by employers, relatively few employees have purchased it. Although the price is substantially lower at younger ages, most active employees still think that private long-term care insurance is still too expensive, and a good quality policy bought at age 50 still costs about $1,000 a year.

Even with the tax clarifications that were in HIPAA 1996, few employers are likely to contribute to the cost of private long-term care insurance. Employers face hundreds of billions of dollars of unfunded liability for retiree acute care benefits that they have already committed to, and as a result, retiree health insurance is falling like a rock. Employers are fleeing retiree health benefits as fast as their legs will carry them. The last thing in the world that they are looking for is yet another expensive benefit to contribute to for their retirees.

Third, the use of tax incentives for the purchase of private long-term care insurance is spending as surely as any direct appropriation. Congress should consider whether the money spent on these inefficient tax incentives would be better spent more directly in public programs for long-term care.

As I have already noted, tax incentives are highly inefficient ways of encouraging behavior and have contributed to making the tax code substantially more complicated than it need be.

In addition, while the quality of private long-term care insurance has improved dramatically over the last 10 years, the lack of inflation protection, and the lack of non-forfeiture benefits in most policies are significant deficiencies that undermine the value of insurance coverage, and these provisions are especially important for policies bought by the working-age population, where people are likely to have to own these policies for 30, 40, or 50 years. Congress missed a major opportunity to upgrade policies when it provided tax breaks to insurance companies without requiring substantial improvements in consumer protections.

Fourth and finally, given the limitations of private long-term care insurance, serious reform designed to make life better for the elderly will require reform of public programs—Medicare, Medicaid, and others that currently are the major source of third-party funding for nursing home and home care. To ignore the public programs in the hope that private insurance will someday replace them is a luxury that the disabled elderly and their families can ill afford.

Thank you, Mr. Chairman. I welcome any questions.

[The prepared statement of Dr. Wiener follows:]

CAN PRIVATE INSURANCE SOLVE THE LONG-TERM CARE PROBLEMS OF THE BABY BOOM GENERATION?*

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*These views are those of the author and should not be attributed to other staff members, officers, or trustees of the Urban Institute.

Testimony presented at "The Cash Crunch: The Financial Challenge of Long-Term Care for the Baby Boom Generation," a hearing held by the Special Committee on Aging, United States Senate, Washington, D.C., March 9, 1998.

The current American system of financing and delivering long-term care for the elderly and the younger disabled population is badly broken. At present, the United States does not have, either in the private or the public sectors, satisfactory mechanisms for helping people anticipate and pay for long-term care. In particular, the disabled elderly and their families find, often to their astonishment, that the costs of nursing home and home care are not covered to any significant extent either by Medicare or their private insurance policies. Instead, the disabled elderly must rely on their own resources or, when those have been exhausted, turn to welfare in the form of Medicaid. Moreover, although the vast majority of disabled elderly live in the community, nearly two-thirds of public expenditures for long-term care for the elderly are for nursing home care (Wiener, Illston and Hanley, 1994).

As the American population ages, demand and expenditures for long-term care are certain to grow. It is projected that nursing home and home care expenditures for the elderly will increase by 123 percent in inflation-adjusted dollars between 1993 and 2018; public expenditures for Medicare, Medicaid and other public programs will increase by 109 percent over that same time period (Wiener, Illston, and Hanley, 1994). Although spending will grow substantially, the burden will not be as heavy as commonly assumed because the economy will be expanding as well. Assuming that the economy grows at a real rate of 2.5 percent a year, long-term care for the elderly will increase from about 1.21 percent of the gross domestic product in 1993 to about 2.14 percent in 2048 when the baby boom generation hits its stride in needing nursing home and home care services. While a nontrivial additional burden, this level of increase is not the end-of-the-world as some would maintain and by itself would be sustainable without much problem. What makes these expenditures more difficult to finance is that they are on top of additional resources that will inevitably be needed for Medicare and Social Security.

To address the problems of long-term care, a small, but growing private long-term care insurance market has developed over the last fifteen years. Although over 95 percent of the elderly have Medicare coverage and about 70 percent have supplemental private insurance policies, insurance against the potentially devastating costs of long-term care is relatively rare (Committee on Ways and Means, 1996). As of the end of 1995, only 4.3 million long-term care policies ever had been sold (although far fewer were in force), overwhelmingly to the elderly on an individual basis rather than to younger people on an employer-subsidized group basis (Coronel and Kitchman, 1997).[1]

By far the greatest impediment is the high cost of good quality policies. Despite the marked improvement in the financial position of the elderly over the past twenty years, long-term care insurance remains unaffordable for most elderly. The average annual premium for policies covering four years of nursing home and home care with inflation protection and nonforfeiture benefits in 1995 was $1,124 per year if purchased at age 50, $2,560 per year if purchased at age 65, and $8,146 a year if purchased at age 75 (Coronel and Kitchman, 1997).[2]

The policies are expensive for two reasons: 9 out of 10 are sold individually and, therefore, carry high administrative costs; and, most policies are bought by older people whose risk of needing long-term care is substantial. Consequently, most studies estimate that only 10

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[1] "The number of policies ever sold" is a highly misleading figure because it does not take into account that many people have let their policies lapse or that some policyholders have died. The Health Insurance Association of America does not collect information on the number of policies in force.

[2] While policies without inflation protection (i.e., at least 5 percent annual compound increase in the indemnity level) and nonforfeiture benefits are cheaper, they are essential elements of good policies.

to 20 percent of the elderly can afford good-quality private long-term care insurance (Wiener, Illston and Hanley, 1994; Crown, Capitman and Leutz, 1992; Rivlin and Wiener, 1988). Other research has found the percentage of the elderly who can afford private insurance to be higher, but these studies have done so by assuming purchase of policies with limited coverage, by assuming the elderly would use their assets as well as income to pay premiums, or by excluding a large proportion of the elderly from the pool of people considered interested in purchasing insurance (Cohen, Kumar, McGuire, and Wallack, 1992; and, Cohen, Tell, Greenberg, and Wallack, 1987). Affordability is not likely to dramatically improve in the future (Wiener, Illston and Hanley, 1994).

To estimate the potential impact of various private long-term care insurance options, Wiener, Illston, and Hanley simulated several different private long-term care insurance options using the Brookings-ICF Long-Term Care Financing Model (Wiener, Illston, and Hanley, 1994). Figure 1 describes the simulation assumptions, which represent an optimistic upper-bound estimate of potential market penetration and impact for some of the options. Under these assumptions, affordability and medical underwriting are the only barriers to the purchase of policies; actual market penetration and impact is likely to be far less than the simulation.

The simulations show that the market penetration and ability to finance long-term care of private insurance aimed at the elderly is likely to remain extremely limited (Table 1). Even under the assumption that the elderly with only minimal assets will spend a substantial portion of their income for policies, only one in five elderly people could have a policy in 2018. Because of limited market penetration, private insurance bought by the elderly is unlikely to substantially ease the burden of out-of-pocket long-term care costs. Moreover, because private insurance is

bought mostly by upper-middle and upper-income elderly with substantial assets, it will have little impact on public spending through Medicaid. For policies sold to the elderly, the projected Medicaid savings are 2-4 percent, basically rounding error for estimates 20 years into the future.

Given the limitations of the current market for private long-term care insurance, public subsidies to promote its purchase are frequently proposed. One approach is to provide employers a tax subsidy for the purchase of long-term care insurance policies for their employees by allowing them to deduct insurance contributions as a business expense. A second strategy is to provide a tax deduction or credit to individuals for purchase of private long-term care insurance. Tax incentives for employers and individuals were part of the Health Insurance Portability and Accountability Act of 1996 (the Kassebaum-Kennedy law). A final strategy is to waive some or all of the Medicaid asset depletion requirements for purchasers of qualified private long-term care insurance policies, an approach being tried in several states. The shared intent of these strategies is to induce more people to purchase policies by lowering premium costs through tax breaks or guaranteeing publicly-funded coverage once privately purchased coverage is exhausted. Proponents argue that a key consequence of any of these actions is public endorsement of the importance and desirability of private long-term care insurance.

All of these options will, no doubt, promote the purchase of private long-term care insurance, but to what extent is unclear. Moreover, with the possible exception of easing access to Medicaid by persons who purchase private long-term care insurance, these strategies are not free to the government. All of these options could result in substantial loss of federal revenue, which is spending just as certainly as the direct expenditures of a public insurance program.

EMPLOYER CONTRIBUTIONS AND THE TAX STATUS OF PRIVATE INSURANCE

One approach to address the affordability problem is to encourage the purchase of private long-term care insurance at younger ages, especially through employers. Since 1987, a tiny but expanding market of employer-sponsored insurance for long-term care has developed. As of 1995, only about 500,000 policies had been sold through 1,260 employers (Coronel and Kitchman, 1997). In a key difference from acute care polices, where most employers pay a large proportion of the cost of insurance, most employer-sponsored long-term care policies are offered on an employee-pay-all basis.

The Advantages of the Employer-Sponsored Market

Theoretically, employer-sponsored plans offered to the nonelderly provide several advantages over those purchased individually. First, premiums for younger policyholders can be substantially lower than those for older policyholders because younger policyholders pay premiums over a longer period of time and because earnings on premium reserves have more time to build. For example, the premiums for a 42-year-old will be approximately one-quarter to one-third of the premium for a 67-year-old (Wiener, Harris and Hanley, 1990). Computer simulations suggest that purchase of long-term care insurance by the younger population could largely solve the affordability problem of private long-term care insurance, even without employer contributions (Table 1). Because of the improved affordability, significant Medicaid savings could be achieved if persons purchased long-term care insurance when they were younger.

Although lower premiums are tied to the age of the purchaser and not necessarily to the fact that the policy is employer-sponsored, the nonelderly are easiest to reach through their place

of employment. The workplace is where most health, life, and disability insurance is purchased and most retirement savings through pensions are established.

Lower administrative and marketing costs offer another potential source of savings over individual policies. Administrative and marketing costs are high in individual policies because sales have to be made one at a time. Group markets are able to achieve lower costs through economies of scale. Moreover, in group policies, employers bear many of the costs of administering the policy, such as collecting premium payments through payroll deductions. Employers may also elect to assume part of the costs of marketing the plan to their employees. However, informal discussions with insurance actuaries suggest that most assume only a ten percentage point difference in the anticipated loss ratio between individual and group plans.[3] Thus, although the administrative savings of group policies are desirable and not trivial, they will not dramatically lower premiums.

Enrolling people at younger ages through the workplace also reduces the risk of adverse selection and therefore the need for medical underwriting. Disability is relatively rare at younger ages. The less frequent underwriting typical of employer-based policies is an improvement over the universally strict practices used for purchase of individual insurance policies. However, most younger persons with significant disabilities are not in the work force and would not, therefore, be eligible for these policies.

Finally, advocates of employer-sponsored insurance argue that the quality of policies should improve through the involvement of company benefit managers. Large groups have

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[3]The loss ratio is the percentage of the premium that is for benefits rather than administrative and other overhead. Many companies assume a loss ratio of 60 percent for individual policies and 70 percent for group policies.

more market power than individuals to negotiate with insurance carriers for less restrictive policies with richer benefits and lower prices. In general, the quality of policies in the employer market is quite good, especially in providing home care benefits. On the other hand, most employer-sponsored policies have grossly inadequate inflation protection. Under most policies, the insured must purchase additional coverage from time-to-time to compensate for inflation, but at the new older age and therefore at a substantially higher premium.[4]

Impediments to an Employer-Sponsored Strategy

Despite the potential advantages of selling to the nonelderly population through employer groups, the employer-sponsored market may not expand enough to play a significant role in financing long-term care. Employers are reluctant to offer the policies, and employees are not rushing to purchase them. In particular, employers have been unwilling to contribute to the cost of policies.

Tax Treatment of Private Long-Term Care Insurance

Employer contributions could make long-term care insurance more affordable by reducing the amount that employees have to pay out-of-pocket and might give employees confidence in the product. Until passage of the Kassebaum-Kennedy bill in 1996, private long-term care insurance was not specifically recognized in the federal tax code. Because of its unique characteristics, long-term care insurance did not fit neatly into the existing tax models of

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[4]For example, if a person buys a policy at age 42 that pays $60 a day in nursing home benefits and if inflation is 33 percent during the next five years, then the insured can buy additional coverage of $20 a day to compensate for the inflation but at the price charged 47-year-olds, not 42-year-olds. We estimate that to retain purchasing power, the inflation-adjusted premium at age 82 would be approximately ten times what they were at age 42. This is because nursing home use is exponential by age.

health and accident, life, or disability insurance, pensions or private annuities. As a result, the tax status of employer contributions and of insurance benefits were unclear and this lack of clarity no doubt slowed the growth of long-term care insurance, at least to some extent. The Kassebaum-Kennedy bill clarified that contributions towards the cost of group long-term care insurance policies was a tax-deductible expense for employers (like health insurance) and that benefits (within limits) were not considered income.

A persistent problem with tax incentives is the probability that most of the tax expenditures will be for people who would have purchased policies anyway. As a result, tax subsidies can be very costly ways of promoting private insurance. For example, Wiener, Illston, and Hanley (1994) estimate that the lost revenue to the federal government of allowing employers to deduct the cost of their contribution to private long-term care insurance would be $7,900 to $11,300 per year per additional policy sold.

These tax benefits are also not free to the federal government, producing potentially substantial tax losses. Some advocates argue that reductions in government expenditures for Medicaid nursing home and home care will offset the tax loss because some people who will buy private insurance would otherwise be eligible for Medicaid. At least for a long time period, these offsets are unlikely to occur because the tax loss will happen immediately, because the revenue loss is linked to premium payments, but the savings, if any will not occur until the benefits are used, typically many years into the future. This imbalance in timing guarantees short-term tax losses. Using a computer simulation model, Wiener, Illston, and Hanley (1994) estimate that it could take twenty-five years before the annual tax loss approximately equals the Medicaid savings.

While the uncertain tax status of long-term care insurance has no doubt prevented some employers from offering long-term care insurance policies to their employees, these factors are likely to be overwhelmed by the financial problems facing employer-sponsored acute health insurance benefits for retired employees which supplement the Medicare program. Unlike pensions, virtually all corporations offering post-retirement health benefits have financed them on a pay-as-you-go basis rather than prefunding them. Prodded by accounting rules established by the Financial Accounting Standards Board that require companies to disclose their future financial liability for these benefits, corporations are now aware that, collectively, they have an estimated $187 billion to $400 billion in mostly unfunded liabilities (U.S. General Accounting Office, 1993; Warshawksy, 1992; U.S. General Accounting Office, 1989).

As a result, large numbers of employers, concerned about health care costs for both their active employees and retirees, are cutting back on retiree benefits, making retirees pay a greater part of the cost or dropping that coverage altogether. For example, data from Foster Higgins' annual survey of mostly large employers found a drop in retiree health benefits between 1988 and 1992 (Foster Higgins, 1993). In 1988, 55 percent of responding firms offered retiree health benefits to Medicare eligible retirees; by 1992, only 46 percent of responding firms did so. The percentage of full-time workers in state and local governments with retiree health benefits declined between 1990 and 1992 from 58 percent to 50 percent (U.S. Department of Labor, 1994, 1991). A recent study of 50 of the largest companies showed that 31 companies reported increases in retiree cost sharing for medical benefits in 1994 (Watson Wyatt Worldwide, 1995). In this environment, it seems unlikely that many additional employers will want to contribute to a new, potentially expensive insurance plan that will primarily benefit retirees twenty to thirty

years after they have left the company. Indeed, employers are trying to distance themselves as much as possible from such benefits.

Limited Employee Demand

To date, employee demand has not played a large role in the decision of companies to add long-term care insurance to their benefit package. The desire to maintain a company's image as a leader in employee benefits or a personal sensitivity to the problem by a senior officer or employee benefit manager have been larger factors. Nonetheless, surveys of large employers suggest the possibility of a large increase in the number of companies offering policies, if not paying for them. Employees also have been reluctant to purchase insurance. The Health Insurance Association of America estimates that, depending on how the universe of eligibles is defined, only 5.3 percent to 8.8 percent of those offered employer-sponsored long-term care insurance have purchased policies (Coronel, 1991).

Several factors limit employee demand. First, although premiums for policies without inflation adjustment are lower at younger ages, they cost more than many people are willing to pay voluntarily. Moreover, a high quality long-term care insurance policy with a level premium, inflation protection, and nonforfeiture benefits purchased at age 50 can cost more than $1,000 a year (Coronel and Kitchman, 1997). In a survey of nonpurchasers of employer-sponsored policies offered by two major insurers, LifePlans, Inc., reported that 82 percent of respondents felt that the fact that "the policy costs too much" was either "very important" or "important" in their decision not to purchase a policy (LifePlans, 1992). Even though economists contend that increased employer contributions for fringe benefits are mostly offset by reduced wages, 90

percent of respondents in this survey said that they would be more willing to purchase a policy if their employer contributed to the cost.

In addition, middle-age workers usually must contend with other, more immediate expenses, such as child care, mortgage payments, and college education for their children. In the LifePlans, Inc. (1992), survey, 80 percent of nonpurchasers stated that "more important things to spend money on at this time" was either "very important" or "important" in their decision not to purchase a policy. The risk of needing long-term care is too distant to galvanize many people into buying insurance.

Finally, selling to the nonelderly population raises difficult considerations of pricing and product design. An actuary pricing a private long-term care insurance product for a 45-year-old must predict what is going to happen forty years into the future, when the insured is age 85. To say the least, this is difficult. Ironically, although one of the advantages commonly claimed for private insurance is its flexibility to respond to the needs and wants of consumers, policyholders who buy insurance at younger ages could be locked into the existing model of service delivery decades before they use services. Who knows what the optimal delivery system will be a half century from now?

TAX INCENTIVES FOR INDIVIDUAL PURCHASE OF PRIVATE INSURANCE

Another set of options would improve the affordability of private long-term care insurance by offering direct tax incentives to individuals who purchase policies. For example, the Kassebaum-Kennedy legislation allow individuals to count private long-term care insurance

premiums as a health expense.[5] Health care expenses in excess of 7.5 percent of adjusted gross income are tax deductible. As a result of the ability to deduct part of the cost of private long-term care insurance, the net price of insurance policies will be reduced. Some insurance advocates argue that providing a tax benefit will have a "sentinel" effect, promoting insurance beyond merely reducing the price. A tax incentive, they contend, will signal potential purchasers that the government thinks private long-term care insurance is a worthwhile product.

The type of tax chosen to provide the tax subsidy defines the scope of who can benefit. Allowing taxpayers to deduct all or part of the cost of a private long-term care insurance policy would provide a premium subsidy valued at the marginal tax rate of the household. Since upper-income taxpayers have higher marginal tax rates than lower-income taxpayers, deductions are regressive in nature. That is, they are worth more to upper-income people than to lower-income people. However, for the 72 percent of taxpayers in the 15 percent tax bracket in 1993, this type of tax subsidy would reduce the cost of obtaining long-term care insurance by only about one-seventh, probably not enough to motivate very many additional people to purchase polices (Cruciano and Strudler, 1996). The other major drawback is that relatively few taxpayers itemize their deductions. In 1993, only 29 percent of all tax returns included itemized deductions; only 4 percent claimed a deduction for medical expenses (Internal Revenue Service, 1996).

The other broad approach is to provide a tax credit, which is a direct reduction in the amount of tax owed, for purchase of policies. In theory, tax credits need not be as regressive as deductions. However, as a practical matter, moderate and low-income taxpayers may not have

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[5] The level of private long-term care insurance that can be included varies by age. For 1997, it is limited to $200 for persons age 40 and younger; for persons aged 70 and older, it is limited to $2,500.

the cash on hand to pay premiums during the year so as to be able to claim a tax credit in the following year. The other problem is that, unless the credit is refundable, it is an ineffective policy for people who do not have a tax liability. This is especially a problem for the elderly; only about half of whom have any federal income tax liability (Committee on Ways and Means, 1996).

As with tax subsidies for employer contributions to private long-term care insurance, the key issue is whether tax incentives are an effective and efficient way to promote the purchase of private long-term care insurance, and thereby, the reform of nursing home and home care financing. For example, estimating the effect of an income-related tax credit for the purchase of private long-term care insurance, Wiener, Illston and Hanley (1994) estimated the cost per additional policy induced by the tax benefit at between $1,700 and $1,900 per year. Similarly, they estimate that the tax loss through 2018 will be at least four times the Medicaid savings.

EASIER ACCESS TO MEDICAID: A PUBLIC-PRIVATE PARTNERSHIP

While changing the tax code is the most commonly proposed way of publicly subsidizing private long-term care insurance, the initiatives by Connecticut, Indiana, California, Iowa and New York take a substantially different approach. Commonly referred to as the "Robert Wood Johnson Public-Private Partnerships" (named for the foundation that promoted this strategy), these states provide easier access to Medicaid for persons who purchase a state-approved private long-term care insurance policy. In essence, these states allow nursing home patients with private long-term care insurance to be Medicaid eligible with substantially higher levels of assets than is normally allowed.[6] At present, Medicaid only allows unmarried nursing home patients to retain

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[6] Medicaid law allows states great flexibility in determining countable income and assets of medically-needy patients--patients with high medical bills in relation to their income. In essence, states using this strategy exclude insurance-related assets from their definition of resources that

$2,000 in assets (excluding the home). While employer-paid plans and tax incentives seek to reduce the net cost of insurance, this public-private partnership does the reverse by trying to increase the amount of benefits received per dollar spent.

There are two models of how to link Medicaid and private insurance.[7] In both cases, Medicaid acts as a kind of reinsurance for persons with limited private long-term care insurance. In one model used by Connecticut, California, Indiana, and Iowa, the level of Medicaid-protected assets is tied to the amount that the private insurance policy pays out. For example, if a person buys a policy that pays $100,000 in long-term care benefits, then that individual can keep $100,000 in assets and still be eligible for Medicaid. Consumers are able to purchase insurance equivalent to the amount of assets they wish to preserve, potentially reducing the amount of insurance individuals need to buy.

The other model, used by New York, provides protection of an unlimited amount of assets if an individual purchases a policy that meets state standards, including coverage of at least three years of a combination of nursing home and home care, with a minimum $100 per day indemnity payment. The rationale for not requiring an asset test for Medicaid coverage is that nursing home costs are so high in New York that few individuals can avoid Medicaid over an extended period

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must be counted in determining Medicaid eligibility. However, the Omnibus Budget Reconciliation Act of 1993 (OBRA 1993) severely restricts the ability of additional states to pursue this option by including the insurance-related protected assets in an individual's estate. OBRA 1993 requires states to attempt to recover the cost of institutional care from the estates of Medicaid patients. Thus, patients may not be able to pass on these additional funds to their heirs, substantially lessening the appeal of this approach.

[7] In both models, nursing home patients must still contribute all of their income towards the cost of care except for a small (usually $30 per month) personal needs allowance.

of time.[8] Thus, New York is targeting a higher income population, with potentially more assets, than are the other states.

