S. HRG. 104–118

PLANNING AHEAD: FUTURE DIRECTIONS IN PRIVATE FINANCING OF LONG-TERM CARE

HEARING

BEFORE THE

SPECIAL COMMITTEE ON AGING UNITED STATES SENATE

ONE HUNDRED FOURTH CONGRESS

FIRST SESSION

WASHINGTON, DC

MAY 11, 1995

Serial No. 104–4

Printed for the use of the Special Committee on Aging

U.S. GOVERNMENT PRINTING OFFICE

91–886 WASHINGTON : 1995

For sale by the U.S. Government Printing Office
Superintendent of Documents, Congressional Sales Office, Washington, DC 20402
ISBN 0-16-047504-X

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THURSDAY, MAY 11, 1995

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

The Committee met, pursuant to notice, at 9:35 a.m. in room 562, Senate Dirksen Building, Hon. William S. Cohen [Chairman of the Committee] presiding.

Present: Senators Cohen, Burns, Pryor, Glenn, Feingold, and Moseley-Braun.

Staff present: Mary Berry Gerwin, Staff Director; Sally Ehrenfried, Chief Clerk; Victoria Blatter, Professional Staff; Michael Townsend, Press Secretary; Beth Watson, Systems Administrator; Theresa M. Forster, Minority Staff Director; and Kenneth Cohen, Investigator.

OPENING STATEMENT OF SENATOR WILLIAM COHEN, CHAIRMAN

The CHAIRMAN. Good morning. Today the Special Committee on Aging is holding a hearing on the role that the private sector can play in financing long-term care for our Nation's elderly and future elderly. Last week, thousands of delegates from all over the country gathered in this city to participate in the White House Conference on Aging. In fact, Senator Pryor and I both had occasion to address that conference, and I thought it was an enormous success overall.

But their mission was a formidable one, to recommend policies on how to address the challenges facing our Nation due to the aging of our society. With baby-boomers facing retirement age in only 15 short years, we have to prepare now for the social and economic demands of an expanding elderly population and a declining work force that is going to be available to support it.

Now that the delegates have packed their bags and returned home, we need to consider what effects their deliberations will have on aging policy. I hope that the participants and spectators of the conference brought away several messages.

First, we really have come a long way in the last 50 years in improving the quality of life for senior citizens in America, and we must not turn back the clock on these reforms.

Second, we must use our public dollars more efficiently and wisely to help those elderly and future elderly who are not doing so well due to sickness, fear of crime or abuse, loneliness and neglect, or the fear that they and their loved ones are losing their dignity and independence to Alzheimer's Disease.

Third, the fiscal status quo is unacceptable. Medicare and Medicaid cannot shoulder the needs of the current elderly population, let alone the enormous burden of the future elderly. We must reform these programs immediately in order to preserve them for current and future beneficiaries.

The pressing need to improve access to long-term care for the millions of Americans who now or soon will need services was a major issue of concern at the White House Conference. According to the GAO study I am releasing today, over 12 million Americans report some long-term care need. About 60 percent of these persons are elderly, and over 5 million of the total number are severely disabled due to a mental or physical impairment. Contrary to the traditional notions of long-term care, the vast majority of those who report needing long-term care services do not live in nursing homes. Rather, over 10 million of them live at home or in small community settings, such as group homes.

And these numbers are growing. By some estimates, the number of elderly needing long-term care may as much as double in the next 25 years. The GAO report contains this item: long-term care is expensive. In 1993, for example, over $107 billion was spent on long-term care nationwide. Almost $70 billion of this price tag was borne by public programs, with the Federal Government spending $43 billion and State governments spending $26 billion on long-term care services.

Long-term care is already the fastest growing segment of State Medicaid expenses, and State budgets are breaking under the weight of these costs. If left unchecked, Medicaid spending could nearly triple to over $36 billion in the next 5 years.

At the same time families are being stretched financially, physically, and emotionally when a parent, spouse or child requires long-term care services. Sadly, many falsely believe that health insurance or Medicare is going to cover these long-term care expenses. Often, it is only when a family member becomes disabled that they discover that long nursing home stays and extended home care services must be paid for out of their pocket.