The key observation supporting the public-private approaches is that long-term care insurance that covers shorter periods of nursing home and home care are cheaper and more affordable than policies that cover longer periods of care.[9] The problem with the current system is that if an individual buys a policy that covers, for example, two years of nursing home care and ends up staying in a nursing home for five years, then the insured's assets can still be lost. Thus, under these Medicaid initiatives, it is possible to obtain lifetime asset protection without having to buy an insurance policy that pays lifetime benefits. Proponents of this approach contend that the goal is not asset protection, per se., but rather to preserve financial autonomy toward the end of life.

Supporters assert that by encouraging purchase of insurance, Medicaid long-term care expenditures will possibly be reduced or, at least, will not increase. This argument is probably stronger for the approach used by Connecticut, Indiana, Iowa, and California, where there is a "dollar-for-dollar" correspondence between the amount the insurance pays and the level of Medicaid protected assets. In New York, the ability to protect potentially very large amounts of assets makes this argument weaker, although still possible. To the extent that these systems are budget-neutral, these strategies will be a move toward what economists call "Pareto Optimality,"

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[8] In 1993, the average Medicaid rate was $185 per day, compared with $88 for the United States as a whole (American Health Care Association, 1996).

[9] At age 67, prototype individual private insurance policy costs $2,337 a year for a policy that covers four years of nursing home and home care, but $1,617 a year for a policy that covers only two years of nursing home and home care (Wiener, Harris and Hanley, 1990).

that is, making some people better off without making anybody worse off. Insurance dollars are simply substituted for private asset dollars.

There are two other potential advantages to this approach. First, since only "approved" policies are eligible for the enhanced asset protection, state regulators can use the initiative as a "carrot" to induce insurance companies to upgrade the quality of their policies.[10] Second, by giving the elderly the alternative of protecting their assets by purchasing insurance, legal and illegal transfers of assets for the purpose of obtaining Medicaid eligibility may be reduced.

Despite these arguments, there are several concerns about the equity and efficiency of this option. The first concern is whether it is appropriate to use a means-tested welfare program-- Medicaid-- as a mechanism to protect the assets of upper-middle and upper-income elderly. Indeed, under this approach, it remains an open question how far down the income distribution insurance purchase will go. Computer simulations by Wiener, Illston and Hanley (1994) suggest that the vast bulk of private insurance expenditures will be for the relatively well-to-do elderly.

The second concern is whether providing improved asset protection will actually induce substantial numbers of people to purchase long-term care insurance who would not otherwise have bought it. As of December 1996, participation in partnership plans has been disappointing, with only 22,000 policies in force, over half of which are in New York State (University of Maryland Center on Aging, 1997). While it is difficult to sift through people's motivations for buying insurance, one recent study of purchasers found that only 23 percent of respondents listed

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[10] For example, Connecticut mandates compound inflation adjustment of indemnity benefits. In addition, the State is requiring a type of nonforfeiture benefit that requires companies to offer a policy with less extensive coverage to individuals who discontinue their premiums payments and let their policy lapse. Connecticut has also mandated training for insurance agents selling certified policies and is requiring the distribution of a consumer booklet that compares insurance policies.

protection of assets as the "most important" reason for buying insurance (LifePlans, 1995). Asset protection may have a narrow appeal because most elderly have relatively modest levels of financial wealth (Radner, 1993).

Even more fundamentally, many elderly do not want easier access to Medicaid. Indeed, one of the major reasons people buy long-term care insurance is to avoid having to apply for welfare. One survey of insurance purchasers found that 91 percent of respondents reported that avoiding Medicaid was an "important" or "very important" reason for buying a policy (LifePlans, 1995). Medicaid's relatively low reimbursement rates have led to inadequate access and quality of care problems in nursing homes heavily dependent on Medicaid (Nyman, 1988; Institute of Medicine, 1986; and, Scanlon, 1980). In addition, upper-middle and upper-income elderly will probably find the $30 a month personal needs allowance of the Medicaid program to be inadequate. Therefore, they would use up at least some of their newly-protected assets for daily living expenses. Avoiding Medicaid is also the principal argument that insurance agents use to market policies; the partnership plans require a radical revision in the agent's "sales pitch." In sum, it is not clear that easier access to Medicaid will be enough of an inducement to get large numbers of additional elderly to purchase private long-term care insurance.

The third concern is whether the public-private partnership will truly be budget-neutral. After all, Medicaid benefits are being offered to people who would otherwise not be eligible. Because most policies probably will be sold to healthy young elderly who are at least 10 to 20 years away from needing nursing home care, even fragmentary evidence as to the effect of the partnership on the public purse will not be available for a decade or two. If additional public

expenditures should prove to be required, then one may well ask whether providing asset protection to relatively well-to-do elderly is the best place to put our next long-term care dollar.

It is also important to realize that an indispensable component for assessing the effect on the Medicaid budget is establishing a comparison level of expenditures. In a world with no private long-term care insurance at all, it is likely, although not certain, that the partnership would be budget-neutral. However, there is likely to be continuing modest growth in the number of private long-term care insurance policies sold. Compared to this scenario, if the partnership does not induce substantial numbers of additional insurance purchasers, then the partnership will require larger Medicaid expenditures than would otherwise be needed. This is because under current Medicaid rules purchasers of insurance who would have bought policies without the public-private partnership would have to spend-down their assets after their insurance benefits have been exhausted before qualifying for Medicaid, something that they are not required to do under the partnership.

In addition, while supporters argue that the partnership offers persons a more appealing alternative to transferring assets as a way to avoid Medicaid's claim on these resources, it is conceivable that it will actually increase the level of premature asset transfer. Current rules prohibit the transfer of assets to other persons at less than fair market value for 36 months prior to application for Medicaid eligibility (Burwell and Crown, 1996). Once the partnership has encouraged the elderly to look to Medicaid as a way to protect their assets, some insurance purchasers may only buy the 36 months worth of coverage required to comply with Medicaid rules and then legally transfer the remainder of their financial wealth upon entry to a nursing

home. Others may calculate that they can transfer or shelter their assets and obtain Medicaid benefits without purchase of any long-term care insurance policy.

CONCLUSIONS AND RECOMMENDATIONS

The United States faces major challenges in the way it organizes and finances long-term care for the elderly. The aging of the baby boom generation absolutely guarantees that expenditures for nursing home and home care will grow substantially in the future. Based on the available evidence, the following observations should form the framework for reform:

- Although the role of private long-term care insurance will inevitably grow over time, it is doubtful that it will ever play a major role in the financing of long-term care. Especially for the elderly population, good-quality policies are simply too expensive. Medicaid savings are particularly unlikely because the people who can afford policies are not the people who spend down to Medicaid.

- Selling private long-term care insurance to younger people through employers can make policies significantly more affordable. However, policies are still costly and employees have so far been unwilling to buy policies in large numbers. Substantial employer subsidies could make private long-term care insurance more attractive, but even with tax subsidies employers are unlikely to make contributions because of their large unfunded liability for retiree acute care benefits. Employee demand among people in their 40s is low because of competing demands for their spending. As a result, market penetration is likely to be far below the levels projected by simulations (including my own) based solely on upper-bound determined affordability.

- While some of the tax clarifications for private long-term care insurance enacted in the Health Insurance Portability and Accountability Act of 1996 were desirable, the tax deduction for individual purchase of private long-term care insurance is regressive, primarily benefits the well-to-do, and is a highly inefficient way to encourage the purchase of private long-term care insurance. Most of the subsidy will go to people who would have bought insurance without the tax benefit. Even clarifying the tax treatment of employer contributions will result in federal tax losses that are "spending" are surely as any direct appropriation. Congress should refrain from providing any more tax incentives for the purchase of private long-term care insurance.

- While the quality of policies has improved dramatically over the last ten years, the lack of inflation protection and nonforfeiture benefits in most policies are significant deficiencies. Congress lost a major opportunity to upgrade policies when they provided tax breaks to insurance companies without requiring any substantial upgrading in consumer protection.

- While a favorite of some policy analysts, the public-private partnerships for long-term care have failed the market test--very few policies have been sold, even in states that have promoted them for several years. Although the reasons are unclear, probably the primary reason is that insurance agents prefer to sell policies by emphasizing the negative aspects of the Medicaid program, a strategy that is inconsistent with a product whose primary benefit is easier access to the program.

- Given the limitations of private long-term care insurance, serious long-term care reform that seeks to make life better for the great majority of elderly will require expansions of public programs--Medicare, Medicaid, and others--that currently are the major source of third-party funding. To ignore the public programs in the hope that private insurance will replace them someday is a luxury that the disabled elderly and their families can ill afford.

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Figure 1

Private Long-Term Care Insurance Options:
Simulation Assumptions

All persons purchase insurance policies that cover two or four years of nursing home and home care and pay an initial indemnity value of $60 per day for nursing home care and $30 per visit for home care in 1986. Indemnity values increase by 5.5% per year on a compound basis. Premiums for nonelderly persons increase by 5.5% per year until age 65 and are then level. All nondisabled person who meet affordability criteria buy as much as insurance as they can afford.

- ***5% Income:*** All elderly purchase policies if they can afford them for 5% of the income or less and if they have $10,000 or more in nonhousing assets.

- ***Medicaid Insurance:*** Elderly who purchase private long-term care insurance may receive Medicaid nursing home benefits while retaining liquid assets beyond what is normally allowed. The additional assets that they keep equal the amount that the private insurance policy pays out in benefits. All elderly persons purchase policies when they can afford them for 7% of their income or less and if they have $10,000 or more in nonhousing assets.

- ***Tax-Favored Insurance:*** Provides an income-related tax credit of up to 20% of the premium cost for elderly purchasing insurance. All elderly purchase policies when they can afford them for 5% of their income or less and if they have $10,000 or more in nonhousing assets.

- ***Employer-Sponsored Insurance:*** Persons as young as age 40 purchase group or individual long-term care insurance policies. Nonelderly purchase policies if premiums are between 2% and 4% of income (depending on age). Elderly persons purchase policies if they can afford them for 5% or less of income and if they have $10,000 or more in nonhousing assets.

Source: Wiener et al., 1994.

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Table 1

How Much Can Private Insurance Do?
Simulation Results for Four Major Options, 2018

Option	Elderly with Private Insurance[a]	Total Long-Term Care Spending Paid by Private Insurance[b]	Private Insurance Spending on Nursing Home Patients with Incomes >$40,000[c]	Reductions in Medicaid Nursing Home Spending[d]	Reductions in Catastrophic Out-of-Pocket Spending for Nursing Home Patients[e]
5% Income	20%	9%	70%	-2%	-6%
Medicaid Insurance	32%	14%	61%	-4%	-11%
Tax-Favored Insurance	28%	12%	64%	-3%	-8%
Employer-Sponsored	80%	35%	26%	-32%	-28%

Source: Wiener et al. 1994.
Notes:
a. Age at initial participation is 67 for all options. Consequently, all are expressed as the percent of elderly aged 67 and older.
b. Total long-term care expenditures vary by option.
c. Income is presented in 1993 dollars.
d. Medicaid nursing home expenditures for the base case are $49 billion.
e. Defined as >40% of income and nonhousing assets.

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The CHAIRMAN. All of you have contributed a great deal through your testimony to knowledge about the problem and what we can do about it, both from the standpoint of the pros of private long-term care insurance as well as opposition to it. So my first question would be for all the panelists. I guess I would start with you, Mr. Morgante, then. Most of the witnesses today cited the importance of consumer education to increase awareness of long-term care issues. What specific actions, if you feel that the Federal Government has a role here, can the Federal Government take in this area?

Mr. MORGANTE. Thank you, Senator. The Federal Government, among the things the Federal Government can do is to join with representatives from the consumer perspective, the State perspective, the provider perspective, and the insurance perspective in developing consumer guides on long-term care. The Health Insurance Association has printed a guide over a number of years and has distributed more than two million copies of that to people in the public. If there were a consistent guide, something that presented a perspective and included the Federal Government's perspective, it would be helpful.

Second, you asked about advertising, and that is an area in terms of public radio and television where you do not see a lot about long-term care. The Health Insurance Association has done a number of media tours on a regular basis, going out to various cities across the country, trying to generate publicity with editorial boards, publicity with local newspapers. They have done TV and radio talk shows where they generate a discussion on long-term care.

In addition, there are tax incentives. There are some issues that we have talked about and I mentioned in my testimony where the current deductions that are available are a percentage of gross income under HIPAA. This could be changed. We could also use contributions from IRA's, 401(k)'s, cafeteria plans, or flexible spending accounts to pay for long-term care insurance.

The CHAIRMAN. Would you like to comment, one or both of you?

Ms. STUCKI. I think there are a couple of different things that could be done. First of all, I think there is still a great deal of confusion among Americans about what types of services that are covered under Medicare in particular, as well as the need for impoverishment under Medicaid. I think there are certainly opportunities to educate individuals, preferably prior to needing Medicare, about the limitations of these programs.

In addition, I think it is very important to develop materials that are targeted specifically for baby boomers. I think there is a tendency to rely on statistics and information, particularly with regard to affordability and other issues that have derived from what we understand among older people and their concerns.

I think the fact that these policies can be more affordable for younger people, the fact that about two-thirds of younger people tend to purchase policies that include inflation protection in contrast to only about a third of people over the age of 65 indicate that we are dealing with a very different population and we need to target information materials specifically towards baby boomers and the realities of what private insurance can do for them.

Dr. WIENER. I think Congress needs to revisit the consumer protections that it enacted as part of HIPAA. As has already been noted, a substantial portion of people, even when they are baby boomers, purchase long-term care insurance polices without inflation protections. That means that if you buy a policy at age 45, you are not going to use it for another 40 years. The devastating impact of inflation over that time period means that the purchasing power of that policy is going to be enormously eroded. The insurance industry should not be selling those types of policies.

So I think similar issues apply to non-forfeiture benefits. Especially when you have a policy that you have to hold for 40 or 50 years for it to be useful, the chances that you are going to drop the policy or let it lapse are very high. As a result, policyholders will pay in a lot of money will get nothing at the end because they dropped the policy. Given the enormous financial reserves that have been built up, it seems unfair to consumers and is an invitation on the part of the industry to underprice its product or to depend on high lapse rates in order to keep prices down. So it seems to me that the primary thing that the Congress should do is revisit its mandatory consumer protections.

The CHAIRMAN. My next question kind of follows on. I was going to ask Mr. Morgante the question about affordability and how these costs are generally in the average premiums, and then I was going to ask you to react. I think you have just reacted. Could you speak to that point, Mr. Morgante?

Mr. MORGANTE. Yes, sir. I would be pleased to. The average premiums that we have been quoted today have generally been in regard to seniors, because it has been recognized as the senior insurance product, and the numbers that were quoted, the average premiums that were over $2,000, are indeed correct.

Dr. Wiener, in fact, quoted, premiums in a range of $1,000 for someone in their 50's. These are correct numbers. If someone were willing to buy this product in their 50's or in their 40's, the premiums are substantially lower. If you purchase this, for example, via an employee benefit plan, someone who gets paid twice a month could be buying significant amounts of long-term care insurance for an average of $20 or less per pay period. So if the premiums are done on a payroll deduction basis and it is paid by someone who is working and in the workplace, the premiums are significantly lower, and the premiums for someone in their 40's would range well below $1,000. For someone in their 50's, it would range about $1,000 per year.

The CHAIRMAN. Dr. Mulvey or Dr. Stucki, have these policies improved over the years?

Ms. STUCKI. There have been substantial developments in the nature of these policies, in large part in response to consumer concerns and consumer preferences. The initial policy was developed very much akin to something like a Medicare supplemental policy. It required all sorts of prerequisites. But since that earliest type policy, there have been a lot of developments. The policies, as mentioned by Mr. Morgante, now cover a wide range of services in every conceivable setting. They include assistance at home, they include assisted living facility coverage, home health care, respite care, so that individuals have a wide range of options in terms of

types of policies and the types of coverage that they can choose to meet their potential lifestyle for the future.

The CHAIRMAN. In your position as a researcher, are you looking ahead to the future? Can you make any statements as to how or if, maybe it is more like if these policies will change in the future, let us say the next 10 to 20 years?

Ms. STUCKI. Well, it is likely that this product will continue to evolve in response to the evolving long-term care delivery system. Part of the aspect of newer policies is that they have incorporated features that allow the existing policies to retain their flexibility through various mechanisms that ensure that people have options to incorporate long-term care services that many not currently be available.

The CHAIRMAN. Dr. Wiener has already responded about reviewing Kassebaum-Kennedy legislation that had the tax incentive in it for long-term care insurance. Your view of how that is working, Mr. Morgante, do you suggest any additional tax incentives for long-term care and the extent to which the tax incentive has worked as opposed to the period of time, a short period of time before that that we had policies without a tax incentive.

Mr. MORGANTE. The most important message that was sent by Kennedy-Kassebaum, by the Health Insurance Portability Act, was that people need to begin planning for their long-term care needs. There was lots of discussion as to whether the Federal Government was going to step in with a Federal program, and the Kennedy-Kassebaum Act answered the question of this is what the Federal Government is going to do.

The impact on the marketplace has been tremendous. What it has caused to happen has been a general upswing in the public knowledge of long-term care needs. The financial press has picked up on this. The financial press has written a lot of articles telling people that long-term care is something that they need to think about. We as an industry have seen this increase in the questions and the kinds of inquiries we are getting, as well as in an increase in sales of the product.

There are some questions that the Act raised, and there could be some additional tax clarification, such as the things that I cited where if the baby boom generation which has been saving retirement were able to use things like cafeteria plans or 401(k)'s, those would provide an added incentive for people to purchase the product. The Health Insurance Act did a good job of addressing this from a senior insurance focus. We need to continue to shift the focus here to a baby boom generation focus.

The CHAIRMAN. Let me follow up on that and also you and then Dr. Wiener to comment. This is in regard to employer-sponsored policies, and you included some of this in your statement, Dr. Wiener. What is known regarding employee interest in a long-term care benefit and what types of initiatives can employers take to inform employees about the value of long-term care policies?

Mr. MORGANTE. What is known is that it is of great interest to the working population, to a sandwich generation, the majority of people who are working in their 40's and 50's who are trying to deal with elder care issues as well as child care issues. This, along with a series of other employee benefits, have come to the forefront

and it is an issue that a lot of employees have expressed an interest in. Employers have certainly expressed an interest in. It is too soon to tell the overall impact of the Health Insurance Portability Act here. It is one that, yes, this is a growing area. It will continue to grow as employees have their own experiences with long-term care and speak to their benefits managers about asking for this type of coverage.

The CHAIRMAN. Dr. Wiener.

Dr. WIENER. Well, so far, I think that the baby boom population is mostly concerned about other things. They are concerned about college education, mortgage payments, and general retirement. They do not believe that they are ever going to need long-term care, and so where private long-term care insurance has been offered by employees on an employee-pay-all basis, relatively few employees actually have purchased it.

Although we may sit here at the table and say that the price is substantially lower and that it is affordable, most employees when surveyed indicate that they consider it to be too expensive and that price is the major factor in their decision not to purchase. Also, the factor that employers are not willing to contribute is a major factor. In one survey, 90 percent of employees said that they would be more likely to purchase a policy if employers were to contribute, but, very few employers contribute. In fact, employees are pulling away from their commitment to retiree health benefits.

So I think while I support the changes in the tax status for employer contributions, and while I do believe that the affordability issues of private long-term care insurance can be very greatly improved by purchase by working-age people, I think it is going to be an enormously difficult sell. We are never going to wake up one day and find that most people have private long-term care insurance.

The CHAIRMAN. My last question would be to all of you and that is the fact that we hear about the challenges of selecting long-term care policy from all the different policies available. Some people would argue that the products are too complicated for the average person to feel confident in their purchase. Do you as a panel envision the insurance industry doing anything to help in making purchasing long-term care policies easier, more understandable, and less complicated if you agree with the presumption? Mr. Morgante?

Mr. MORGANTE. Yes, sir. I believe that there had been major efforts in that direction. One of the things that was only touched on today were some of the consumer protections that were included in the Health Insurance Portability and Accountability Act. That Act did a great job in terms of making sure that there were certain standards that these policies adhered to.

Some of the issues that had arisen earlier in this decade and in the 1980's in regard to these policies were about the quality of the companies offering these policies along with the quality of the insurance policies. We heard Dr. Wiener today discuss the fact that the quality of the policies that are available has increased.

What we have seen there has been significant changes. We have seen a prohibition on preexisting conditions. We have seen removal of things like prior hospitalization requirements. We have seen that the policies that are sold today are guaranteed renewable. We

have seen that there is a required offer of inflation protection, there is a required offer of non-forfeiture protection in these policies.

We have seen things that are incorporated into all policies today, like a 30-day free look period for the consumer, so that major efforts that have been underway there. We continue to work with the regulators and we will work with the Federal Government or the State Governments to make sure that those continue on.

The CHAIRMAN. Ms. Stucki.

Ms. STUCKI. As baby boomers are more likely to purchase insurance through the employer, they are clearly going to have a more limited set of options that the employer will offer them and I think that is one of the advantages of having the insurance offered through the employer, is that the employer will then go ahead and do some of the screening and select what they consider to be an appropriate policy and I think this will reduce some of the concerns of baby boomers in purchasing a policy.

The CHAIRMAN. Am I not right, though, from previous statistics that 86 percent are individual policies and 14 percent are——

Mr. MORGANTE. That is correct.

The CHAIRMAN. So what you are saying is, for that 14 percent, it is a lot easier, and you are assuming that more employers will do it and less individual policies, is that your position, or how do you solve the issue for the 86 percent of the individuals that do not have an employer to screen for them?

Ms. STUCKI. I think Mr. Morgante has raised some of the specifics that have taken place in the regulatory environment.

The CHAIRMAN. OK.

Ms. STUCKI. I mean, the reality is, of course, that consumers want choice and they want a product that is going to meet their specific lifestyle goals, and there is always that challenge between offering a diverse set of products that can really be tailored to meet an individual's needs versus the complexity that arises when people have to make these kinds of choices. So there is always that side of the consumer issue, too.

The CHAIRMAN. Dr. Wiener.

Dr. WIENER. I think this is an enormously complicated product. It requires elderly individuals to estimate not only what their income and assets will be when they are 85, but it requires them to estimate the cost of nursing home care and home care and how much informal care they are likely to get. Those uncertainties are increased exponentially when you are talking about a 45-year-old trying to plan for the future.

I am not optimistic about this product getting much simpler. As Barbara indicated, there is a lot of innovation going on, a lot of changes going on that make the product more complicated. But I would assume, that at some point out in the future we will get enough commonality so that we may be able to think about doing something like what we are doing with Medigap and have a fairly standardized set of policies that people can compare on a price basis. One of the problems now is it is nearly impossible to compare prices across similar policies. I would not propose standardization now, but I think it is something that we should come back to in the future.

The CHAIRMAN. I am going to dismiss this panel. Thank you very much for your participation and the public education on this very important issue.

The CHAIRMAN. I would ask our next panel to come to the table. Roger Auerbach from the State of Oregon, he is taking time from a busy schedule to be here. He is Administrator of Senior and Disabled Services Division and that is for the State of Oregon. This State agency purchases long-term care services for poor and frail seniors as well as individuals with disabilities. Mr. Auerbach also serves as a member of the Board of Directors of the National Association of State Units on Aging and chairs its Health and Long–Term Care Committee. The State of Oregon has received distinction for its initiative and innovation in long-term care programs. We are pleased to have his testimony.

The next witness is Dr. Alan Lazaroff. He is Director of Geriatric Medicine for the Century Senior Life Center in Denver. He has many accomplishments in the area of geriatric medicine. For one, Dr. Lazaroff founded the PACE program there in Denver and that acronym stands for Program for All-Inclusive Care for the Elderly. I thank him because he had to rearrange his schedule to be with us for today.

Finally, we will hear from Mark Schulte, President and Chief Executive Officer of Brookdale Living Communities, Chicago. Brookdale is a premier provider of senior and assisted living services. It combines congregate care and assisted living units. It was formerly the Senior and Assisted Living Division of the Prime Group, which Mr. Schulte was Executive Vice President of that. Mr. Schulte has 13 years' experience in the development and operation of multi-family housing, senior housing, assisted living, and health care facilities.

Before you folks begin, I think we are all right as far as time is concerned, but just so I do not run over a certain hour, we gave you 5 minutes and I know 5 minutes has been stretched out for a lot of people. If you see the red light come on, just finish your thought at that point. I do not want to cut you off in the middle of a thought.

Mr. Auerbach.

STATEMENT OF ROGER AUERBACH, ADMINISTRATOR, SENIOR AND DISABLED SERVICES DIVISION, OREGON DEPARTMENT OF HUMAN RESOURCES, SALEM, OR

Mr. AUERBACH. Thank you very much, Mr. Chairman. I appreciate the opportunity to share Oregon's experience in creating a long-term care system which gives Oregonians a choice of cost-effective community-based alternatives to nursing facility care. We built this system through a Medicaid waiver based on consumer preference to remain at home as long as possible or in a non-institutional setting with great savings for our taxpayers.

In the chart on page two, nursing facilities and community caseloads, you will see that since July 1985, our total Medicaid long-term care caseload has grown almost 100 percent. While the people we serve in home and community-based care has grown 224 percent, people served in nursing facilities has dropped by almost 10 percent. As of December 31, 1997, a little more than 2 months ago,

we served 75 percent of our Medicaid clients in home and community-based care settings.

In the chart on page three, long-term care resources, you will see that we accomplished this by developing a series of community-based options, more fully described in my testimony, including those defined in the chart. As you can see, over the past 4½ years, between 1993 and 1997, there has been a continued dramatic increase in home services and assisted living facilities and a continued decline in nursing facility beds.

The chart on page four, cost per case, we have examined the costs associated with a number of clients with similar care needs. This survival priority level ten includes people who need substantial assistance with mobility, who are dependent in bathing and dressing and may need assistance with eating and toileting. As you can see, the difference in cost per case to our program is dramatic when you compare nursing facility costs against community-based care services. Also note that there are client contributions with each community-based care service.

These cost-effective alternatives are also used by private pay consumers, meeting their preferences for living at home and in community-based care and slowing the pace at which they may spend down to Medicaid eligibility, thus helping to slow the growth of publicly-funded long-term care.

Our system has been successful, not only because of the creation of these options, but also because of our effective case management system. We assess clients' needs and arrange for long-term care services, but we also determine eligibility for medical assistance, food stamps, the qualified Medicare beneficiary program, and other State programs. We really develop an action plan with the consumer and use community resources, such as transportation, nutrition programs, neighbors, support groups, and other services that can enhance independence, and then we monitor our clients' progress to ensure their maximum well-being.

We also have State requirements that all residents be screened before they enter a nursing facility. This screening assures that the client's service needs match the care they will receive and ensures that clients and their families are aware of alternatives to nursing facility care.

I do not want to pretend that this is a system without flaw. We are constantly challenged by quality issues, provider payment and recruitment and retention issues, ensuring sufficient services in all geographic areas, and balancing client desire for choice against the need to control costs.

As I conclude, I would like to raise just two issues that could really help us deliver quality, cost-effective services in the near future. First, we would like the Federal Government to be financial partners with us to intervene earlier with people who are near Medicaid eligibility and who will become dependent without some limited services. We can keep people healthier and more independent a lot longer if we just intervene earlier.

Second, services and quality of life for people dually eligible for Medicaid and Medicare can be greatly improved by better coordination of those systems, lessening administrative complexity and paperwork, and mitigating cost shifting between programs.

I appreciate the opportunity to discuss our cost-effective, consumer responsive system with you today. Thank you, Mr. Chairman.

The CHAIRMAN. Did you actually finish?

Mr. AUERBACH. I did. Thank you. I appreciate that.

[The prepared statement of Mr. Auerbach follows:]

Statement by

Roger Auerbach, Administrator

Oregon Department of Human Resources

Senior & Disabled Services Division

on

"Reforming the Delivery System"

before the

Senate Special Committee on Aging

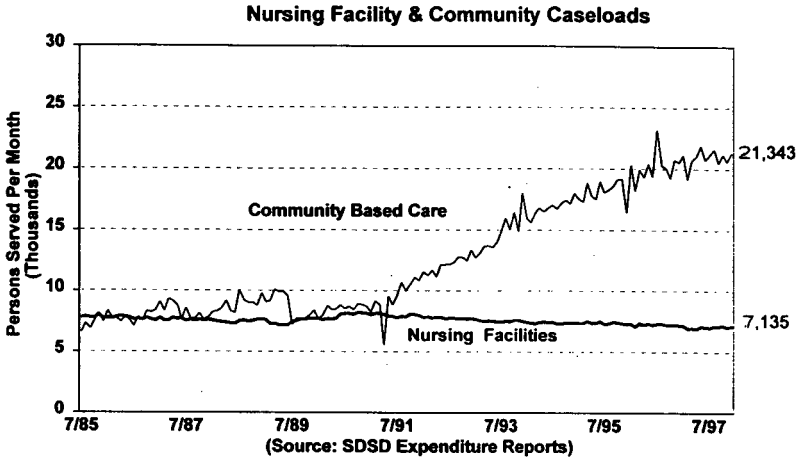
March 9, 1998

Thank you very much for this opportunity to share Oregon's experience in creating a long-term care system that gives Oregonians cost effective community-based alternatives to nursing facility care. While our experience may not be immediately transferable to other states, we believe we have created a long-term care system that is responsive to both consumers and taxpayers and that can serve as a model for policy makers.

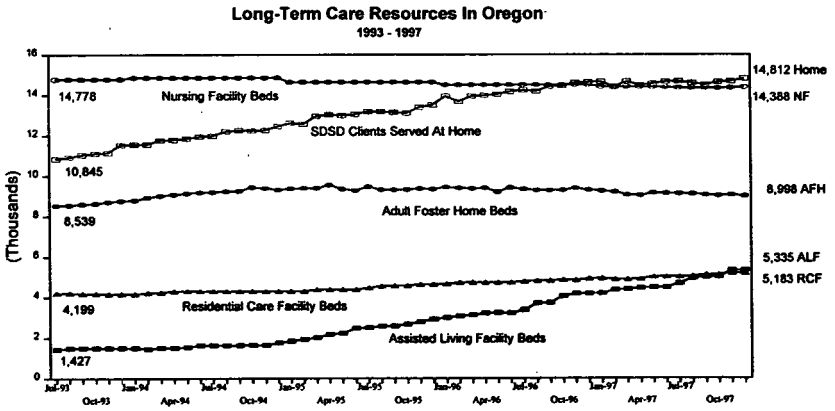
During the late 1970s, Oregon experienced a number of years of rapidly growing costs in our long-term care system. Oregon's Medicaid long-term care planners had to develop a creative and dramatic response. That response became the Oregon Model of Long-Term Care, a model which gives Medicaid clients choice among alternative care settings and which has significantly curbed the increase in Medicaid long-term care program costs.

Some of the causes of those rapidly growing costs continue. Oregon, like other states, is experiencing rapid growth in two "indicator" populations for long-term care use: the 85+ population and the 18-64 (younger) disabled population. (See Appendix A.) However, despite a 98 percent growth in total caseload since 1985, Oregon's nursing facility caseload has dropped 8.91 percent, while the percentage served in Home- and Community-Based Care has grown 224 percent. This has been accomplished through the reduction of inappropriate nursing home utilization and the development of community-based care options.

As of December 31, 1997, we served 75 percent of our Medicaid clients in home and community-based care settings.



Private pay consumers are also choosing community-based care at a much higher rate than 15 years ago. Oregon's system increases choices for all Oregonians and these cost-effective alternatives slow the pace at which long-term care consumers spend-down to Medicaid eligibility, thus helping to hold down the growth of publicly funded long-term care caseload.



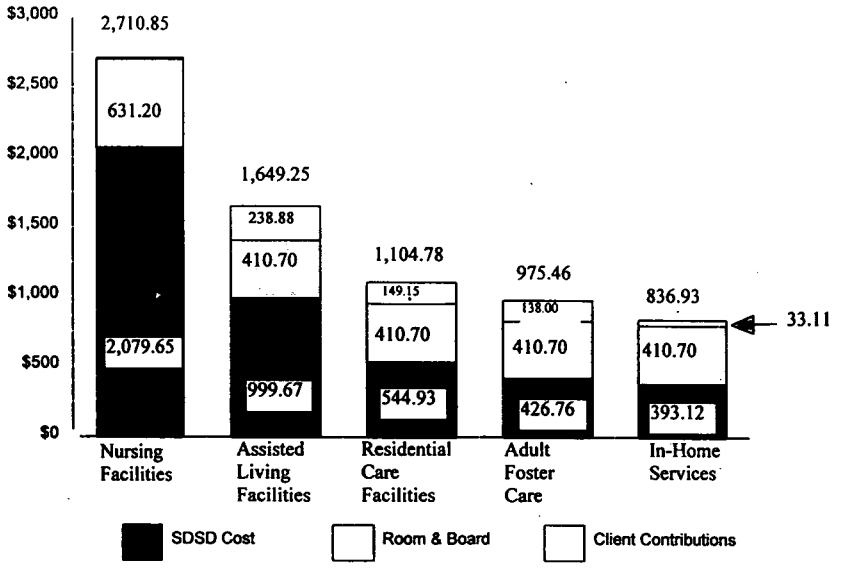
Oregon's system is made possible by a federal waiver that allows Oregonians eligible for Medicaid-covered nursing facility care to be eligible for a range of Medicaid-funded community-based care settings. The options available in Oregon are: respite care, adult day services, adult foster care, assisted living facility care, residential care, and in-home care. (See Appendix B.) Oregon offers services in a range of settings to people who need assistance with activities of daily living. Case management staff helps clients select the option that is right for them.

How Community-Based Care Options Were Developed

The waiver allowed Oregon to "guarantee" a demand for community-based care providers. However, the growth of the state's community-based care options really began to accelerate when the private sector began to take advantage of the new options. Early in the evolution of the system, the majority of community-based care consumers were Medicaid eligibles. This is no longer the case. While it took time to turn public opinion about community-based care, the private pay client most often chooses alternatives to nursing facilities because these alternative are less expensive and allow more personal independence.

Utilization of Oregon's community-based care options has become increasingly viable and desirable for significantly impaired individuals who previously used nursing facilities. Pre-admission screening and case management have helped consumers develop a plan of care that can eliminate the need to choose an institutional care setting. In-home care is frequently chosen by younger clients with significant disabilities. A critical component driving this trend is individual clients' preferences. Increasing expertise among community-based care providers also means that the system can support more impaired people in non-institutional settings. These trends increase the cost-savings Oregon is able to achieve.

Cost-Per-Case Survival Priority Level 10



Oregon's continuing success is demonstrated by the fact that our cost-per-case continues to increase at a rate slower than inflation. (See Appendix C.)

SDSD's System

A client entering our system goes through an eligibility determination process in which they may obtain the following services:

- Long-term care services
- Oregon Health Plan (medical assistance)
- Food Stamps
- Qualified Medicare Beneficiary Program
- Pre-Supplemental Security Income General Assistance (state-funded program)
- Oregon Project Independence (state-funded program)

If eligible, clients are assigned a case manager who serves as the client's primary contact with long-term care program. A case manager is responsible for:

- Comprehensive assessment
- Exploring the client's care setting alternatives
- Arranging for in-home care givers or other long-term care placement
- Coordination of community resources such as transportation, nutrition programs, neighbors, support groups, and other services that can enhance independence
- Assistance in obtaining necessary medical equipment and supplies
- On-going involvement to assure adequacy of care provision
- Emphasis on client's ability to function as independently as possible

The components of effective long-term care case management (including Oregon Project Independence) are the client assessment, the development of care plans, assistance with long-term care placement, and on-going monitoring of the client.

The Role of Pre-Admission Screening

Oregon requires that all residents be screened before they enter a nursing facility. This screening assures that clients' service needs match the level of care they receive. The screening also helps clients and their families explore other possible settings.

The Challenges that Face Oregon

Quality of care

Monitoring an institution with 100 residents is easier than ensuring quality in 20 adult foster homes, with five residents each. We believe that the lower cost of home- and community-based care, as well as its popularity with consumers, warrant an enhanced investment in quality assurance efforts. SDSD continues to strive toward better quality care across our long-term care system.

Capacity

Certain geographic areas continue to be under served and not enough options are available in all areas.

Provider Payment

As the acuity level of community-based care clients increases, SDSD is challenged to find simple ways to appropriately and adequately reimburse these providers.

Recruitment/Retention

Direct care worker turn-over rates are very high. This is partially attributable to our low-unemployment economy. Moreover, many workers do not have benefits or paid time off; they work in a traditionally undervalued field. Some solutions are simply monetary, but we must also identify ways to make care giving a more attractive profession.

Choice/Cost

Balancing client desire for choice against the need to control costs is one aspect, but the other is creating choices that suit the needs and preferences of a changing aging society.

Benefits of the system

Clients get alternatives to nursing facilities with a system based on choice. Taxpayers get a less costly program and slower cost growth than the rate of inflation.

The Future

Oregon will seek ways to intervene earlier with "non-traditional" services such as home modifications, chore services, and assistive technology that can enhance independence, prevent disabling accidents, and reduce social isolation. We will be focusing on

individuals who are likely to become Medicaid eligible.

More will need to be done to help people stay independent, prevent impoverishment and spend-down to Medicaid eligibility. The federal government should be financial partners with states to intervene earlier with people who are near income eligibility and who will become dependent without some limited services.

Oregon also looks toward a future in which the Medicare and Medicaid programs work better together. Services and quality of life for people in both systems will improve by reducing fragmentation, administrative complexity and paperwork; by coordinating services and funding; and by mitigating cost-shifts to state Medicaid programs.

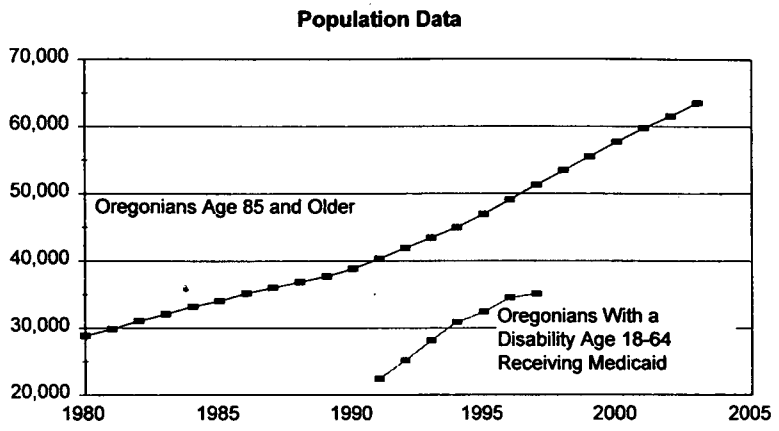
Conclusion

Oregon's system of comprehensive home- and community-based alternatives to nursing facility care has helped Oregon limit the growth of its Medicaid long-term care program.

Oregon's model provides services that are desirable to consumers and control costs. We have created options that serve private-pay consumers as well as Medicaid clients. Our state has much to share about creating a consumer responsive, cost-effective system.

I appreciate the opportunity to talk with you about it.

Appendix A:
Oregon "Indicator Population" Growth



Appendix B:
Oregon's Long-Term Care Options

Respite Care
Respite Care services give families and other care givers temporary relief from providing care for frail adults. Companionship, light assistance, recreational activities, and security are provided in a client's home, out of home in a group setting, or overnight in a residential setting. Respite care fosters a healthier quality of life for both the care giver and care receiver.

Adult Day Services
Adult day services can help people with physical and cognitive impairments remain independent. They are offered in a variety of centers around Oregon. People with chronic or progressive health problems can be served by adult day services; the clients most often served in this setting have difficulty performing familiar daily tasks, have lost initiative, motivation or memory, or need a safe environment and supervision. Adult day programs typically provide socialization, reminiscing, recreational exercise, counseling, support groups, information, nutritious meals and snacks, health monitoring, and art/music therapy. Some day centers also offer nursing, physical therapy, and personal care.

In-home Services
This is the most rapidly growing and popular part of Oregon's Long-term care System. Seniors and people with disabilities can receive services in their own home. Those services include help with personal or health care needs and housekeeping. Nursing services and home delivered meals can also be arranged. In-Home Services include:

- Meal Preparation
- Shopping and Transportation
- Home Health Services
- Assistance with Medication
- Housekeeping and Laundry
- Medication Management
- Money Management
- Assistance with Medical Equipment
- Dressing and Personal Hygiene Assistance

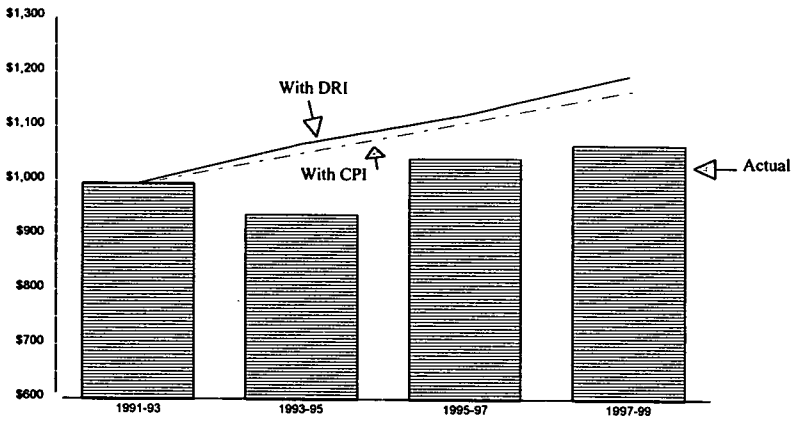
Adult Foster Homes
Adult foster homes are private residences licensed to provide care to five or fewer residents. They offer room and board, personal care from a care giver in the home 24 hours a day. Planned activities and medication management are available, and some provide transportation services, private rooms, or nursing services. A wide variety of residents are served in adult foster homes, from those needing only room, board and minimal personal assistance to those residents needing full personal care and skilled nursing tasks. The care provided depends on the client's needs and the skills, abilities, and training of the provider. Adult foster homes are inspected, licensed, and monitored by the state or by the local Area Agency on Aging (AAA).

Assisted Living Facilities
Assisted living facilities have six or more private apartments. They are fully wheelchair accessible and offer full dining room services, housekeeping and call systems for emergency help when needed. Registered nurse consultation is available. Physical care and additional health care supervision and assistance can be provided in the client's own apartment. Organized activities and transportation are available. These facilities follow guidelines that promote the residents' right to privacy, personal choice, and independence. Assisted living facilities are inspected, licensed and monitored by Senior and Disabled Services Division.

Residential Care Facilities
Residential Care Facilities serve six or more residents. They offer room and board with 24-hour supervision, assistance with physical care needs, medication monitoring, planned activities, and often transportation services. Some offer private rooms; some registered nurse consultation services. They are inspected, licensed and monitored by SDSD.

Nursing Facilities
Nursing Facilities provide nursing care on a 24-hour basis in a more institutional environment. They provide skilled care, rehabilitation, and end-of-life care. Nursing facilities are required to have licensed nursing staff in the facility 24 hours per day. Nursing facilities are most appropriate for people who need a more protective setting. Many residents have medical and behavioral needs that cannot be met in other care settings. Nursing facilities are inspected, licensed, and monitored by the state, in compliance with both state and federal regulations.

Appendix C:
Changes in Long-Term Care Cost-Per-Case



Biennium	Actual	CPI	DRI
1991-93	995.10	995.10	995.10
1993-95	937.30	1,051.13	1,068.38
1995-97	1,041.98	1,111.42	1,123.15
1997-99	1,166.66	1,164.15	1,194.19

Roger M. Auerbach
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Roger Auerbach serves as Administrator of the Senior and Disabled Services Division (SDSD) of the Oregon Department of Human Resources (DHR) and Assistant Director of the DHR. Auerbach is the chief executive of the state agency which purchases long-term care services for poor and frail seniors and people with disabilities. SDSD also operates protective service programs, and licenses and monitors long-term care facilities. SDSD also contracts with local Area Agencies on Aging to provide an array of community services such as congregate and in-home meals, transportation, legal services, and employment programs.

Auerbach serves on the Executive Committee of the National Association of State Medicaid Directors. He is a member of the Board of Directors of the National Association of State Units on Aging and chairs its Health/Long-Term Care Committee.

Auerbach has served as Acting Director of the Oregon Employment Department and as Senior Policy Advisor to Governor Barbara Roberts. He has a B.A. from Alfred University and a J.D. from Boston University School of Law.

The CHAIRMAN. Dr. Lazaroff.

STATEMENT OF ALAN LAZAROFF, M.D., DIRECTOR OF GERIATRIC MEDICINE, CENTURA SENIOR LIFE CENTER, DENVER, CO

Dr. LAZAROFF. Thank you, Mr. Chairman. I appreciate the opportunity to appear before the committee today.

I have practiced geriatric medicine in Denver for 20 years. My patients live with chronic diseases, such as diabetes, osteoporosis, and Alzheimer's disease. Over time, each chronic condition exacts a toll of functional impairment. Sometimes a patient's course is punctuated by catastrophic losses caused by conditions such as stroke, heart attack, or hip fracture, but these are themselves the potentially avoidable consequences of chronic disease.

Care of a person with chronic disease must be provided over a period of years in a variety of settings. The services of multiple professionals may be needed in various combinations at various times. A rational system for caring for such persons would facilitate coordination of care over time, across settings, and among those of varying disciplines and responsibilities.

I would like to illustrate the impact of system rules and financing structures on everyday medical practice by describing how care would be delivered for the same person with the same problems under three different scenarios, the first scenario being an individual with Medicare and the Medicare supplemental insurance policy, and this is Mrs. G, a frail 83-year-old widow who lives alone. I have known her for 10 years.

When she contracts influenza, she cannot manage at home. She becomes dehydrated. She is unsteady on her feet. I could care for her in the hospital's affiliated SNF unit, but Medicare will not pay for the care unless there is a preceding three-day hospital stay, so she is admitted to the hospital, where she is given IV fluids, physical therapy. One night, she becomes agitated. She tries to climb over the side rails and the nurse restrains her for her safety.

After 3 days, she is moved to the hospital's affiliated SNF. It is in a separate building. It has a different staff. To comply with Medicare rules, a new medical record is created, a new set of nurses and therapists repeats all of the assessments that were done a few days earlier in the hospital.

After 2 weeks, she is ready to go home and Medicare home health is arranged, a nurse, physical therapist, but after a month, it becomes clear she will need services for a longer period of time and a social worker arranges for her to be enrolled in Medicaid's home and community-based services program. Services will now be provided by a different agency.

Some months later, she breaks her hip. An ambulance is dispatched to her home. She is brought to the closest hospital, since Medicare will pay only for transportation to the closest hospital. She demands to be transferred to our hospital, and this is done, but later Medicare denies the claim for the second ambulance and she must pay $500.

After surgery and a short hospital stay, she goes back to the hospital's sub-acute unit. It becomes clear she needs to go to a long-stay nursing home. Her daughter chooses a facility near her own

home, 17 miles from the office, and her care is transferred to a new physician.

The new physician is not comfortable with the ability of the nursing home staff to evaluate and treat patients when they develop new problems. If the nursing home were to improve its staffing, invest in staff education so that the capacity to care for acutely ill patients would improve, no extra payment would be made to the nursing home. But the nursing home will be paid to hold the bed if she is hospitalized. It is just easier all around to send her to the hospital if she becomes sick.

So when she develops pneumonia, she is sent by ambulance to the nearest hospital, admitted to the care of the doctor who is on call for the emergency room, and over the next 9 months, she is hospitalized twice more, each time with a different doctor. She remains in the nursing home until she dies.

A second scenario is the same set of facts except that the patient now has joined a Medicare HMO, which offers us some greater flexibility in how the care is provided. For example, when she develops influenza, it is possible to admit her directly to the SNF because the three-day prior hospitalization rule is waived. Three days of hospitalization, multiple reassessments, and the trauma of an extra move are eliminated.

When she becomes agitated, instead of restraining her, the nurse in the SNF brings her out to the nursing station and she calms down. The SNF is a more senior-friendly facility where restraints are rarely used.

When she is transferred to the nursing home after her hip fracture, at least her care is assigned to a physician on the HMO's provider panel, since the HMO remains responsible for the Medicare services, and there is some movement whereby the HMO is trying to enhance care capacity in the nursing home in hopes of avoiding expensive hospitalizations.

When she develops pneumonia, she goes to the same hospital each time, the HMO's participating hospital. She sees the same doctor at each admission.

The third scenario is the same set of facts again, but this time Mrs. G joins a PACE program when she becomes eligible for long-term care services through Medicaid. A primary goal of PACE is to permit the frail elderly to remain in the community. The program offers a comprehensive package of acute and long-term care services, coordinated and delivered by an interdisciplinary team of professionals under a capitated model which pools Medicare and Medicaid dollars.

PACE providers are able to offer whatever combination of services is most appropriate, without the restrictions normally imposed to control fee-for-service utilization. In this case, her services are provided by an interdisciplinary team, not by two, three, or four different agencies paid by different programs which follow different rules and make no attempt at coordination.

When she fractures her hip, her primary care physician from PACE visits her daily. The PACE social worker develops her discharge plan. The PACE physical therapy supervisor begins to coordinate her rehabilitation. She is surrounded by the familiar faces

of people who are knowledgeable about her condition wherever her care is provided.

When she goes to a PACE-contracted nursing home, the same team oversees her care. Physical therapy services for Mrs. G are provided for a longer period, but at a lower intensity than usual. This is what she needs. After 3 months, she can walk safely with a walker and returns home instead of spending the rest of her life in a nursing home.

Chronic disease and its complications and exacerbations are already the dominant problem for Medicare, our ostensibly acute-care system for the elderly. Chronic disease produces the functional impairment in which the need for long-term care has its genesis. We maintain separate Medicare and Medicaid systems to deal with problems which are fundamentally inseparable.

Two long-range strategies for controlling the cost of long-term care have potential, the prevention of disability through better management of chronic disease and better care of those with functional impairment through flexible approaches adapted to their needs. The financial incentives and regulations of the traditional systems do not support these approaches.

For all its flaws, capitated managed care is, in my view, a promising development for the chronically ill. Disability prevention, better coordination of care are not only appropriate clinical goals but also offer the possibility of large cost savings for health plans. However, unless the opportunity to shift costs to a separately financed long-term care program is removed, Medicare HMO's will operate under conflicting economic incentives. Finally, the success of PACE demonstrates what can be achieved under circumstances in which both the financial and clinical aspects of care are thoroughly integrated.

I thank you, Mr. Chairman, and will be happy to answer questions.

The CHAIRMAN. Mr. Schulte, before you speak, I assume that you did not give dollar figures on each of the three scenarios, but I assume that the last scenario is the best investment for the taxpayer. That is your point, right?

Dr. LAZAROFF. That is the point. It is best for the patient and the taxpayer.

The CHAIRMAN. Were those real cases that would have a dollar figure on them if you wanted to compare one with the other?

Dr. LAZAROFF. We could certainly try to develop that information. The case is a composite, but all of the things mentioned are things that I encounter every day in my practice.

The CHAIRMAN. A figure in a bottom line would quantify it for us.

[The prepared statement of Dr. Lazaroff follows:]

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TESTIMONY OF ALAN LAZAROFF, M.D.
Before the
U.S. SENATE SPECIAL COMMITTEE ON AGING

"The Cash Crunch: The Financial Challenges of Long-Term Care Financing For the Baby Boom Generation"

March 9, 1998

I. INTRODUCTION

My name is Alan Lazaroff. I have been a practicing geriatrician for twenty years. Currently, I serve as the Director of Geriatric Medicine for Centura Health in Denver, Colorado and as Chairman of the Board for Total Longterm Care, Inc., a PACE project which has been in operation for seven years. Centura is a multi-hospital not-for-profit health system which offers the full array of primary, acute and long-term care services. Our organization is a member of the National Chronic Care Consortium (NCCC) and has developed a special focus on caring for persons with serious and disabling chronic conditions.

NCCC is a national nonprofit organization representing 33 of the leading edge health care organizations operating integrated delivery systems in the U.S. and Canada. NCCC and its member organizations are committed to testing and implementing innovative models of health care financing and delivery which are targeted to fully integrating providers, professionals and payers at every level of the health care system. NCCC has developed a special focus on the dual eligible population and provides consulting services in this arena to such entities as the Minnesota Senior Health Options Program and the Robert Wood Johnson Medicare/Medicaid Integration Program.

I appreciate the opportunity to testify on behalf of the National Chronic Care Consortium and Centura on a topic of critical importance to the elderly and chronically-ill. As the title of your hearing suggests, financing indeed presents a challenge to those of us serving the elderly, chronically-ill and other persons in need of long-term care services. Our current health care system has long been biased toward acute care services which are but one care component needed by the elderly and chronically-ill. This bias has increasingly undermined quality and cost containment goals as our country's health care problems have shifted from a

preponderance of acute care illnesses to an era where chronic conditions are the highest-cost, fastest growing segment of health care.

Yet, while publicly financed health care benefits for primary and acute care services continue to expand, benefits for long-term care services remain nonexistent except for the low-income who can access public assistance after they have depleted all of their resources on costly long-term care services. Until we recognize long-term care services as legitimate health care benefits, and begin to offer them under an insurance model, our delivery system will remain fragmented and the health care needs of the elderly and chronically-ill will continue to go unmet. For these reasons, we applaud the Senate Special Committee on Aging for addressing these critical issues and providing the opportunity to develop a meaningful agenda for long-term care financing and delivery reform. For as we enter the 21st Century, baby boomers need these services for themselves, not just their aging parents.

My testimony today will focus on three areas:

- Barriers to integrating primary, acute and long-term care services for the elderly and chronically-ill and the implications of these barriers relative to cost and quality;

- Three variations on one case study which will illustrate the relationship between financing and care delivery and demonstrate why we must modify our current health care financing and administrative structures to permit positive changes in the way care is delivered; and

- Recommendations for modifying our current financing and delivery structures to better serve the elderly and chronically-ill.

II. BARRIERS TO INTEGRATING CARE FOR THE ELDERLY AND CHRONICALLY-ILL

A. Overview

To date, our health care system has failed to recognize the need for integration of primary, acute and long-term care services in a fashion that:

- simplifies access for consumers;
- offers providers the flexibility to provide whatever combination of services are most appropriate and cost-effective at a given time for a specified population;

- recognizes the potential to improve quality and reduce costs through an integrated delivery systems approach; and
- takes a long-run view of systems reform and cost-containment.

Managed care approaches hold promise for helping to improve health care quality and thereby rein in the costs of care for he chronically-ill and elderly who often are dually eligible for Medicare and Medicaid benefits. While bout 30% of Medicaid and 13% of Medicare beneficiaries are enrolled in managed care programs, however, only 3% of the dually eligible receive services from HMOs and like entities. Federal demonstrations like the Social Health Maintenance Organization and the Program of All Inclusive Care for the Elderly (PACE) and state demonstrations for the dually eligible represent important steps toward better meeting the multidimensional, longitudinal needs of the chronically-ill and dually eligible more effectively. Each of these programs integrate, to varying degrees, the financing and delivery of health and related services for these populations.

Although 26 states enroll the elderly and disabled in risk-based managed care programs, only about 16 states enroll the dually-eligible in such programs. Further, few integrate coverage of long-term care services under capitated payment systems. Even states that are working toward integration of Medicare and Medicaid programs such as Minnesota have not fully integrated the financing and delivery of primary, acute and long-term care services and continue to pay for many long-term care services on a fee for service basis.

B. Systems-Oriented Approach

Historically, the movement toward managed care has been focused on cost-containment through the greater use of preventive services, reduced hospitalization, more prudent use of specialty care physicians and prior authorization of inpatient and specialty services. To improve quality of care and health outcomes and reduce costs, we must move from an acute care to a chronic care orientation; i.e., we must adopt an interdisciplinary approach which recognizes the multidimensional and progressive nature of chronic disease. Care for the same person frequently is provided by multiple organizations with little or no incentive to work together to meet common goals regarding patient outcomes and cost containment. Yet cost containment and quality of life for persons with serious and disabling chronic conditions are significantly dependent upon the full array of primary, acute and long-term care providers working together to prevent, delay or minimize disability progression.

The current system must be restructured to allow providers the flexibility and to offer the financial incentives to more effectively respond to the needs of the chronically-ill, manage their care across time, place and profession, and to use

whatever combination of care is most clinically- and cost-effective. Providers must have the ability to make patient care decisions based on clinical judgements about the most effective treatments and settings, not based on which programs and services are reimbursed by a particular payor.

C. Cost Containment through Improved Quality & Outcomes

In moving from a health care approach that focuses on single settings to an approach oriented toward systems integration, new quality assurance measures are necessary. For example, rather than judging a provider's effectiveness in caring for a patient at every stop along the continuum, we should develop tools that measure a person's health care status over the course of their condition. Further, since the goals of serving the chronically-ill typically are directed toward disability prevention, not disease cure, we need quality assurance measures that reflect a different expectation with regard to outcomes.

Quality of care for the elderly and chronically-ill could be enhanced by establishing new guidelines and outcome measures which are designed to identify:

- Risk factors and interventions associated with progression of disability;
- Interrelationships among medical, functional, cognitive, social and environmental conditions;
- Clinical and financial effectiveness of different treatment protocols for specific chronic conditions across settings;
- Patient encounter data across settings; and
- A core data set (i.e., utilization, costs, quality, outcomes, etc.) and methods for managing care across time, place and profession.

D. Payment Reform

For integration to occur under managed care plans, all providers serving the same patients must share in the financial risks and rewards associated with providing care, with all providers working toward common cost and quality goals across the network. We must move beyond containing costs within isolated health care sectors such as hospitals and nursing homes and toward establishing administrative, clinical and financial incentives for managing aggregate costs across time and settings.

Most cost containment strategies, including those involving capitated, managed care financing, focus on short-term cost savings within existing provider structures with separate contracts and risk arrangements. Control is organized around service amount, frequency, and duration for specific care segments, rather

than on strategies to reduce aggregate costs over the long-run. There is little if no incentive for providers to collaborate in cost-savings across the continuum of care. This approach is likely to actually increase aggregate costs in the long-run, not decrease them. Even managed care organizations engage in a certain amount of cost-shifting within the system. For example, many HMOs limit their financial risk by passing it on to the providers with whom they contract on a fee-for-service basis. The result is risk management on a piece meal basis by negotiating the lowest-priced contract for each provider or service. The result is a high cost administrative structure and an ineffective delivery model for serving people with chronic conditions.

Policies governing provider practices must be less prescriptive of process and more focused on health outcomes and aggregate cost savings across settings. Federal and state policies must shift from containing costs within each program (e.g.) Medicare and Medicaid – and provider category (e.g., hospitals, nursing homes, physicians, etc.) to containing aggregate costs over the course of a chronic condition. Financial incentives must encourage providers to collectively contain costs and prevent disability progression across time, place and profession. Provider systems should be paid under shared risk arrangements with incentives for achieving cumulative cost and outcome targets. Providers and health plans should receive financial incentives to accept and target the high-risk, high cost populations through risk-adjusted payments, not incentives to shun those with serious and disabling chronic conditions because payment methods do not recognize the higher costs of caring for this population. And for the chronically-ill, this means risk-adjustments which account for functional disabilities and comorbidities, not just the severity of the primary medical diagnosis or condition.

Current payment policies place providers very much in a "catch-22" situation. Those of us operating in systems which have special capabilities for effectively treating the needs of the elderly and chronically-ill, ironically, have a disincentive for promoting these capabilities because current payment policies do not protect us against adverse selection. It seems that health care payment policies have spawned a contest to see who can outwit whom – providers or regulators – instead of focusing on the very real needs of one of our most vulnerable populations – the elderly, chronically-ill.

E. Uniform Administration and Oversight

Health care administrative policies and procedures exist for each Federal program and provider setting. Regulations governing eligibility criteria, coverage rules, payment policies and evaluation methods differ across programs categories such as Medicare and Medicaid. Requirements regarding patient assessments, care planning, data collection and record keeping are separately defined for

clinics, hospitals, nursing homes and community-based service settings resulting in high costs and care fragmentation. Separate program administration makes it virtually impossible to measure the relative effectiveness of various treatments and interventions.

Policies governing acute and long-term care programs must be made more consistent through strategies such as standardized goals, objectives, service definitions, standards and reporting requirements for programs serving the elderly and chronically-ill. All networks providers should be required to collect a standard set of core data on client characteristics, health status, service use, costs and quality outcomes with a special focus on conditions with long-term service trajectories.

This section of my testimony has summarized the major barriers to integrating primary, acute and long-term care services for the elderly and chronically ill from a regulatory perspective. Following are three case studies which progressively move from a traditional fee-for-service model to a fully integrated model of comprehensive care with pooled financing from the Medicare and Medicaid programs. These case studies are intended to illustrate how financing drives approaches to care and health outcomes and how regulations prevent providers from offering whatever combination of care and services we deem most clinically and cost effective in meeting our patients needs.

III. CASE STUDIES

My patients live with chronic diseases like congestive heart failure, emphysema, arthritis, osteoporosis, diabetes, and Alzheimer's disease. Over time, each chronic condition exacts an increasing toll on functional impairment, sometimes punctuated by catastrophic abrupt losses caused by conditions such as stroke, heart attack or hip fracture. These are themselves the potentially avoidable consequences of chronic disease. In many patients, multiple chronic conditions coexist and interact, generating needs which transcend the boundaries of any single professional discipline. Most of my patients enjoy satisfactory health at any give time, but unless death intervenes first, all of them, and all of us, face a future which includes coping with chronic disease. When chronic disease produces permanent functional impairment which renders us less than fully independent, we will have entered the long-term care population.

The management of chronic diseases and disabilities demands a longitudinal perspective, with emphasis on maintenance or improvement of function and prevention of additional disability. Care can be provided at home, in the office or clinic; in the hospital, in various types of licensed residential facilities such as personal care homes or assisted living facilities, and in nursing homes.

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The services of doctors, nurses, rehabilitation therapists, social workers, psychologists and nutritionists, among others, may be needed in various combinations at various times. Less skilled staff such as nurse aides are critical as well. The patient's self-care ability and the quality of his/her informal support network are important but hard-to-measure determinants of the need for formal assistance. A system designed to meet the needs of a person with chronic illness would facilitate coordination of care over time, across settings, and among those of varying disciplines and responsibilities.

Most chronically ill elderly individuals today rely upon a poorly coordinated hodgepodge of programs and services whose operation is driven by complex and inflexible eligibility and payment rules. In some instances, the person is shunted from place to place, offered services which start and stop suddenly accordingly to a logic opaque to the consumer, all the while feeling overwhelmed and fearful of the financial consequences.

From the perspective of a geriatrician, the fee-for-service Medicare system is replete with irrational incentives – and downright disincentives to providing the most appropriate and cost effective care. It was designed to pay for the care of discrete episodes of acute illness, each of which is treated in a single specified setting, using well-defined technological interventions . These interventions result in a return to health until the next episode, but do little to prevent the next incident from occurring. My most important work deals with the management of chronic disease between periods of acute exacerbations. Adjustment of medication, early detection of problems, referrals to and coordination of other services, teaching and counseling – these are the things I spend my time doing. My goal is to avoid acute exacerbations and progressive disability. Acute disease arising de novo is an inconsequential part of my practice. The structure and rules of Medicare, governing areas like billing and eligibility for services, must be meant for someone who does something else.

Much of my most important work is unrecognized and uncompensated. If I hospitalize a patient, I can bill Medicare every day I make a hospital visit– never mind whether this is the most appropriate treatment. If I meet with family members of a patient with Alzheimer's Disease, coordinate the services of several professionals, counsel patients and families about both the benefits and limitations of aggressive treatment, and help my patients cope with the emotional consequences of their illness, however, I can bill nothing. I may be able to improve quality of life at the same time that I reduce inappropriate and unproductive hospitalizations, ICU care and emergency room visits, but the more I focus on preventing or delaying the progression of disability, and the more money I save the Medicare program, the less I am paid. Something is terribly wrong with a system that rewards the unnecessary use of high-cost, high tech services for a

patient population that is equally dependent upon a vast array of supportive services and which penalizes practitioners who provide the services needed most, often at a lower cost.

I'd like to illustrate the impact of Medicare payment rules on medical practice and health care decision making by describing how care would be delivered for the same person with the same problems under three different payment approaches. Each approach I describe will progressively add incentives for integration of care across settings. The first scenario assumes the patient's care is financed under Medicare and Medicaid fee-for-service plans with no structure or incentives for service integration or coordination across payers or provider settings. The second approach does a better job of integrating primary and acute care services across settings under a Medicare risk contract, but continues largely to ignore coordination with long-term care services. The third approach describes PACE -- a fully integrated program which pools Medicare and Medicaid funding to provide a comprehensive package of primary, acute and long-term care services without regard to scope or duration of coverage.

Scenario 1: Medicare and Medicaid Fee-for-Service: No Integration

Mrs. G is an 83 year old widow of modest means who lives alone in an apartment. I have been her physician for ten years. Her insurance is Medicare and she also has supplemental coverage. She has a daughter who lives in another city and a frail older sister who lives nearby. The sisters have helped each other over the years, but this no longer is feasible.

Mrs. G's problems include osteoporosis, arthritis, and hypertension. She walks with a cane. She has fallen several times without injury and has become a bit confused at times, probably from early Alzheimer's Disease. During an influenza episode, Mrs. G becomes ill in spite of having taken a flu shot. She falls at home and calls a neighbor, who brings her into the office. She has been eating poorly, has lost five pounds since her last visit, and is unsteady on her feet. She is more confused than usual and appears mildly dehydrated. It is unsafe to send her home. Her needs could be met in the hospital-affiliated skilled nursing facility (SNF), but Medicare will not pay for the care unless she is hospitalized in an acute care facility for three days first. She is admitted to the hospital where she is given IV fluids and begins physical therapy. One night she becomes agitated and tries to climb over the side rails. She is restrained for her safety.

After three days, with the help of the hospital discharge planner, she is transferred to the lower-cost skilled nursing facility. In fact, we don't know if her care will cost less if we transfer her but the transfer produces more revenue for the hospital system. In addition to getting paid the DRG case rate for Mrs. G's

inpatient stay, when transferred to the nursing home, the hospital can begin billing Medicare a daily rate for SNF care. Had she stayed in the hospital a few days longer, payment would have been limited to the flat case rate. The SNF is in a separate building and has a completely different staff. A new medical record is created and Mrs. G goes through a series of assessments by nurses and therapists-- many of which already have been performed in the hospital -- and tries to adjust to her new surroundings. Another admission, another history, and additional lab tests are needed because Medicare won't allow providers simply to transfer patient records with the patient to a new setting.

Mrs. G improves and after ten more days is ready for discharge. Concern is raised about her living situation, which is felt to be marginal, but she badly wants to return to her own apartment and familiar surroundings. A visiting nurse, physical therapist, and home health aide are ordered through the home health care agency owned by the hospital system. After a month, although she still is marginal, I am informed that the home health agency will discharge her because of concern about her continued eligibility for Medicare home health benefits. Why did this happen? Because aggressive pursuit of fraud and abuse in the home health care industry has led many providers to adopt a conservative approach to continuation of home health care benefits of a lower intensity which could be viewed as "long-term care" as opposed to post acute care benefits. Of course, provider behavior in this regard will vary based on geographic location since interpretation of HCFA's payment policies varies from region to region.

In my office at Centura, we have the unusual advantage of having ready access to social workers, one of whom is already familiar with Mrs. G. She suggests that we seek to enroll Mrs. G in the Home and Community-Based Services program (HCBS) offered by Medicaid as an alternative to care in a nursing home. After a time she is approved, having satisfied requirements related to financial need (i.e., low-income) and medical necessity (i.e., she is deemed "nursing home certifiable" and absent home health services, would likely be institutionalized at a higher daily rate). Since the hospital's home health agency does not have a Medicaid contract, however, another agency with new staff who is unfamiliar with Mrs. G's history and needs begins serving her. The second agency also has a Medicare contract and quickly calls me to request that I approve a visiting nurse, physical therapist and home health aide, social worker and occupational therapist to be funded by Medicare – in addition to the services provided under the HCBS contract. The request is for the same services that the hospital's Medicare certified home health agency just discontinued due to concerns about denial of claims for ongoing services. This is a classic case of cost-shifting where the Medicaid agency is attempting to shift the cost-burden back to Medicare.

Some months later, Mrs. G falls again at home and is found on the floor by her neighbor. She has pain in her left hip and can not move her left leg. The neighbor calls 911 and requests that Mrs. G be transported to the emergency room of the hospital where I practice. She is told that Medicare will pay for travel only to the closest hospital. An evaluation in the emergency room of the closest hospital confirms the suspected hip fracture. She demands to be sent to our hospital and is transported by a second ambulance and admitted.

She has surgery on her hip and after three days is transported to the SNF, where she is remembered by the staff. She is confused and has difficulty cooperating with physical and occupational therapy, but makes slow progress. After 15 days she still requires assistance with transfers and walking, and it is clear she will require longer term nursing home care. She is promised that when she improves she can return home. Her daughter chooses a nursing home 17 miles from my office, and her care is transferred to another physician. Although she could be transferred by a wheelchair-equipped van, Medicare will not reimburse for nontraditional medical services like vans, so she is sent by ambulance.

Four months later, her daughter telephones and is irate that payment for the ambulance ride between hospitals was denied by Medicare, resulting in an outstanding bill of $500. She wants to know why I did not arrange for her mother to be sent to the right hospital in the first place. I promise to write a letter appealing the denial.

Meanwhile, her new physician, Dr. K, sees her each month for a scheduled visit. He is not comfortable with the ability of the nursing home staff to evaluate and treat patients with new problems, and feels he cannot visit frequently enough to supervise the care if she becomes acutely ill. But he has been told that Medicare may not pay him for visits more often than monthly unless he justifies the care with a lot of paperwork. The physical therapist reports that because of her dementia, Mrs. G cannot benefit from therapy so this is discontinued after a week. Later, when Mrs. G develops pneumonia, her physician instructs the nursing home to call an ambulance to take her to the emergency room. While the nursing home is capable of attending to Mrs. G's medical needs, it does not get additional reimbursement for increasing its staffing to provide more care if she becomes acutely ill. The facility will be paid, however, for holding an empty bed when patients are hospitalized. Once again, the misalignment of financial incentives drives Mrs. G's care instead of factors related to her medical needs. Once again, Mrs. G is subjected to a needless discharge and transfer process, further exacerbating her increasingly fragile cognitive health.

She is transported by ambulance to the emergency room of the nearest hospital and admitted under the care of the physician who is on-call for the

emergency room for the day. A list of diagnoses and medications is provided by the nursing home, but no information is available about her care or her function before her admission to the nursing home. After a week she returns to the nursing home, having been proceeded through yet another discharge and readmission, but has lost ground. On two other occasions in the next nine months she returns to the hospital, receiving care from a different physician in each instance. She is less functional than ever, increasingly confused, and will reside in the nursing home until her death.

Scenario 2: Medicare HMO Risk Contract: Partial Integration

In the second scenario, Mrs. G has joined a Medicare HMO because she could save quite a bit of money. Since the HMO is a zero-based premium plan, the only cost-sharing requirements are modest copayments of $5 for certain services such as physician visits and prescription drugs. Further, the minimal cost-sharing requirements enable Mrs. G to discontinue her Medicare supplemental insurance plan for which she paid in excess of $1,500 annually for premiums. In addition, at the marketing presentation, Mrs. G was told that the HMO was "just as good as Medicare." In fact, the Medicare HMO provides additional coverage for such benefits as dental visits, eyeglasses and prescription drugs – expenses Mrs. G funded out-of-pocket under her Medicare fee-for-service plan. Since I serve on the HMO's physician panel, Mrs. G does not have to change doctors . Further, although she is unaware of it, the global capitation structure of the plan allows the provider network considerably more flexibility in caring for her than did the Medicare FFS plan.

Let's consider the same scenario with respect to Mrs. G's episodes of illness under a Medicare HMO plan:

- When she develops influenza, she is admitted directly to the SNF since Medicare HMOs have the authority to waive the 3-day prior hospitalization rule. This direct admission saves the costs of three unnecessary days in the hospital, reduces the administrative burden and expense of a hospital admission and discharge, eliminates the cost of the ambulance as well as a number of reassessments and duplicative lab tests, and eliminates the transfer trauma to Mrs. G which, in the earlier scenario, exacerbated her confusion.

- When she becomes agitated this time, the nurse decides to bring her out to the nursing station while she does her charting *instead of restraining her*. Nursing facilities are much more "senior friendly" than hospitals because they have a better understanding of elderly persons' needs. Nurses and aides receive education about agitation, confusion and other "behavioral problems" and how

to address these problems in a more humane and effective fashion than through the use of restraints.

- Upon discharge to home, a social work case manager is assigned to Mrs. G to assist her with the transition. She visits Mrs. G at home to gain a better understanding of her living situation so that the necessary supports are made available. Where a Medicare FFS plan would not have covered the social worker visit, Medicare HMOs have the flexibility to substitute or provide alternative services. Centura pays social workers out of the physician capitation to help manage care in the community and prevent hospitalizations.

- After two weeks, the plan utilization review nurse questions whether Mrs. G is receiving services that are really long-term care and should not be the plan's financial responsibility. The case manager and utilization review nurse debate the boundaries between Medicare and Medicaid, but services are continued for two more weeks while the case manager works to get Mrs. G enrolled in the HCBS program. Upon approval, a Medicaid certified HMO begins serving her. Again, the home health agency requests that I approve a visiting nurse, physical therapist, home health aide and social worker for Medicare payment. This time, however, I inform the agency that, since they are not a network provider in Mrs. G's Medicare HMO, I cannot approve these Medicare services. The HCBS agency increases Medicaid-funded services somewhat as a result. In the event that Mrs. G does need Medicare funded home health care in the future, however, she will be served by two agencies simultaneously with no attempt at coordination since each agency employs their own staff who are paid by different programs.

- When Mrs. G is discharged from the hospital following surgery for a hip fracture, she is transported to a nursing home by a wheelchair-equipped van which the HMO pays for, unlike Medicare FFS, which sent her in an ambulance at a considerably higher cost.

- While Medicare FFS would pay for only one nursing home visit per month, the HMO will pay more frequently when necessary, enhancing care and very likely preventing a rehospitalization.

- Although the plan does not bear responsibility for nursing home care, discussions begin about using the plan's resources to enhance the capabilities of the nursing home, so that more problems can be treated there as an alternative to hospital readmission. For example, some Medicare HMOs dispatch nurse practitioners to nursing homes on a routine basis to assist them with patient care with a view toward improved outcomes.

Scenario 3: PACE: Full Integration of Medicare & Medicaid Benefits

In this scenario, Mrs. G is referred to the local PACE program when her Medicare home health care benefit is exhausted. PACE, or the Program of All Inclusive Care for the Elderly, provides all Medicare and Medicaid health-related services to a population of dually eligible individuals in an integrated manner with a single capitated budget. PACE strives to maintain frail individuals in the community, reducing reliance upon institutional settings such as hospitals and nursing homes. If Mrs. G elects to enroll in PACE, she first must disenroll from her HMO (if any), change her physician, and agree to receive all care for both acute and long-term care needs through PACE. PACE , in turn, will :

- provide or arrange for *all* of Mrs. G's care needs including hospital care, physician care, medications, home health, and nursing home care if it cannot be avoided;

- dispatch an aide to Mrs. G's apartment for one hour each morning to help her get ready for the day;

- provide the following services at the day care center: bathing, since she cannot manage this task without assistance; access to a physician or nurse practitioner as often as needed; rehabilitation therapy at whatever intensity is needed for as long as required; a noon meal and possibly food to take home at the end of the day.

Mrs. G's services will be provided by an interdisciplinary team which can discuss any urgent issues on a daily basis and which will comprehensively reevaluate her health status quarterly. When she falls and breaks her hip as a PACE participant, her PACE primary care physician visits her daily, a PACE social worker visits her in the hospital the day after her surgery and the physical therapy supervisor visits to begin coordinating Mrs. G's rehabilitation therapies. Each is knowledgeable about Mrs. G's health problems and needs and provide continuity of care as well as emotional support at this distressing time. On the second post-operative day, she is transferred to a community nursing home with which has a PACE contract . Since many PACE participants receive services from this nursing home, PACE staff are often in the facility, again offering continuity. Physical therapy is provided by contracted therapists who work regularly with the program and understand the needs of PACE participants.

Because Mrs. G is confused, her progress is slow. Therapy services are provided less intensively, but for longer than usual since PACE is not subject tot he same restrictions on home health care services as Medicare fee-for-service providers. The interdisciplinary team at the day center reviews her status each

week. After three months of therapy, she can walk safely with a walker and is returned to her apartment instead of spending the remainder of her life in a nursing home.

Mrs. G is brought to the day center six days weekly, but after a month of further gradual improvement, this is reduced to three times a week. When she later develops pneumonia, she is treated with antibiotics and IV fluids in the day center during the day and in transitional housing operated by PACE for several nights (instead of the hospital per Scenario 1 or the nursing home per Scenario 2). Over the next nine months, she develops a urinary tract infection and dehydration and spends two weeks in the nursing home where she has stayed previously. Her physician and social worker supervise her care in all settings. She does not require hospitalization. Recently she can no longer manage at home and moves to an assisted living facility with which the PACE project works closely. She continues to attend the day center four days each week.

IV. CONCLUSIONS

Chronic disease, the dominant problem in the health care of the elderly, will become an overwhelming concern as America's population continues to grow older. Medicare, our "acute care" system for the elderly, even now deals almost exclusively with chronic disease and its complications and consequences. But the program has not made the transition to a chronic care approach to financing and delivery, nor will this transition be possible absent changes in health care regulations. Chronic disease produces the functional impairment in which the need for long term care has its genesis. Thus, there is an unbreakable link between the treatment of chronic disease in all its stages in the Medicare system and the provision of long-term care through Medicaid. Yet progress toward integration of these two programs has been marginal.

Two strategies for controlling the cost of long term care have great potential: the prevention of disability through better management of chronic disease, and better management of the care of those who require long-term care through more flexible approaches adapted to their needs. Catastrophic illnesses like strokes, hip fractures, and heart attacks can be reduced through treatment of the chronic diseases which produce them. We know how to do this today, but need to operate in a system which promotes prevention and rewards better clinical outcomes. In my view, the fee-for-service Medicare system is a Byzantine tangle of fragmented services and complex, often counterproductive rules. It has degenerated into an unseemly contest between the regulators and the regulated. It rewards overuse and poor results. It provides what is paid for, whether needed or not, and nothing else.

For all its flaws, capitated managed care is a promising development for the chronically-ill. Since those who are sick are costly, the needs of the chronically ill are of exceptional interest to those who bear the financial risk for their care. Prevention of additional disability among those with chronic illness offers the allure of large cost savings which can be realized within a business executive's planning horizon. Investments in care management and population-based approaches, which were unthinkable in the old system, could contain costs by helping people to stay healthier. Integrated systems of care, the progeny of managed care financing mechanisms, can develop information about effectiveness and cost which will support the creativity and risk-taking needed for real reform.

Viewed from ground level, the separation of Medicare and Medicaid is unfortunate. Cost-shifting opportunities produce irrational patterns of care, resulting in lower quality and higher costs for both. The nether region at the boundary between the programs is rife with gaming and anomalies. In fee-fore-service, home health agencies provide lots of long-term care in the guise of something else. In managed care, much less home care is provided with the rationale that it is really long-term care. Managed care encourages the flexible use of resources guided by clinical and financial effectiveness rather than reimbursement opportunities. Rather than deciding where to treat a patient, the PACE physician and his interdisciplinary team partners consider what services she needs and how to provide them in the least costly and least disruptive manner. The lessons of PACE have broad applicability to the problems of chronically ill of all ages.

The National Chronic Care Consortium has developed a legislative proposal to address the many short-comings with our current health care financing and delivery system. Key components of this legislation are summarized below in the form of recommendations for Congressional action. A complete copy of the specifications for this legislation is attached to my testimony.

V. RECOMMENDATIONS

The NCCC currently is working with Members of Congress to develop capacity building legislation to improve health care services for the elderly and chronically-ill and to achieve long-term cost savings through more effective care. Our model legislation is called the Chronic Care Act of 1998: Living Well with Chronic Conditions – A Blueprint for the 21st Century." Below is a summary of key provisions in this Act for which we seek the support from all members of this distinguished panel.

A. Chronic Care Agenda for the 21st Century

To achieve the type of structural transformation of our health care system needed to address the needs of the elderly and chronically-ill and to improve quality of care and reduce costs, we must change the public's perception of the problem. We must create a sense of urgency born out of an understanding of the needs of the chronically-ill. While chronic diseases and disabilities are the highest cost, fastest growing segment of the health care population, our system continues to focus on the acute care system. Our model legislation would shift the focus to chronic disease by establishing a National Commission on Chronic Care charged with:

- identifying the special problems of the elderly, disabled and chronically-ill;
- assessing the aggregate costs of caring for this population well into the next century;
- developing quantitative targets for reducing the prevalence of chronic conditions, improving health outcomes among those who have chronic conditions and decreasing the costs of treating this population; and
- developing options for addressing these problems and meeting established targets.

The findings and recommendations of the Commission would be unveiled at a Chronic Care Summit with participation among consumers, providers, payors, policymakers and regulators. Further, a Clearinghouse on Chronic Diseases and Disabilities would be established to educate consumers and professionals alike on issues related to the nature of and treatment for chronic conditions and to collect and disseminate best practices for a targeted set of conditions.

B. Quality Measurements

The Secretary would be directed to develop methods for measuring quality and outcomes based on a chronic care model where functional capacity or impairments would be as relevant to outcome measures as are medical conditions. Outcomes would be based not on cure, but on preventing, delaying or minimizing disability progression.

C. Financial Incentives

The Medicare Payment Advisory Commission would be directed to study payment issues related to care of the chronically-ill, including an assessment of current incentives for cost-shifting between programs and providers and avoiding enrollment of high-risk populations in capitated heath plans. The Commission

further would be directed to identify financial incentives which would encourage plans and providers to target high cost, high risk clients, to focus on disability progression and to measure the effectiveness of clinical interventions across programs and providers and over time.

D. Regulatory Barriers

The Secretary would be directed to establish a Task Force on Regulatory Simplification composed of federal and state officials, consumers, providers and other appropriate representatives of the chronically-ill and their providers and payers. The Task Force would be charged with identifying barriers to integration and developing options for streamlining administrative and oversight regulations across providers and programs, with a special focus on developing uniform standards for Medicare and Medicaid.

E. Prototype Models

A partnership would be established between the Department of Health & Human Services and the Veteran's Administration to develop prototype models for targeted chronic conditions which later would be mainstreamed to other programs and populations. The prototype modeling would include the development include high risk screening and intervention strategies for the chronically-ill and disabled and best practices for a targeted set of chronic conditions such as CHF, COPD, Alzheimer's Disease and diabetes.

Detailed specifications for the model Chronic Care Act are attached. I respectively request your careful consideration of and support for this important legislation which could provide the basis for fundamentally transforming the way primary, acute and long-term care services are delivered today.

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SPECIFICATIONS FOR CHRONIC CARE ACT OF 1998 -- LIVING WELL WITH CHRONIC CONDITIONS: A BLUEPRINT FOR THE 21ST CENTURY (February 25, 1998)

I. PURPOSE

A. To create a sense of understanding and urgency regarding the need for systems transformation in the care of persons with serious and disabling chronic diseases and disabilities.

B. To establish guidelines for effective public policies regarding care of the chronically-ill, including specific quantifiable targets for improving quality, reducing prevalence rates and reducing costs.

C. To develop the capacity to improve care for the chronically-ill and disabled through better information regarding the problems of the chronically-ill:

- identify the special problems of serving the chronically-ill and assess aggregate costs of health care for this population;
- develop options for improving health care delivery focused on the special needs of the chronically-ill;
- identify appropriate methods for measuring health care outcomes related to preventing, delaying or minimizing disability progression;
- identify financial incentives for serving high-risk, high cost populations;
- identify regulatory barriers to continuity of care among providers and payors serving the same person;
- establish a clearinghouse for providing consumers, providers and payors information about chronic disease and disabilities and best practices for effective intervention;
- establish a partnership between HHS and the VA in developing prototype models for targeted chronic conditions.

II. ESTABLISH NATIONAL CHRONIC CARE POLICY FRAMEWORK

A. Preamble: Call to Action

1. **Demographic Imperative:** The nature of illness in our country has shifted from a preponderance of acute care illnesses to one of chronic diseases and disabilities.

   - Almost 100 million Americans have one ore more chronic condition; this number will increase by more than one third in the next 25 years.
   - Chronic conditions account for about 80% of all deaths and 90% of all morbidity.
   - About 40% of the all chronically-ill and disabled persons and 69% of the elderly chronically-ill (65+) suffer from more than one chronic condition.
   - Persons over 85 have the highest percentage of chronic conditions and represent the fastest growing segment of the population.
   - Persons dually eligible for Medicare and Medicaid are more likely to have one or more chronic condition than Medicare only enrollees (e.g., twice as many suffer stroke, 2.5 times as many have broken a hip, 50% of dementia patients are dually eligible).

2. **Financial Imperative:** While Congress addressed the solvency of the Medicare Trust Fund on a short-term basis through the BBA, long-term solvency continues to loom as a major concern. Further, Medicaid has become the single largest expenditure for many states. Approximately two thirds of all Medicaid dollars are spent on the elderly and disabled who represent only one third of the total case load. Chronic conditions play a large role in these growing expenditures:

   - Chronic conditions represent the highest-cost fastest growing segment of health care.

- Chronic conditions account for 70% of all personal health care expenditures.

- Per capita health care expenditures for fee-for-service clients with one chronic condition were about 2.25% more costly than expenditures for those with only acute care illnesses; for persons with multiple chronic conditions expenditures were almost 6 times higher than for acute conditions.

- A 1995 study by a large staff-model HMO found a 14 fold difference in the average annual cost of caring for persons 85 plus with and without chronic conditions. Per capita costs were $723 for those with no chronic conditions and $9,869 for persons with two or more chronic conditions.

- The chronically ill represent about 69% of all hospital admissions and 80% of hospitals days and have average lengths of stay of 7.8 days compared to 4.3 days for acute episodes.

- Approximately 30% of Medicare expenditures and 35% of Medicaid expenditures are spent on dual eligibles who represent only 16% and 17% of total beneficiaries, respectively.

3. **Regulatory Imperative:** Administrative, financing and oversight requirements for providers and payors vary according to program funding source (Medicare, Medicaid, VA, etc.). This results in duplication of functions, fragmentation of care and poor health outcomes, difficulty in assessing data and costs for a common population, and increased costs of care.

   - Chronic conditions require the full spectrum of primary, acute and LTC services, but payment rules are biased toward institutional care.

   - Regulations and financing are focused on individual provider settings, with little regard for the cost and care effects across time, place and profession.

- Regulations provide disincentives for serving this high-cost population. Chronic care needs are managed by Federal mandate instead of clinical and financial incentives to achieve defined outcomes.

- Separation of Medicare and Medicaid functions prevents evaluation of the total costs of care for the chronically-ill, prohibits Congress from scoring aggregate Federal and state savings across programs and encourages cost-shifting across programs.

B. Establish Chronic Care Goals for 21st Century

1. To reduce prevalence rates for the highest cost chronic diseases and disabilities.

2. To reduce the average per capita costs for persons with targeted chronic diseases and disabilities through interventions that prevent, delay or minimize disability progression.

3. To increase the number of plans employing population-based planning and disease prevention and managed strategies for the chronically-ill.

4. To increase the number of Americans engaging in health promotion activities.

5. To shift health care financing policies to provide payment for whatever combination of care is the most cost-effective across settings and over time and to pay for services in the least restrictive settings.

C. Establish Criteria for Effective Policy

1. National health care policy must recognize the changing nature of illness in our country from short-term, acute care conditions to long-term, chronic conditions.

2. Quality assurance and cost containment must be interdependent goals for serving individuals with chronic conditions.

3. Long-term cost containment must include strategies to prevent, delay or minimize the progression of disability associated with chronic conditions.

4. Since chronic conditions are multidimensional and providers are interdependent:

   - the chronically-ill must have access to the full array of primary, acute and long-term care services;

   - care coordination/care management must be an essential component of every delivery system for the chronically-ill;

   - financial incentives must be developed for targeting high-cost conditions, using whatever combination of services are most cost-effective.

   - care management fees must be included as a standard, reimbursable benefit;

   - cost-savings strategies must shift from establishing separate limits for individual providers (e.g., hospitals, physicians, home health agencies) to reducing the growth of aggregate health care costs across providers and programs (i.e., public and private payors).

   - Purchasers, payers and providers must use integrated administrative, financing and delivery methods.

5. Since persons with chronic conditions by definition require services over the long-term:

   - care delivery strategies must focus on preventing, delaying or minimizing the progression of chronic conditions;

- preventive services must be a standard, reimbursable benefit; and

- cost savings must be measured relative to dollars saved *over the course of a chronic condition*, not in short-term savings associated with a defined budget cycle (e.g., 2 years for state budgets, 1, 5 and 10 year increments for Federal budgets).

6. Quality Assurance methods must be developed for measuring quality where the outcome is preventing, delaying or minimizing disability progression, not curing a disease or condition.

7. Since many chronically-ill individuals are eligible for multiple health care programs (i.e., Medicare, Medicaid, Veterans Health Administration, etc.):

   - health benefit programs must interface to provide for continuity of care and to prevent disruptions in services as individuals move in and out of benefit eligibility;

   - cost-savings must be measured across programs, not on a program-by-program basis, to reduce incentives for cost-shifting and to develop an accurate picture of expenditures and savings.

8. The health care system must empower consumers to maximize their own health and well-being through health promotion, education and self-care programs, as opposed to creating dependency on formal caregivers through paternalistic policies and practices.

9. Incentives must be provided for health care providers to adapt to changing environments, including support for development of new technology.

10. Current health care regulations are directed toward individual programs such as Medicare or Medicaid and individual providers such as hospitals and nursing homes. Future Federal and state administration and oversight must be streamlined and standardized across providers, professionals

and payor sources to eliminate duplication of functions and services.

III. DEFINITIONS

A. A Serious and Disabling Chronic Condition is one or more biological or physical condition which is likely to last for an unspecified period of time, or for the duration of a person's life, for which there is no known cure, and which may affect an individual's ability to carry out basic activities of daily living and/or instrumental activities of daily living. Such conditions may include, but are not limited to:

- Alzheimer's Disease and related disorders
- Arthritis
- Cancer
- Cerebrovascular disease
- Diabetes
- Emphysema and bronchitis, including chronic obstructive pulmonary disease (COPD)
- Hip and other fractures
- Hypertension
- Ischemic heart disease
- Multiple sclerosis
- Parkinson's disease
- Peripheral vascular disease
- Renal disease
- Other diseases specified by the Secretary of HHS.

IV. STRATEGIES FOR POLICY INTERVENTION

A. Establish National Chronic Care Commission

1. **In General:** Congress will establish a National Commission on Chronic Care to develop an agenda for the 21st Century regarding chronic illness. The Commission will be a public/private partnership with representation and funding from both sectors. The Commission will be authorized for a two year period to study the problems of individuals with chronic diseases and disabilities as well as issues affecting purchasers, providers and payors serving this population.

2. **Charge**

- Identify the "best and brightest minds" in the public and private sectors to analyze and identify solutions to the problem.

- Review recommendations of the Bipartisan Medicare Commission with respect to the cost and quality implications of chronic diseases and disabilities under the current system.

- Establish fiscal targets for cost savings through improved care delivery methods; e.g., 10% cost-savings by 2005, an additional 10% cost savings by 2010. In 2010, CBO or OMB would be required to develop additional cost-savings targets for the period of 2010 to 2020.

- Develop projections of the aggregate costs (at a minimum, for Medicare, Medicaid and the VA) of caring for targeted high-cost conditions over a defined period of time (e.g., five year projections for costs at the years 2000 (baseline), 2005, 2010, 2015, 2020, etc.).

- Establish targets for reducing the incidence of the highest cost, fastest growing chronic conditions; i.e., reduce prevalence rates by 25% by the year 2010 and 50% by the year 2020.

- Other targeted areas specified by the Commission.

- Establish procedures for achieving the targets specified for each category above.

3. **Composition:** Members of the Commission will include representatives from:

- Federal and state agencies serving the elderly, disabled and chronically-ill

- Public health officials
- Consumer representatives from chronic disease organizations
- Primary care provider organizations
- Acute care provider organizations
- Institutional and community-based long-term care provider organizations
- Managed care health plan organizations
- Researchers in health care financing and chronic disease management

4. Report to Congress

The Commission will be required to issue a report to Congress within 2 years of the date of enactment of this Act.

5. National Summit on Chronic Care

- **In General:** Public and private sector organizations would convene a "National Summit on Chronic Care" to review the options and recommendations developed by the Commission on Chronic Care and to develop consensus on a focused set of strategies for addressing the problems of the chronically-ill.

- **Participation:** Participants would be similar to the National Commission -- public and private sector representatives of consumer, provider, payor and government organizations-- but the number of participants would be expanded to include additional representation from consumers, providers and experts in chronic care.

- **Funding:** Jointly funded by public and private sectors.

6. Funding

The Act will be financed through a combination of public sector grants and contributions from private foundations and

industry. It will provide funding for staffing of the Commission and expenses for public servants. Such sums as may be necessary will be authorized by Congress for the public contribution to this initiative.

B. Identify Legislative and Regulatory Barriers to Integration of Care for the Chronically-ill and Disabled

1. Directs the Secretary to establish a Task Force on Medicare and Medicaid Regulatory Simplification.

- The Task Force will be chaired by HHS and composed of representatives of HHS, MedPAC and the States.
- The Task Force will examine legislative and regulatory barriers to the integration of health care delivery and financing for those with chronic diseases and disabilities.
- The Task Force will develop recommendations for simplifying Federal and state oversight and for establishing uniform policies and procedures for administration, financing and delivery of care across providers serving chronically impaired people consistent with the criteria identified in Section II(C) of this Act.

2. Charge: The Task Force will be directed to review current Medicare and Medicaid statutes, regulations, administrative and interpretive guidelines and other appropriate administrative directives and state licensure and certification requirements to assess the following:

a. Duplicative Requirements Across Provider Settings under the Medicare Program

- Inconsistencies in administrative, financial and clinical requirements across health care settings;

- Requirements that result in duplication of functions across provider settings;
- Policies that result in cost-shifting between health care settings.

b. Duplicative Requirements Across Provider Settings under the Medicaid Program

- Inconsistencies in administrative, financial and clinical requirements across health care settings;
- Requirements that result in duplication of functions across provider settings;
- Policies that result in cost-shifting between health care settings.

c. Impediments to integration of Medicare and Medicaid benefits for the dually eligible:

- Inconsistencies in administrative, financial and clinical requirements between the Medicare & Medicaid programs;
- Requirements that result in duplication of functions between the Medicare & Medicaid programs;
- Policies that result in cost-shifting between the Medicare & Medicaid programs;
- Requirements that impede the integration of financing and delivery functions for providers serving the dual eligible population;
- Impediments to establishing care delivery systems consistent with the criteria identified in Section II(C) such as disability prevention, use of least restrictive settings, cost-containment related to condition, not provider or setting, etc.

3. **The Task Force will submit recommendations to Congress** regarding uniform administrative, clinical and financial standards for provider networks in the following areas:

   a. Provider networks serving Medicare beneficiaries;

b. Provider networks serving Medicaid beneficiaries;

c. Provider networks serving the dually eligible.

4. **Report to Congress:** The Commission will deliver a report to Congress within two years of the date of enactment of this Act.

C. MEDPAC REPORT

1. **Chronic Care Costs:** Directs MedPAC to review the Medicare Commission report on the impact of chronic disease trends on Medicare cost and quality and, as appropriate, to supplement this report with additional expenditure data and analysis, such as data on Medicaid expenditures for the chronically-ill.

2. **National Data Base:** Requires MedPAC, working in conjunction with the States, to develop recommendations regarding the establishment of a national data base which standardizes Medicare and Medicaid cost and quality data for persons with chronic diseases and disabilities.

3. **Financial Incentives: Requires MedPAC,** working in conjunction with the States, to develop recommendations regarding financial incentives for health plans and provider networks in the following areas:

a. incentives for serving persons with serious and disabling chronic diseases and disabilities;

b. risk-adjustments to Medicare and Medicaid capitated payments which recognize the prevalence, mix and severity of chronic conditions among persons enrolled in a network;

c. the viability of developing setting neutral health status risk adjustments versus making institutional payment rates available to all health plans for Medicare beneficiaries who are nursing home certifiable, but receiving services in the community.

d. incentives for serving persons in the least restrictive environments;

e. incentive payments for reducing the prevalence of targeted high-cost, high-volume chronic conditions;

f. incentives for providers to work cooperatively toward common clinical and financial goals;

g. incentives to prevent cost-shifting between the Medicare and Medicaid programs.

h. other incentives deemed appropriate by the MedPAC and/or the Secretary.

4. **Report to Congress:** MedPAC will deliver a report to Congress within two years of the date of enactment of this Act.

D. REPORT ON QUALITY MEASURES FOR THE CHRONICALLY-ILL AND DISABLED

1. Directs the Secretary, in conjunction with NCQA, AHCPR or other appropriate entities, to undertake a study regarding methods for measuring quality across the span of a chronic illness or disability. This report will:

   - identify risk factors associated with progression of chronic conditions;
   - examine the clinical and financial efficacy of different treatment protocols that span time, place and profession for specific chronic conditions;
   - make recommendations regarding disease prevention guidelines for the highest-cost chronic diseases and disabilities, measured by severity and prevalence;
   - include outcome measures that are not specific to individual provider settings, but measure quality across time, place and profession.

2. The results of the study will be reported to Congress no later than 2 years after enactment of this Act.

E. NATIONAL CLEARINGHOUSE ON CHRONIC DISEASE MANAGEMENT

1. **Requires the Secretary to establish a National Clearinghouse on Chronic Disease Management which would be charged with the following responsibilities:**

   a. Develop a national education/awareness campaign on chronic diseases and disability prevention methods and create linkages between this

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campaign and the chronic care agenda created by the Commission on Chronic Care.

b. Survey best practices in chronic disease management in the private sector (e.g.extended care pathways, quality indicators, case management methods, etc.) and disseminate these to public.

c. Create information and referral function which (1) identifies and assembles existing information and data on chronic disease and prevention strategies; (2) develops new educational materials related to chronic conditions and chronic disease management; and (3) packages information for distribution to the public through publications, AV materials, CD roms, data base searches, etc.

d. Develop training programs for health care professionals and caregivers relating to chronic disease management.

2. **Permits the Secretary to enter into contracts with non-Federal entities to carry out the activities identified in Paragraph (1).** Eligible entities must have expertise in chronic care, provider network development and managed care financing methods, working relationships with key national organizations representing chronic diseases, consumers, and providers, and demonstrate expertise in innovations regarding chronic disease management.

G. ESTABLISH PARTNERSHIP BETWEEN HHS AND THE VETERAN'S ADMINISTRATION (VA) FOR DEVELOPING PROTOTYPE CARE DELIVERY MODELS

1. Establish the VA as an Operational Laboratory for identifying costs and service delivery prototypes in chronic care that can be applied inside and outside the VA system (e.g., also applied to Medicare and Medicaid populations).

2. Develop high risk screening & intervention strategies for the chronically-ill and disabled.

3. Develop best practices and clinical protocols for a targeted set of chronic conditions to include CHF, COPD, Alzheimer's Disease, Diabetes and Depression

4. Work with private agencies to develop primary, secondary and tertiary disability prevention interventions for health

promotion, chronic disease management and care of the frail elderly.

5. Establish compatibility among Medicare, Medicaid and VA information and data systems, with uniform coding for clients and uniform documentation of utilization, costs and outcomes.

H. MODIFY FEDERAL INFRASTRUCTURE

1. Integrate Federal budget functions for Medicare and Medicaid.

2. Establish Subcommittees on Chronic Care under Senate Finance and House Commerce and Ways & Means Committees or expand responsibilities of existing health subcommittees to include chronic care issues.

I. CARE MANAGEMENT BENEFITS

Amend Titles XVIII and XIX of the Social Security Act to include care management as a standard benefit for chronically-ill persons and those requiring the services of multiple providers.

The CHAIRMAN. Mr. Schulte.

STATEMENT OF MARK J. SCHULTE, PRESIDENT AND CHIEF EXECUTIVE OFFICER, BROOKDALE LIVING COMMUNITIES, INC., CHICAGO, IL

Mr. SCHULTE. Thank you for this opportunity, Chairman Grassley, to represent both Brookdale Living Communities, which operates 14 senior and assisted living facilities in 10 States across the United States, but also I am here today on behalf of the American Seniors Housing Association, which represents the interests of the much larger and more prominent firms in the country participating in the seniors housing industry.

Given the dramatic demographic changes we have heard about today, policy makers must create incentives to encourage those who can afford to do so to pay for their own long-term care needs in the most cost-effective, desirable settings possible. In recent years, seniors and their families have developed and helped create an innovative and highly-efficient long-term care option, seniors housing, that combines residential multi-family housing with direct access to needed supportive services and health care.

The emergence of seniors housing, and this includes congregate care, assisted living, and continuing care retirement communities, has occurred because these residences have been tailored to accommodate the demands of older adults and their families. Typically, seniors housing facilities provide residents with an apartment, meal service, housekeeping activities, and transportation, as well as emergency response, and when and if needed, access to personal care and even nursing care.

There are estimated to be 20,000 senior-oriented communities around the United States, ranging from small rural ten-unit facilities up to large retirement villages that are home to thousands of residents.

Regardless of size or location, these facilities share several important characteristics. They are community-based settings, they give direct access to supportive services and health care, they provide security, opportunities for social interaction, individualized care, provide wide ranges of personal choice, and access to wellness and preventative health programs, and are environments that enhance independence.

The cost-effectiveness of seniors housing over long-term care options stems from natural economies of scale, on-site centralization of services, and built-in incentives for residents to utilize services only when they need them. Since services provided in seniors housing are typically paid for out-of-pocket, there is no incentive for residents to use services unnecessarily. Many residences have capacity, either directly or indirectly, to allow residents to purchase needed services in the most cost-effective manner and at appropriate time increments.

As residents age in place, care often can be provided in a resident's apartment, ranging from personal care to nursing to hospice, obviating the need for an individual ever to set foot in a nursing home.

The current system routinely fails both the taxpayer and consumer alike. These systematic difficulties occur in large part be-

cause of longstanding Federal and State policies that have created powerful financial incentives for even the wealthiest Americans to spend down to poverty levels or transfer assets in order to qualify for Medicaid-funded long-term care services.

Although Medicaid can serve an important social function as a safety net to individuals truly in need, the reality is that many seniors continue to game the system by transferring their assets and income to family members in order to meet Medicaid eligibility requirements. By the time we feel the effects of the baby boom generation sometime around the year 2020, it is estimated that nursing home costs for disabled, older persons will exceed 110 billion a year.

Although an increasing number of States now utilize Medicaid waivers or other programs to fund long-term care services, the preponderance of public funds for long-term care continue to flow into nursing homes. The system is further flawed because policy makers have relied almost exclusively upon a heavy-handed regulation rather than competition to control the quality of care in nursing homes. Massive government regulation implemented to ensure residents' safety has resulted in institutional and impersonal living environments. In addition, the regulation thrust upon nursing homes has steadily driven up long-term care costs.

A final flaw is that Medicaid pays 100 percent of the beneficiary's cost, both in shelter and services, in a nursing home, but does not provide any reimbursement either for shelter or service components in seniors housing. Thus, older adults who plan for their long-term care needs and moved in seniors housing are not eligible for any assistance until they become impoverished. Those residents may be capable for paying the cost of their shelter and unable to fund needed services over time as frailty increases. The system leaves the household with no choice but to spend down in order to qualify for Medicaid's nursing home benefit, which picks up all costs, room and board plus services.

We need policy measures that eliminate the incentive for seniors to "game the system" and instead encourage individuals to pay for their own long-term care in privately-funded residential care settings. While greater numbers of seniors and their families are turning to seniors housing each year to provide affordable, high-quality shelter and assistance, with the activities of daily living, public policy can provide further stimuli to reduce the nation's over-reliance on nursing homes for taxpayer-funded custodial long-term care.

The American Seniors Housing Association urges policy makers to consider the following proposals: First, to encourage individuals to use their own resources, such as home equity, savings, or insurance proceeds to pay for long-term care, eliminate the 7.5 percent of adjusted gross income threshold applicable to medical deductions for qualified long-term care premiums, and for entrance fees, continuing care retirement community entrance fees and other prepaid long-term care expenses. Expand the medical savings account demonstration to include participation by individuals and to clarify that assisted living residences are eligible for tax-exempt financing.

Thank you for this opportunity and I will be happy to answer any questions.

[The prepared statement of Mr. Schulte follows:]

The Cash Crunch:
The Financial Challenge of Long-Term Care for the Baby Boom Generation

Testimony of Mark J. Schulte
President and Chief Executive Officer
Brookdale Living Communities, Inc.
Chicago, Illinois

On behalf of the
American Seniors Housing Association

Before the
United States Senate
Special Committee on Aging

March 9, 1998

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Chairman Grassley, Senator Breaux, and Members of the Committee, my name is Mark Schulte. I am President and Chief Executive Officer of Brookdale Living Communities, a publicly-traded provider of seniors housing and assisted living services headquartered in Chicago, Illinois. Brookdale's portfolio consists of 13 seniors housing properties containing 2,795 units located in 10 states, with additional properties now being developed in Illinois, Michigan, Texas, North Carolina, and New York.

I am here today on behalf of the American Seniors Housing Association (ASHA), which was created in 1991 by the National Multi Housing Council (NMHC) to represent the interests of the larger and most prominent firms in the country participating in the seniors housing industry. ASHA's members are engaged in all aspects of the development and operation of housing for seniors, including the construction, finance and management of such properties.

* * *

Executive Summary

With the population of older Americans projected to increase dramatically over the next several decades, and the cost of long-term care spiraling, policymakers must act now to create incentives that encourage those who can afford to do so to pay for their own long-term care needs in the most cost-effective, desirable setting possible. In recent years, seniors and their families have helped to create an innovative and highly efficient long-term care option – seniors housing – that combines residential multifamily housing with direct access to needed supportive services and health care.

The emergence of seniors housing, including congregate, assisted living, and continuing care retirement communities, has occurred because these residences have been tailored to accommodate the demands of older adults and their families for:

Community-based settings;
Direct access to supportive services and health care;
Security;
Opportunities for social interaction;
Individualized care;
Economic efficiency;
Personal choice;
Wellness and preventive health programs; and
Independence-enhancing living environments.

While greater numbers of seniors and their families are turning to seniors housing each year to provide affordable, high quality shelter and assistance with the activities of daily living, public policy can provide further stimuli to reduce the nation's over-reliance on nursing homes for taxpayer-funded custodial long-term care. The American Seniors Housing Association urges policymakers to consider the following proposals:

1. Encourage individuals to use their own resources (e.g., home equity) to pay for long-term care, eliminate the 7.5 percent of adjusted gross income threshold applicable to medical deductions for qualified long-term care insurance premiums, continuing care retirement community (CCRC) entrance fees, and other prepaid long-term care expenses.

2. Expand the Medical Savings Account demonstration to include participation by individuals.

3. Clarify that assisted living residences are eligible for tax-exempt bond financing.

Introduction

Between 1910 and 1990, the number of individuals aged 65 and over in the U.S. soared from 3.9 million (4.3 percent of the population) to 31.2 million (12.6 percent of the population). And while widespread concern already exists over how to fund the long-term care needs of the elderly, the U.S. has not yet even begun to experience the impending onslaught of the fast approaching "age wave." According to the U.S. Census Bureau's population projections, the elderly population will double between 1990 and 2025, reflecting the aging of the post-World War II baby boom generation and a projected increase in life expectancy at birth to 81.2 years.

Of particular importance to policymakers who are addressing the impact and needs of a rapidly aging America is the imminent increase in the population's older age cohorts. In this decade alone, the population aged 85 and above is projected to increase by 42 percent. Between 2000 and 2010, this age group is expected to increase again by an additional 32 percent. The implications of these projections for publicly funded long-term care are sobering, given the widespread strain both state and federal budgets are already experiencing.

Although long-term care services can be delivered effectively in a variety of settings, the U.S. has historically relied on nursing homes to provide the bulk of these services to the frail elderly. Spiraling costs and increasing consumer discontent, however, have led policymakers and advocates for the elderly to search for even more desirable and less-costly long-term care options. Perhaps the most promising long-term care solution for the elderly is seniors housing, a rapidly emerging industry well-suited to delivering affordable services and supportive care in residential, community-based settings. Drawing on its diverse influences from the multifamily housing, health care, hospitality, and long-term care industries, seniors housing effectively responds to the needs and desires of elderly persons who require varying degrees of supportive assistance.

Seniors Housing: A Market-Driven Long-Term Care Option

The care needs of most frail elderly persons are primarily supportive – not medical in nature. In recent years, hundreds of thousands of older adults and their families have embraced the

development of a variety of non-subsidized, private pay seniors housing residences across the country. While the services, living units and amenities of each residence are unique and can be classified under a variety of different categories (including congregate seniors housing, assisted living residences, and continuing care retirement communities), collectively they share a number of common attributes that effectively and efficiently meet the shelter and supportive health care needs of older adults.

Because these residences and associated services are typically not reimbursed by federal or state funding sources, consumer preference and choice have defined this long-term care option. This attribute, perhaps more so than any other distinct feature of seniors housing, has fueled the development of a market-driven product that can be found in communities large and small in all 50 states. To understand how and why seniors housing has become a growing, privately funded long-term care option, one must appreciate its unique characteristics.

Residential Community-Based Settings

Seniors housing comes in a wide variety of shapes and sizes, from 300-unit high-rise buildings in urban centers to 50-unit Victorian-style, low-rise residences tucked quietly in suburban neighborhoods or rural communities. In general, much of the nation's seniors housing stock is conveniently located near shopping, restaurants, medical facilities, places of worship, libraries, public transportation, and other popular community resources. This should come as no great surprise, however, given the industry's responsiveness to consumer preference and seniors' overwhelming desire to remain well-integrated within the community. In addition, although seniors housing must meet a host of life safety and accessible design requirements, most residences feature all the high quality residential characteristics sought by persons of all ages. Unlike most institutional care settings, seniors housing residents generally decorate their living space with their own furniture, pictures, drapery, and other treasured amenities of home.

Opportunities For Social Interaction

Forty-three percent of all older households in 1989 were single-person households, the majority of which (79 percent) were women. Because the elderly are subject to attrition in their

social and familial networks, many older persons living alone experience a profound decline in the quality and quantity of their personal relationships. In addition, gerontologists who have studied elderly persons living alone have found that social isolation and loneliness frequently result in low levels of self-esteem and diminished life satisfaction.

Problems related to social isolation and loneliness, however, are extremely rare for the five to six percent of elderly Americans who reside in seniors housing. Additionally, prominent gerontologists such as Dr. Lenard W. Kaye and Dr. Abraham Monk note that the research findings confirm positive effects of planned housing for the elderly on a variety of measures including: housing satisfaction, general life satisfaction, involvement in community and on-site activities, and the quality of socio-behavioral relations.

Security

Although Americans of all ages fear crime, older adults who live alone often feel particularly vulnerable. Fear of being victimized has been effectively neutralized by practices routinely employed by the seniors housing industry. In addition to the widespread practice of staffing residences with on-site personnel 24-hours a day, 90 percent of all residences utilize security systems which help reduce the fear of crime. Indeed, according to a recent study by the American Association of Retired Persons, residents of seniors housing feel more secure from crime than any other segment of the older adult population. Another common fear of older adults – being unable to elicit help in the case of medical emergency – has also been effectively addressed by the seniors housing industry. Since over 95 percent of seniors housing residences feature monitored emergency response systems, residents know that immediate help is available should an emergency occur.

Access to Supportive Services and Health Care

Recent research conducted by the American Seniors Housing Association and the public accounting firm Coopers & Lybrand challenges the widely held belief that seniors housing serves only the active and independent elderly. The findings from this research suggests otherwise, since the average seniors housing resident is nearly 82 years old. Most residents choose to move into the supportive, nurturing residential environment of seniors housing after experiencing significant life

changes, such as the loss of a spouse or increased physical frailty. By responding to the needs of these older persons and their families, seniors housing offers direct access to an array of independence-enhancing supportive and health care services.

In the ASHA/Coopers & Lybrand survey, for example, housekeeping services were available in 86 percent of all seniors housing residences; on-site nursing services in 63 percent; transportation services in 95 percent; social programs in 82 percent; emergency call systems in 96 percent; and security systems in 89 percent. The widespread availability of both supportive services and health care reflects the industry's responsiveness to the demands of the market shaping the development and operation of seniors housing. Unlike other long-term care options, appropriate access to supportive services and health care in seniors housing is not determined by government formulas, third-party reimbursement, or federally-mandated regulatory requirements. Service delivery is driven solely by the needs and desires of the elderly and their families.

Individualized Care and Economic Efficiency

Because market forces are the primary determinant of service delivery systems in seniors housing, the supportive care available to each resident can be individually tailored to meet his or her unique and ever-changing needs. The cost-effectiveness of seniors housing over other long-term care options stems from natural economies of scale, on-site centralization of service delivery, and built-in incentives for residents to utilize services only when needed. Since services provided in these dwellings are typically paid for out-of-pocket, there is no incentive for residents to use services unnecessarily. In addition, many residences have the capacity either directly or indirectly (through third-party providers, such as home health agencies) to allow residents to purchase needed services in the most cost-effective and appropriate time increments. For example, since many seniors only require short-duration personal care assistance (such as assistance with dressing or eating), supportive care can often be purchased in 15- or 30-minute increments.

The individualized seniors housing approach encourages residents to remain as independent as possible, avoiding the pitfalls of "learned helplessness" that arise when mandated services are provided in institutional environments to individuals regardless of whether they require assistance. This highly personal approach to service delivery, unique to seniors housing, keeps costs down and

at the same time assures that the quality of supportive and health care services will be high. Additionally, by carefully monitoring and incrementally accommodating increased supportive care needs that often accompany the aging process, seniors housing plays a critical role in delaying or eliminating the need for more costly institutional care.

Another advantage of seniors housing over other forms of long-term care is that providers are not required to use overqualified and more costly medical personnel to deliver services that are supportive in nature. Unlike other long-term care options that are driven by a "medical model," seniors housing uses appropriately trained, non-medical professionals to deliver most of the supportive care that is needed by residents.[1] Seniors housing has the added advantage of enabling residents to establish stable, ongoing relationships with caregivers who become familiar with each individual's unique care needs.

Seniors housing further distinguishes itself by actively seeking family involvement in care planning, resident assessment, and service delivery. This "hands-on" role played by family members augments services, encourages meaningful social interaction, and contributes to the affordability of seniors housing.

The broad flexibility of seniors housing to accommodate the changing needs of older adults also allows many residences to care for persons with higher acuity needs. Some residences, such as continuing care retirement communities, offer residents the full spectrum of housing and supportive health care services, including skilled nursing care provided in the community's licensed nursing beds. Other residences offer combination care levels, such as assisted living and skilled nursing, while some provide highly specialized care for individuals suffering from Alzheimer's disease or related disorders.

Personal Choice and Wellness

By allowing even the frailest of elderly persons to maintain as much control over their lives as possible, seniors housing is fundamentally different than other long-term care options, particularly

[1] Recognizing that measuring functional impairment is the most effective means to determine an individual's capacity for independent living, many professionals use activities of daily living (walking, eating, toileting, transferring, and bathing) to gauge the care needs of persons with physical or mental health disabilities.

those now reimbursed by the government. Residents are treated as individuals, not as patients, and are encouraged to remain as independent as possible. Since the popularity of seniors housing has grown, in part, out of rejection of an historically paternalistic and medically-oriented long-term care system, personal choice has become one of the industry's most notable features. Residents can maintain as much control over their lives as they would in conventional apartments, while having the ability to easily access supportive services and other preventive health programs necessary to enhance independence.

Many residences routinely offer supervised fitness programs, health fairs, wellness seminars, scheduled transportation to medical facilities and other requested destinations, and a host of other preventive programs that encourage resident health and well-being. In addition, many residences also offer a range of activities and programs that encourage social, intellectual, and personal growth. While not all residents choose to participate in every activity offered, opportunities for individual growth and well-being abound – from community volunteer programs to college-level educational courses. Residents can continue to enjoy lifelong hobbies, but at the same time take advantage of countless new opportunities to expand their horizons. Thus, while it is true that leisure activities are plentiful in most seniors housing residences, it is equally true that seniors housing offers residents numerous avenues to remain engaged in activities that foster self-esteem, life satisfaction, and physical and mental well-being.

Special Accessibility Design Features

Numerous researchers have identified specific housing conditions that can jeopardize the health, safety, and security of older persons. And although decreased sensory ability and physical frailty can predispose older individuals to accidents in the home, the primary culprit is often unsafe home features. Accidents, the fifth leading cause of death for persons over the age of 65, occur most frequently in the home and result primarily from falls on stairways, floors and in bathtubs. Seniors occupancy of older dwellings places them at greater risk of experiencing physical deficiencies, frequently because deferred maintenance and inaccessible design features are common in older homes. According to the U.S. Census Bureau, nearly three of every 10 older households live in homes built before 1940, and over 36 percent in houses built before 1950.

Despite the high estimates of need, home design modifications are rarely made by seniors. A national study conducted in 1987, for example, found that among elderly households with at least one member with a health or mobility problem, only two percent had made two or more design modifications in a two year period. Long before accessible design standards were mandated in the Fair Housing Amendments Act of 1988 and the Americans with Disabilities Act, seniors housing had taken a leadership position with regard to constructing high quality interior and exterior environments that are accessible to those with disabilities.

As numerous gerontological researchers have noted, seniors housing incorporates a range of design features to address the physical, informational, perceptual, cognitive, and social needs of the elderly. Recognizing the unique needs of older persons, seniors housing has developed a host of design techniques that result in supportive environments that maximize an individual's ability to function. In addition, unlike other institutional long-term care settings that are developed and operated much like acute care medical facilities, seniors housing maintains the residential qualities that seniors and their families overwhelmingly prefer.

A Flawed Long-Term Care System

Seniors advocates, health care professionals and numerous academicians agree that the U.S. long-term care system routinely fails both the taxpayer and consumer alike. These systemic difficulties, which have serious economic consequences for the U.S., occur in large part because of long-standing federal and state policies that have created powerful financial incentives for even the wealthiest Americans to "spend down" to poverty levels, or transfer assets, in order to qualify for Medicaid-funded long-term care services provided in nursing homes.

Medicaid, a federal/state welfare program created in 1965, contributed $36 billion to pay 51.7 percent of national nursing home costs in 1993, and 50 percent of all nursing home residents use Medicaid as their primary source of payment. In order to qualify for Medicaid-funded nursing home benefits, elderly persons must either be poor or become poor by divesting their assets and incomes. Although Congress and President Clinton imposed a criminal penalty on certain asset transfers in the Health Insurance Portability and Accountability Act of 1996 and targeted the penalty toward lawyers in the recent budget bill, Medicaid planning continues to be practiced by persons of all

economic strata across the country. And although Medicaid can serve an important social function as a "safety net" for individuals truly in need, the reality is that seniors continue to "game the system" by transferring their assets and income to family members in order to meet Medicaid eligibility requirements.

Since Medicaid pays for long-term care in nursing homes once a person has "spent down," the system strips away the incentive individuals might otherwise have to plan for and fund their own long-term care needs. As noted in *Long-Term Care Public Policy & The Future of Seniors Housing*, "...Americans do not plan ahead for long-term care, because they can wait until the last minute and receive publicly financed care. They often go to nursing homes instead of seniors housing or home care, despite their preferences, because Medicaid pays generously for nursing home care, but covers very little home care or seniors housing. Few people take advantage of home equity conversion to finance long-term care or insurance, because Medicaid exempts the home (and all contiguous property) regardless of value. Long-term care insurance is unpopular because most people will not pay for something they can get from the government for free."

While Medicaid pays for the vast majority of public funding for long-term care, Medicare, a universal insurance program for all persons aged 65 and older, primarily provides acute care coverage for hospital and surgical care and accompanying rehabilitation. Consumer misperceptions notwithstanding, Medicare covers neither long-term care nor custodial care (although Part A of the Medicare program will cover care in a skilled nursing facility for up to 100 days if a beneficiary requires skilled nursing care on a daily basis for an acute illness).

The obvious incentives created by these policies encourage even the wealthiest individuals to transfer their assets in order to qualify for Medicaid nursing home benefits. This extremely expensive and inefficient approach to publicly-funded long-term care warrants immediate attention in light of the rapidly changing demographic composition of the U.S. Since 1970, costs for nursing home care have increased by an annual average of 12.6 percent – far above the rate experienced in other health care sectors including hospital care, drugs, and physician services.

The rapid aging of the U.S. population will further cause the government costs associated with providing nursing home care to older persons to skyrocket, from $37.6 billion in 1990 to a projected $64 billion in 2005. By the time the U.S. begins to experience the full effects of an aging

post-World War II baby boom generation sometime around the year 2020, it is estimated that nursing home costs for disabled older persons will exceed $110 billion per year.

Although an increasing number of states now utilize Medicaid-waivers or other programs to fund long-term care services in community-based seniors housing, the preponderance of public funds for long-term care continue to flow into nursing homes. States, which are required to contribute between 21 and 50 percent of Medicaid financing, have instead responded to spiraling costs of long-term care by limiting the number of nursing home beds that can be built through moratoria on the issuing of licenses or through Certificate of Need (CON) restrictions. These widespread practices, while minimizing states' long-term care costs, created an artificial scarcity of supply in most states, resulting in guaranteed demand for services. Thus, even the lowest quality nursing homes – those most likely to fail in a free market economy – often run at or near full occupancy.

The U.S. long-term care system is further flawed because policymakers have relied almost exclusively on heavy-handed regulation, rather than competition, to control quality of care in nursing homes. Massive government regulation, implemented by policymakers to ensure resident safety, has resulted in institutional and often impersonal living environments. In addition, the federal regulation thrust upon nursing homes has steadily driven up long-term care costs.

A final, but significant flaw, is that Medicaid pays 100 percent of a beneficiary's costs (both shelter and services) in a skilled nursing facility, but does not provide any reimbursement for either the shelter or service component of seniors housing. Thus, older adults who planned for their long-term care needs and moved into seniors housing are not eligible for any assistance until becoming impoverished. These residents may be capable of paying for the cost of their shelter, but unable to fund needed services over time as frailty increases. Rather than providing necessary financial assistance for these incremental service needs, the system leaves the household no choice but to "spend down" in order to qualify for Medicaid's nursing home benefit, which picks up all costs – room and board – plus services.

Creating The Right Incentives

Because seniors housing is predominately a private pay business operating in a competitive, free-market environment, consumers (seniors and their families) have unquestionably been the

driving force behind the industry's steady proliferation. What is most remarkable about seniors housing's rapid emergence, however, is that it has occurred in spite of financial incentives available to persons who can transfer their personal assets, "impoverish" themselves, and apply for government-funded long-term care benefits provided by nursing homes.

The monumental demographic changes that will occur in the next few decades make it imperative that policymakers seek ways to create a more efficient, competitive, market-driven long-term care system that will deploy the nation's limited resources more responsibly and better meet the needs of an aging population. An improved paradigm for long-term care is needed – one that is sensitive to consumer needs and preferences, free from the harmful effects of over-regulation, and driven by free-market principles that foster high quality, efficient service delivery, as well as affordable shelter.

Forging a stronger, more efficient long-term care delivery system does not necessarily mean policymakers must create new programs and increase government outlays on long-term care. Indeed, policy measures that eliminate the incentive for seniors to "game the system," and instead encourage individuals to pay for their own long-term care in privately funded residential care settings, will result in a dramatically more efficient and less costly long-term care system.

Conclusion and Recommendations

While greater numbers of seniors and their families are turning to seniors housing each year to provide affordable, high quality shelter and assistance with the activities of daily living, public policy can provide further stimuli to reduce the nation's over-reliance on nursing homes for taxpayer-funded custodial long-term care. Recognizing this, the American Seniors Housing Association urges policymakers to consider the following proposals:

1. Encourage individuals to use their own resources (e.g., home equity) to pay for long-term care, eliminate the 7.5 percent of adjusted gross income threshold applicable to medical deductions for qualified long-term care insurance premiums, continuing care retirement community (CCRC) entrance fees, and other prepaid long-term care expenses.[1]

2. Expand the Medical Savings Account demonstration to include participation by individuals.

3. Clarify that assisted living residences are eligible for tax-exempt bond financing.

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Brookdale
LIVING COMMUNITIES, INC.

MARK J. SCHULTE
President and Chief Executive Officer

Mark J. Schulte is President, Chief Executive Officer and a Director of Brookdale Living Communities, Inc. (NASDAQ symbol "BLCI"). Brookdale is a public company that is the successor to the Senior Housing Division of The Prime Group, Inc. From January 1991 to immediately prior to Brookdale's offering, Mr. Schulte was employed by The Prime Group, Inc. as Executive Vice President, heading the division. Prior to joining Prime, Mr. Schulte had 13 years of experience in development and operation of multi-family housing, senior housing, senior and assisted living and health care facilities. Mr. Schulte received a B.A. in 1975 and a J.D. in 1978 from Saint Louis University. Mr. Schulte is licensed to practice law in the State of New York and serves on the Executive Committee of the American Seniors Housing Association.

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Brookdale Living Communities, Inc. - Brookdale Living Communities, Inc., (NASDAQ symbol "BLCI") is a premier provider of senior and assisted living services in properties that combine congregate care and assisted living units in single facilities. Brookdale was formerly the senior and assisted living division of The Prime Group, Inc., a full service real estate company based in Chicago, Illinois. Brookdale completed its IPO in May of 1997 with a 5.2 million share common stock offering. Brookdale operates facilities located in major metropolitan areas, but focuses on middle-to-upper income individuals who desire an upscale environment with a high level of service and value. A secondary offering was completed in December, 1997 for an additional 2.3 million shares of common stock. Brookdale's portfolio consists of thirteen properties containing 2,795 units. Brookdale owns four properties (980 units), leases seven properties (1,455 units) and manages two properties (360 units).

The average monthly fee at a Brookdale facility is approximately $2,200 and is evenly allocated among housing costs and the cost of services provided to residents. In addition to studio, one and two bedroom apartments, Brookdale provides meal service, housekeeping, concierge service, transportation, activities and 24-hour emergency response to all of its residents. The company also provides assistance with activities of daily living to approximately 25-30% of its residents.

Brookdale currently operates properties in ten states, and will grow through acquisition and development of additional properties. Brookdale is currently developing properties in Illinois, Michigan, Texas, North Carolina and New York.

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The CHAIRMAN. I would have questions for each of you. I will start with you, Mr. Schulte. For an individual who is interested in senior housing, when should they begin to plan for this choice of care and are there any obstacles that they could encounter, such as waiting lists?

Mr. SCHULTE. Yes. To answer your question, there are usually people who plan starting about the age of 65, but many times when they have experienced some sort of an unsettling event, like a death of a spouse or a medical emergency where it is clear that their current environment, say a house that they raised their children in that they have lived in for 40 years, has become inappropriate. But we are seeing many more seniors plan earlier and earlier for this eventual type of a move.

I am sorry. What was your second question?

The CHAIRMAN. If there are any obstacles, and particularly I mentioned waiting lists.

Mr. SCHULTE. Yes. In many markets, we are seeing a supply shortage. Most of our facilities are 100 percent occupied with long waiting lists and we are seeing that across the senior housing industry, that there is a dearth of supply in many areas of the country.

The CHAIRMAN. As senior housing might become more and more popular among baby boomers, do you think that the industry will have any problems meeting the demand?

Mr. SCHULTE. Not if the proper resources are there and financing tools are there, such as tax-exempt financing, but also, I think over time that as it becomes more well accepted by consumers, that you will see an increasing supply that will hopefully keep up with the demand.

The CHAIRMAN. In your testimony, you referred to the ASHA and Coopers and Lybrand survey. It shows impressive statistics about available services in senior housing. For instance, it said 86 percent had housekeeping services, 63 percent had on-site nursing services, 95 percent had transportation services, 96 percent had emergency call systems.

As senior housing moves into more rural areas to meet the needs of those seniors who want to stay in their communities and close to their roots, do you foresee any problems in maintaining the current level of services, such as providing transportation or maintaining outside community involvement?

Mr. SCHULTE. There are many providers that have moved into rural settings and building smaller facilities, say 20-unit or even 10-unit, to meet those demands in a cost-efficient way, and many of those providers are able to supply amenities and supportive services, both with networking with existing community providers and community health providers, but also being able to manage these facilities or maybe cluster a number of these facilities geographically so that these amenities can be provided.

The CHAIRMAN. Mr. Auerbach, I assume that over the 50 States, your system is unique and kind of first of the kind. If that is not the case, obviously it is still well-known and innovative. As baby boomers retire and the potential increases for enrollment in Oregon's home and community-based system, what are some ideas that your State has to maintain the quality of its system and ad-

just as the aging population grows, both from longevity as well as the number of people who are baby boomers coming into the age of retirement?

Mr. AUERBACH. Mr. Chairman, I appreciate the opportunity to answer that question. We think about it a lot and talk about it a lot and hopefully we are doing some things that prepare for the additional numbers.

One of the things that we think is going to continue to happen is that we very much concentrate on the level of service and the amount of service and trying to keep people where they are, where they are living, in their home. If it is in senior housing, we deliver services to people who live in senior housing. We do not care where people live. We want them to live where they want to live, which is in the home where they have been for a long period of time.

We have a very rural State and I was in a rural community the other day with an 87-year-old woman who did not want to go on welfare, as she calls it, and take part—really, she was entitled to many more services than she was getting, but she said, all I need is someone to help me go to the store, someone who will help me build a ramp so I can get out to the store, someone to come and cut the grass. This is someone who, if we just gave a small amount of services to, could stay in their home. They would not have to spend down and be on Medicaid and potentially be outside of their home, where they do not want to be, and obviously at a higher cost for taxpayers.

Senator we are not alone. There are States across the country who are looking not only at our programs, but are looking at other innovative programs. Senator Feingold mentioned earlier Wisconsin has a long-term, State-funded program for community-based services, and right now with the demographics and also with the costs associated with providing long-term care, all States are looking for other options.

The CHAIRMAN. Let me follow up with another question. You offer as part of the future goal that Oregon will seek ways to intervene earlier with non-traditional services, such as home modification, chore services, and assistive technology that can enhance independence. In these efforts, you suggest that the Federal Government could partner with States to intervene earlier with people who are near income eligible for Medicaid and who will become dependent without some services. Could you elaborate on the types of partnerships that could address this goal while still allowing State flexibilities with innovation?

Mr. AUERBACH. Mr. Chairman, what we are talking about here is opportunities. Right now, we have State-funded programs that serve people who are not on Title XIX Medicaid. We serve not nearly what the demand is. And again, when we talk about chore services, home modification, or assistive technology, those are things to keep people independent at home. If we could expand the same type of Federal partnerships that we have in the Title XIX Medicaid program to people who are not quite yet financially eligible for Medicaid, we could potentially keep them out of higher care costs, which obviously is better for them and better for the taxpayer.

The CHAIRMAN. Dr. Lazaroff, we put some confidence in patient feedback to monitor whether systems are working. Do your pro-

grams that you are involved with have patient or family satisfaction surveys and how do these programs incorporate the patients' and families' wishes?

Dr. LAZAROFF. The programs that I am involved in do, indeed, have patient satisfaction measures regularly used. Particularly in PACE, the family is intimately involved in the planning of care of the individual who is enrolled in the program. In fact, one of the major challenges to providing care for people with chronic illness is that one needs to include their informal caregiving system as the target of interventions or as part of the network of people with whom one needs to work to achieve a successful outcome. So it is very important we do that.

The CHAIRMAN. Let me ask both you as a follow-up and ask Mr. Auerbach to comment. We hear about the important role of the case manager in systems that care for frail elderly and disabled individuals. Could you elaborate on the role of the case manager in each of your programs?

Dr. LAZAROFF. Case management is one approach to serving as a guide for a person through a complex system. It is a way of ensuring continuity as the person moves through various aspects of the system. A similar approach which is perhaps more effective in some situations is actual managing by a team of providers, such as one would find in the PACE project, where several people or a whole team really performs the case management role for a person.

Nevertheless, for less-frail people, certainly a case manager can play a vital role in ensuring that the person works their way through the system and gets the outcomes that are desired.

Mr. AUERBACH. Mr. Chairman, in our case management system, anytime anybody is eligible for Medicaid long-term care services, they are assigned a case manager who does an initial assessment. They sit down with the consumer and their family and explain the alternatives to them. They actually go and help with any long-term care placement. They arrange for services. They are really a coordinator of community resources, whether it be transportation, home-delivered meals, or any other type of programs that are available.

Finally, we find on the acute care side with the development, really more with the Medicare risk HMO's, we find that now the medical side is, in fact, assigning case managers to the same clients that we have, so the opportunities for coordination with case managers—I think you call them case managers on the acute care side—and our case management system on the long-term side really affords an opportunity for people not to fall through the cracks as they move from one system to the other.

The CHAIRMAN. Do either one of you know of family members being a case manager? Can they be, and if they can be, do you train them to be?

Mr. AUERBACH. Mr. Chairman, we do not personally give them the title of case manager, but it is incredible how much family members do and how closely we work in our system with family members because they can do so much for us and they really want to be part of our team. So there is no question. Not only family members, churches, community groups, they are all part of the support network that can help people stay independent.

The CHAIRMAN. But they would serve the role as a case manager, or do you still have another case manager over this case?

Mr. AUERBACH. Mr. Chairman, we do have another case manager over that case, but I can tell you candidly that when we know that there is an active, involved family, our case manager can spend time with people who do not have close family living near them.

The CHAIRMAN. Dr. Lazaroff.

Dr. LAZAROFF. Family members are, in fact, case managers for many chronically ill people. If I could use the example of Alzheimer's disease, one of the approaches that we are very interested in is working with the Alzheimer's Association to try to enhance the skill level and the understanding and the capability of family caregivers so that they can be more effective managers of the care of the elderly individual who is afflicted with Alzheimer's disease.

The CHAIRMAN. Oregon's system is patient-oriented, leaving the conventional medical model of treatment behind. Do you feel a social model of treatment is more effective in dealing with long-term care and do you feel that a social model of treatment will be harder to provide as more people enter the system?

Mr. AUERBACH. Mr. Chairman, we like our social model very much. We think that now, especially with a lot of focus of the medical community on chronic care and chronic disease, people do not get cured. They do not get well overnight if they, in fact, have illnesses that continue and progress and they become more dependent. So the social model—we do medication management also with care givers and with clients to help them stay in their home.

So I think that we will be challenged because there will be more and more people in the system, but if we continue to work with active families who care very much and active civic organizations, I think we can continue to provide a social model of care.

The CHAIRMAN. That is the end of my questioning. Before I gavel the meeting to a close, I not only thank you as our third panel for your participation and your involvement with this kind of on-the-spot involvement, a practical aspect of some of the things that we want to educate the public about. I think all of our panels have helped us provide and get some insight into the challenges that we are going to face, not only today but the enhanced challenges of providing long-term care for the baby boom generation that is going to be quite a challenge because of longevity as well as the biggest demographic shift that we have ever had in the history of our population.

I think today's hearing is an important step in raising awareness about many of the issues involved in obtaining long-term care services for a rapidly-aging population, but obviously we cannot stop with one hearing. We have to do more and agencies beyond the Congress have to be involved if we are really going to make the public aware of the challenge that we face. As the number of Americans requiring long-term care increases, both public and private costs are going to escalate.

We have to start now to develop policies that will ensure that public programs can deliver efficient and cost-effective services, and, of course, at the same time we have to provide incentives for people to take responsibility for their own long-term care needs. While Congress prepares for the aging of society, the long-term

needs of our elderly must not be ignored. Now, of course, is not too soon to begin this process.

I thank you all very much for participating and I adjourn the meeting.

[Whereupon, at 3:25 p.m., the committee was adjourned.]

APPENDIX

National
Association of Health
Underwriters

NAHU is an association of health and disability insurance professionals serving the needs of over 119 million Americans.

Testimony of

Diane Mahoney

Senior Products Chair

National Association of Health Underwriters

to

United States Senate Special Committee on Aging

March 9, 1998

1000 Connecticut Avenue, N.W., Suite 810 ■ Washington, D.C. 20036 ■ (202) 223-5533 ■ *facsimile* (202) 785-2274

Chairman Grassley and members of the Special Committee, my name is Diane Mahoney. I am an insurance agent who specializes in Senior Products with Velco Insurance Agency in Randallstown, MD. I am also the Senior Products Chair of the National Association of Health Underwriters (NAHU) Legislative Council. NAHU's members are insurance professionals involved in the sale and service of health insurance, long term care insurance, and related products, serving the insurance needs of over 100 million Americans. We have more than 14,500 members around the country. I appreciate this opportunity to present these comments to the Special Committee on Aging. These comments will focus on the Long Term Care provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The major theme of our comments about HIPAA can be expressed in one word: **choice**. Whereas last year's Balanced Budget Act has allowed more choice for seniors in the Medicare arena, HIPAA has inadvertently denied choice for policyholders and purchasers of long term care (LTC) policies.

Specifically, we are concerned with the taxation of benefits received from non-qualified plans. Under HIPAA, insurance companies must report to the IRS the aggregate amount of insurance benefits paid to any individual during the calendar year who has received nursing home or home health care insurance dollars. The IRS requires that a statement of compensation (1099) be issued to the insured patient. It does not matter if the patient owns a qualified plan or a non-qualified plan. Everyone who receives convalescent care in a nursing home or at home will be issued a statement of compensation from their insurance company for dollar amounts paid during their confinement.

The statute is clear about how the expenses of qualified plans will be treated, but it is silent on the tax treatment for non-qualified plans. Tax experts are warning non-qualified insurance purchasers that the insured patient will receive an income statement that must be reported to the IRS, and that the expenses will not be deductible. NAHU does not believe that it was the intent of Congress or the President to punish seniors for purchasing such plans.

There are important differences between the qualified and non-qualified plans that make the latter attractive to participants. The qualified policy benefit triggers are restrictive. There are two restrictions that are required in a qualified plan. The following qualifications are necessary before payment can be made to the senior beneficiary:

- Medical necessity, which is recognized in every state, was not recognized by the federal government as a lone or separate "trigger" for claim purposes. A doctor's certification, that a patient needed medically necessary care in a nursing home or at home by a home health agency upon its own merit, was not enough reason to pay the senior's claim in a qualified plan.

- The "triggers" for claims that were accepted were: a) inability to perform 2 of 5/6 Activities of Daily Living (ADL's or functional impairments) or b.) Severe cognitive impairment, but a doctor must issue a certificate which states that 90 days of actual (vs. expected) care is necessary for the senior's claim to be paid. Both of these "triggers" for claim payment must accompany a doctor's certification that the individual receiving LTC care must need substantial or continual human assistance or supervision, versus the friendlier term, regular or routine human assistance.

Our seniors must not be forgotten or pushed into living without proper care, putting their welfare in jeopardy. Furthermore, they should not become destitute paying for the care they cannot afford. If their claims are left uncovered, many will be forced to rely on Medicaid. This is a cruel fate to those whom we have asked to provide for their final years by protecting themselves with long term care insurance. The point at which one becomes ill/incapacitated enough to need long term care is frequently not the point at which one becomes classified as chronically ill. Some seniors may require some form of long term care for the remainder of their lives and never become chronically ill. Others will deteriorate to the point where they do become chronically ill and, as a result, need more care and a more intensive, more costly setting than would have been necessary had they purchased a policy providing earlier intervention in the form of adequate benefits.

The insurance dollars paid out in a qualified plan to the Nursing Home or Home Health Agency can be as little as 50% of some of the non-qualified plans. The differences in the plans are significant enough that most seniors would likely choose a non-qualified plan. Older Americans should be given that choice. **NAHU, therefore, strongly urges that non-qualified plan benefits not be taxed.**

Taxing the benefits of a policy that does nothing more than reimburse for legitimate long term care expenses incurred is not fair and could be financially devastating to elderly Americans. Taxation of non-qualified plan benefits will likely cause the extinction of the non-qualified policies and restrict seniors from better plans. What will be sold will be only the qualified policy which will be a standardized, inflexible, benefit-deficient policy.

Our second concern pertains to the deadline for exchanges of non-qualified policies to qualified. Currently policyholders have the right to exchange their policies until January 1, 1998. There are many states that have not approved plans that have been submitted. **We recommend that the subcommittee consider extending the deadline at least to January 1, 1999.**

Our third concern deals with the nature of the qualified plan. States have been monitoring the quality of long term care insurance plans for many years. Many states

have minimum standards that far exceed those provided for in HIPAA. To comply with federal standards, these same states will now be required to lower the standards already in place which have been implemented to protect consumers. **With all of the hours already spent by so many states in defining the appropriate standards for their citizens, would it not be simpler and more cost effective to consider the HIPAA long term care plan as a minimum standard policy and allow the individual states to address the riders and additional benefits best suited to the needs of our seniors?**

In addition to the time and expense already incurred by states and Treasury, new time and expense will be required when the IRS must act as a claims department for individuals who did not purchase an insurance policy but wish to deduct their expenses. The IRS will receive a Certification of Chronic Illness on an uninsured individual who intends to deduct the cost of their long term care services. Abuse could occur if the IRS accepts this at face value. The uninsured could very well receive a tax break under HIPAA when they are not chronically ill while those with the qualified policy will be subject to insurance company scrutiny.

In summation, it does not seem logical that the same Congress and President that agreed to more choice within the framework of Medicare benefits would support less choice for long-term care. **We hope the subcommittee will join with us and other consumer groups to address the concerns we all have for our senior population.**

Thank you for this opportunity to share our views. I will be happy to answer any questions you may have.

Qualifying For Benefits

Tax-Qualified Plans vs. Our Non-Tax Qualified Plans

(Personal freedom PF2608, Assisted Living PF2400, Independent Living PFIL94, California Comprehensive PFCLTCA4R(CA)N and Home Health Care Plans PFHHC94R(CA)N)

- You must need "Substantial Assistance" with at least two Activities of Daily Living,

AND

You must need this "Substantial Assistance" for at least ninety days in order to be eligible for benefits. A Doctor's certificate stating that the patient will need at least 90 days of actual (vs. expected) care.

OR

- You must have "Severe Cognitive Impairment" in order to qualify for benefits. Final clarification of "Severe Cognitive Impairment" has not been forthcoming.

- You qualify when you are unable to perform two or more Activities of Daily Living (ADL's) without human assistance or continual supervision. Or on Personal Freedom and Independent Living you qualify for Home Health Care when you are unable to perform one or more ADI's. Human assistance include hands on physical aid or support, as well as reminders and verbal cueing.

OR

- You become eligible for benefits when you have Cognitive Impairment which is defined as confusion and/or disorientation resulting from deterioration or loss of intellectual capacity.

OR

- You qualify for benefits when your Physician certifies the care/services to be Medically Necessary.

OR

- You qualify for Homemaker Services on Personal Freedom when you are unable to perform two or more Instrumental Activities of Daily Living which include, cooking, shopping, cleaning, telephoning, bill paying and laundry.

How Does This Impact You?

This impacts you in Two ways. First, if you do not elect an elimination period, coverage begins on the first day you receive care on non-tax-qualified plans. In 1997, we paid out $46 million in claims to our policyholders. 35-40% of the claims we received were for a period of less than ninety days. Second, 40% of our Home Health Care and 20% of our Nursing Facility claims are paid based on the One Activity of Daily Living, Instrumental Activities of Daily Living and Medical Necessity triggers. Therefore, eliminating these triggers as a way to qualify for benefits directly cuts the benefits paid to Seniors who have entrusted us to protect them.

Courtesy of Penn Treaty Life Insurance

EXHIBIT I

EXHIBIT II

Courtesy of Penn Treaty Life Insurance Co.

We received the following case studies that are presently being paid by "grandfathered" policies that would not be paid if the claimants had purchased their policy after January 1, 1997 from a long term care insurance carrier.

Long Term Care Facility Claims

Edith
This is an 89 year old woman who is residing in an assisted living facility. Her conditions are Diabetes, Abdominal Aortic Aneurysm, Peripheral Vascular Disease and Osteoarthritis. She receives assistance with one ADL only, however, she is a frail elder and claims are being paid under the Medically Necessary trigger. To date, the insurance carrier has paid $58,000, (20 months).

Wilbur
This 93 year old man with Post-Polio Syndrome entered an Adult Congregate Living Facility. The health assessment form completed at the time of his admission indicated he was independent with his ADLs, however, his physician subsequently stated due to his age and conditions, is simply unable "to care for himself". In other words, even though he can perform his ADLs, he cannot safely live at home on his own. The insurance carrier has paid the claim based on this statement of medical necessity and has, thus far, provided $17,000 in benefits (14 months).

Ethel
This 90 year old woman fell and injured her back and also has Coronary Artery Disease, Congestive Heart Failure and Degenerative Arthritis. She is living in a Personal Care Facility. She is currently independent with her ADLs, however, she is blind and another frail elder. The insurance carrier is paying benefits based on her confinement being Medically Necessary and has, to date, paid $19,000 (15 months).

Loraine
This 83 year old woman with Congestive Heart Failure and Degenerative Arthritis is confined to a Personal Care Boarding Home. She requires stand-by assistance with bathing and infrequent assistance with dressing. She also has panic attacks and requires a supervised environment, although she is not cognitively impaired. To date the insurance carrier has paid $20,000, (200 days).

Margaret
This 87 year old, with frequent falls and hypoxia, is living in a Personal Care Facility. She can presently perform her ADLs independently but needs assistance with medication management

and other IADLs. She is another frail elder who could not safely live at home and needs a structured/supervised environment. Since her admission, the insurance carrier has paid $30,000, (12 months).

Gertrude
This 92 year old woman, who has been living in an Adult Congregate Living Facility with Osteoarthritis, requires assistance/supervision with only one ADL, bathing, and IADLs. This is another case of a frail elder who genuinely requires assisted living, but is not "Chronically Ill." The insurance carrier has paid $26,000, (12 months), thus far.

Mildred
This 86 year old woman is confined to an Assisted Living Facility. She is independent in all ADL's, but has Multiple Sclerosis. She entered the facility when it became difficult to remain self sufficient and perform routine household tasks, such as cooking and cleaning, due to weakness and loss of balance (with a tendency to fall). Even though she is independent with her Activities of Daily Living, she could not remain in her home. Benefits were provided under the Medically Necessary benefit trigger of her policy. The total amount paid to date is $8,050.00, (6 months).

Edith
This 81 year old woman was admitted to an Assisted Living Facility with recurrent compression fractures, CHF and COPD. She receives assistance with one ADL, Bathing.
She also receives IADL care with medication management, housekeeping services, meals and transportation. Because of these deficiencies, she was unable to remain at home. The insurance carrier has paid a total of $22,680.00, (11 months), on this claim thus far.

Edajane
This 76 year old woman is confined to an Assisted Living Facility. She is independent in her ADL's, however, due to her extremely poor eyesight, she cannot manage her own insulin injections or check her blood sugar. These tasks are performed by the facility's staff. Benefits were paid under the Medically Necessary benefit trigger and the insurance carrier has paid $23,600.00, (8 months), to date.

Hersel
This 68 year old man has been confined to an Assisted Living Facility since October 1994. He is "modified independent" with all ADL's, which means that he requires equipment and/or extra time to complete those tasks; yet, he does not meet the "Chronically Ill" hurdle of the Tax-Qualified plan. However, due to his partial hemiparalysis, he cannot live independent of the support provided by the facility. To date, the insurance carrier has paid him $101,400 in benefits, (39 months).

Dorothy
This 79 year old woman has degenerative arthritis and is currently confined to an Assisted Living Facility. While she is able to perform all her ADL's, she must use a walker. She cannot perform the tasks, (i.e. cleaning, laundry, cooking, etc.), that would allow her to live independently in her own home. To date, the insurance carrier has paid $25,380.00 in benefits for her confinement, (15 months).

Eva
This 81 year old woman is confined to an Assisted Living Facility. She requires assistance with one ADL, Bathing. Due to generalized frailty, she is unable to care for herself independently. She cannot do her laundry or cook for herself. The insurance carrier paid this claim on the basis of Medical Necessity. To date, benefits in the amount of $9,816.94 have been paid, (6 months).

Jean
This 84 year old woman was confined to an Assisted Living Facility secondary to a Cerebral Thrombosis. While she was able to perform all her Activities of Daily Living independently, she suffered from left side weakness and was unable to perform her IADL's and therefore, could not live on her own. Benefits totaling $37,400.47 were paid on this claim over an 18 month period.

Ruth
This 87 year old woman was admitted to an Assisted Living Facility following a hip fracture and for care of a torn rotator cuff. She was independent with all her ADL's, except bathing. She could not, however, live independently. She qualified for benefits under the Medically Necessary trigger of her policy and the insurance carrier paid $11,666.67 for her claim, (12 months).

Home Health Care Claims

Anthony
This 88 year old man with arthritis had mini strokes in December 1995. He is independent with his ADL's, with the exception of Ambulating due to an unsteady gait. He does need assistance with most IADL's. He has received the services of a homemaker/companion 7 days per week, 8 hours per day at the rate of $6.25 per hour. To date, the insurance carrier paid $52,300.

George
He is 90 years old and has prostate cancer, hypoglycemic episodes and had a stroke in 1995. The caregivers provide some assistance with one ADL, bathing, but most of the services provided are for IADL's and supervision due to his age and unsteadiness. He receives care 7 days per week, 8 hours per day at a cost of $10.00 per hour. Thus far, the insurance carrier paid $27,760.

Jule
This is an 85 year old woman with osteoporosis, chronic bronchitis and asthma. She does not need care with her ADL's, but due to her limitations, namely, her asthma and shortness of breath, she is unable to do the everyday household chores such as cleaning, laundry, meal prep and shopping. She receives care 5 days per week, 3 hours per day at a rate of $10.00 per hour. The insurance carrier paid $4,231.25 thus far.

Evelyn
This is a 77 year old woman with degenerative osteoarthritis and a deformed left knee.
She is independent with all ADL's, however, she needs care with 4 out of 6 IADL's.
Due to the knee and pain from osteoarthritis, she is unable to stand for any great length of time and therefore, needs assistance with housework, shopping, laundry and meal prep. She is receiving care 4 hours per day, 4 days per week at a rate of $10.00 per hour. The insurance carrier has paid a total of $3,745.00.

Beulah
This 77 year old woman with a recent stroke is independent with her ADLs but needs assistance with cleaning. laundry, cooking and shopping/transportation in order to continue safely living at home. A Plan of Care has been developed through which she receives the services of a homemaker 4 hours per day 5 days per week. The homemaker is charging $12.50 per hour, ($250/week). Care just recently began and the insurance carrier, as a result, paid only $432 so far.

Ruby
This 77 year old woman had a laminectomy in January, 1997. She is independent with ADLs but needs assistance with IADLs. We have approved a Plan of Care offering her 3 hours of help 2 days per week for the next 4 weeks at a cost of $13/hr. (This care just began and the insurance carrier has not yet received any bills.)

George
This 79 year old male with metastatic esophageal cancer needs help with dressing only. He also requires assistance with most IADLs. We are paying for 4 hours of homemaker care, 7 days per week, at a daily rate of $37.50. This care just began and the insurance carrier paid $132.

Millicent
This 82 year old woman recently underwent carpal tunnel release. She is independent with ADLs, except eating, but needs help with 4 IADLs. We have approved a Plan of Care providing 3 hours of homemaker care. 7 days per week, at the rate of $10.50 per hour until such time as she recovers from the surgery. This care just began and the insurance carrier paid only $252 to date.

Sarah
This 81 year old woman recently had a pacemaker implant inserted. She is independent with ADLs, but needs help with shopping, meal preparation, housekeeping and laundry. She is receiving benefits for 4 hours of care per day, 5 times a week at $10.50 per hour.
The insurance carrier paid $1500 to date.

Helen
This 85 year old woman with rheumatoid arthritis and osteoporosis is another example of a frail elder who needs help to be able to continue living at home. She can perform her ADLs, but not her IADLs, what her physician has referred to as "routine activities". We are paying for 3 hours per day for 5 days per week at $10 per hour. To date the insurance carrier paid $2500.

AMERICAN HEALTH CARE ASSOCIATION

Meeting the Needs of an Aging Nation

Testimony

before the

SENATE SPECIAL COMMITTEE ON AGING

March 9, 1998

PAUL WILLGING, Ph. D.
Executive Vice President
American Health Care Association

Mr. Chairman and members of the committee, on behalf of the American Health Care Association (AHCA), I am pleased to have this opportunity to provide testimony on long term care financing and the need for reform. AHCA is a federation of 50 affiliated associations that represent more than 11,000 non-profit and for-profit assisted living, nursing facility and subacute care providers nationwide.

The future is clear. Medicaid cannot and will not continue as our nation's primary source of financing long term care. This federal-state welfare system, which now pays the nursing home bills for two out of three Americans, is beyond repair. Comprehensive long term care financing reform is the only cure and here is why.

Today, most older Americans simply cannot afford the $41,000 annual average cost of nursing home care or the average $89 per visit fee charged by a registered nurse for home care. Most Americans (76%) do not believe they will ever need long term care, but the facts are that two out of five will at some point in their lives, and that one in five over the age of 50 is at risk of needing long term care within 12 months. None-the-less few take any steps to plan for that possibility, believing Medicare will provide for their needs. Medicare, of course, will not. It only provides limited long term care, so government help for most Americans comes only when they have exhausted their personal savings and are forced onto welfare.

The sad reality is that Medicaid was never intended to be a long term care program for the none poor elderly. Yet more Americans rely on it than any other health care program, including Medicare. Though the elderly comprise less than one-third of Medicaid's entire population, $6 of every $10 goes for their care. The financial nightmare worsens when you look at the 77 million baby boomers preparing to retire and enter the system, more than double today's senior population.

According to a recent study, by the year 2020, government revenues will equal entitlement spending (See Attached Graph). By 2030, entitlement spending will exceed government revenues. Factor in longer life expectancies and the approaching tidal wave of aging baby boomers and today's financially squeezed Medicaid program will be pushed over the brink and into bankruptcy.

The need for senior health care reform is great and the process to achieve positive change is already underway. This hearing is one key example. Another is the National Bipartisan Commission on the Future of Medicare. The Commission was established by the Balanced Budget Act of 1997 to explore ways to ensure the fiscal integrity of Medicare, a program that provides for the acute care needs of America's seniors. These forums open the door for new thinking and the improved restructuring of a comprehensive health care financing system – a system that can meet both the acute and long term care needs of seniors in a progressive and compassionate way.

Today, senior health care needs (acute and long term care) are met by a patchwork of government programs. Indeed, most Americans now receiving long term care services under Medicaid are also receiving benefits under the Medicare program. They are simply receiving both sets of services in a totally uncoordinated and badly mismanaged system, mismanaged not by reason of incompetence, but simply as a result of inherent complexities of any system bifurcated because of its location between two separate political entities: Federal and State government.

The American Health Care Association has begun working with other health care provider organizations, consumer and insurance groups, business leaders and policy makers to recommend a comprehensive health care system – a system that creates a seamless system for meeting senior needs for acute and long term care.

Central to our approach is the concept that people who *can* pay for their own long term care *should* pay for that care. A 1995 Luntz public opinion survey found that most Americans support that concept. 76 percent surveyed said they want the government to shift long term care out of the current Medicaid program and into one that is rooted in private long term care insurance. A Gallup poll found that more than eight out of ten Americans said it made sense to develop a reform policy that encourages people to buy long term care insurance, but that the government must continue to provide care for the "genuinely destitute."

Our approach embraces that public opinion in four key principles which state that, as a nation, we must:

- transform long term care from a welfare program to a health care program;
- coordinate long term care private resources with Medicare and Social Security;
- encourage personal and family responsibility for long term care; and,
- maximize quality and control costs through market competition and consumer choice.

While these principles help us understand the reforms we must achieve, they do not tell us how the policy will actually work. Defining each principle further will. That work is well underway.

We propose moving the responsibility for the Medicare-eligible population from the state to the federal level and coordinating it with Medicare and Social Security. Responsibility for those under 65 would be moved to the states. This swap would be phased in over a number of years and be budget neutral.

The new system would provide a public/private insurance-based benefit package that integrates long term care with Medicare hospital and physician services. At a minimum, that package would include today's required Medicaid long term care services for assisted living, nursing homes, sub-acute care facilities and home care. It would also include those optional long term care services now provided by a majority of states.

There will always be a need for the government to fully subsidize long term care for the poor elderly. Eligibility for full or partial government benefit payments would be based on an individual's income and assets on a sliding scale. Those who exceed that scale would become fully responsible for providing for their own needs. For most, this would be done by buying a long term care insurance policy. Expectations are that private long term care insurance can provide up to 25 percent of the total cost of our nation's long term care bill, which will help to reduce pressure on government to finance long term care.

Personal responsibility and family planning for long term care must be encouraged by educating consumers about the risks and options they have and by providing the economic incentives they need to buy long term care insurance. Creating

tax incentives is one option. Enforcing laws that prohibit asset transfers for the purpose of qualifying for government assistance, establishing the purchase of a long term care insurance policy as a prerequisite to transferring assets and eliminating the barriers to family supplementation of a loved-one's care are additional options.

To provide all Americans with care that is efficient and cost-effective, we must create a competitive marketplace. Consumers must have the freedom to choose the most appropriate setting for their care, whether it be at home, in a community-based program or in a nursing facility. They must also have a variety of financing options available to pay for their care. This is critically important because no single care or financing option can meet the needs of all Americans. What works for some one person in Brooklyn, New York may be ill-suited for another in Billings, Montana. What works for Alzheimers patients may be wholly inappropriate for diabetics or those with Parkinsons disease.

In a competitive marketplace created by this new system, the decisions consumers make regarding where to spend their long term care dollars will not only work to hold costs down, but to also to enhance the quality of care they receive. Insurers and providers would be held accountable for the quality of care they provide as measured by quality outcome indicators that are privately validated, scored and publicly reported. Having that information readily available will greatly aid consumers in making informed choices.

Just as Americans select day care for their children from among many options, or choose colleges and educational financing from among many public and private options, they will find making long term care selections a similar experience if we can provide the right mix of options. This is no small challenge and one which will require many minds, many ideas and great innovation.

The need for long term care reform is compelling. Failure is not an option since it would deny older Americans access to quality long term care and deny them the dignity and independence they rightfully deserve. Continuing to allow a welfare system – Medicaid – to work like an entitlement for the majority will bankrupt the federal budget and cripple American taxpayers.

AHCA commends the committee for taking a long look at the growing crisis in long term care financing. Clearly, the entitlement system in its existing structure will not be able to withstand the demographic demands that will be placed on it. Private sector ways and means must be harnessed in partnership with public programs and resources. We are committed to working with you to create an economically sound, quality-oriented long-term health care system for our nation. Thank you for permitting us the opportunity to share our views.

The Present Trend Is Not Sustainable

PURPOSE OF QUESTION: TO ESTABLISH THE QUALITY OF THE LONG-TERM CARE DELIVERY SYSTEM.

QUESTION FOR LYNDA GORMUS

This is a question about the delivery of long-term care. Can you tell us more about the types of services your mother is able to receive in the facility where she is currently living?

For instance, does the facility provide for all of the services she needs, including nursing care and personal care? Who is mainly responsible for coordinating her care?

The facility provides assistance with bathing and other personal care needs, as well as meal preparation. Mom has recently reached a point in her illness where she is no longer able to give herself medication. I do her laundry and her hairdressing.

I coordinate her care along with the nursing staff and physicians.

Follow-up question.—If your mother applies to Medicaid for assistance, will she be able to stay where she is and receive the same services?

Mom will have to move into a nursing home if she depletes her funds, because she will need Medicaid to support her. This facility accepts auxilliary grants when possible, but Mom has a little too much monthly income to qualify.

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