The catastrophic costs of long-term care places almost every family in America at risk. Fewer than 3 percent of all Americans have insurance to cover long-term care costs. As a nation, we are living under the false impression that Federal and State programs will be there to pick up the tab for long-term care costs.

We have to stop kidding ourselves. It is unrealistic and fiscally irresponsible to create new, unrestrained non-means-tested programs, even for long-term care. As Abraham Lincoln cautioned, "We must not promise what we ought not, lest we be called on to perform what we cannot."

Public programs, such as Medicaid, must be preserved to provide services to those who cannot afford care, but more must be done to encourage personal responsibility among middle and upper income Americans to prepare for their own long-term care needs.

Today's hearing will examine what the private market can do to assist American families in planning for their own future needs. We must encourage individuals and families to view long-term care needs as a very likely risk of growing old, much as they now purchase automobile, accident, and life insurance.

As we will hear today, the private market has tremendous potential for financing long-term care. While these insurance products acquired a bad reputation when they emerged a decade ago, the market has evolved rapidly to meet consumers demands for more flexible, affordable, and fair insurance coverage. A wider range of policies are now available that cover home health care, adult day care, assisted living, respite care, and skilled and intermediate nursing care.

Insurance is by no means the panacea for the long-term care needs of our Nation. But a private long-term care insurance market is crucial if we are to alleviate the burden now placed on Medicaid. As the GAO report points out, directors of State Medicaid programs often cited long-term care insurance as an effective means to reduce Government spending on long-term care.

Earlier this year, I introduced S. 423, the Long-Term Care Family Protection Act, to make it easier for individuals to plan for their future long-term care needs by clarifying the tax treatment of long-term care insurance, and allowing families to keep more of their assets and still qualify for Medicaid if they have purchased long-term care protection. This legislation also established consumer standards so that purchasers will know exactly what type of insurance protection they are getting.

The House of Representatives has already passed legislation to provide fair tax treatment to long-term care policies. It is my hope that the Senate will swiftly follow suit by passing legislation to encourage the purchase of long-term care insurance and place consumer protections on these products.

It has been said that the real health care decisions are not made in Washington, but rather around the kitchen table. Educating and helping families plan for their future long-term care needs now will help them make the most appropriate decisions for themselves. Once more, it is a sound investment decision for taxpayers, since these efforts will ease the financial burdens of Medicaid in the years to come.

I look forward to hearing from the variety of witnesses that we have today. Before doing so I want to call on Senator Pryor, the former chairman of the Aging Committee and a gentleman who has worked closely with me over the years since we have been in the Senate on aging issues. I now yield to Senator Pryor.

Senator PRYOR. Thank you, Mr. Chairman. Let me if I might, yield at this time to a former-former chairman of the Senate Aging Committee, Senator John Glenn, who beat me here by a few moments. John, if I might, I yield to you at this time.

STATEMENT OF SENATOR JOHN GLENN

Senator GLENN. Thank you, David.

Mr. Chairman, I am very pleased that the Aging Committee is holding this hearing. It will provide an update on the current and the future role of private insurance in financing long-term care.

About 10 years ago, I chaired an Aging Committee hearing in Cincinnati at a field hearing, which was in a series of hearings on the general topic of women in our aging society. The main purpose of the hearing was to look ahead and plan for the needs of our

changing population, rather than just waiting to act when a crisis is upon us, which is what we seem to do all too often.

Our growing elderly population should be enough of a reason to expand and improve home and community based long-term care, as well as nursing home care. You have to have several options, and then choose the one that is the most appropriate option.

We have gone from last year's discussion of health care reform, which was going to cover the whole population, to today's debate in the Congress on slashing Medicare and Medicaid expenditures. That gives us an even more urgent reason to educate people about the need for long-term care services for the elderly and the disabled, and to work to insure the availability of both public and private financing for high quality care.

I can only be here for the opening this morning, and give this statement. Then I have to leave. Diane Lifsey, who is behind me here, has worked on these matters with me for years and years and years, and with my personal staff while on this committee. She will be here all through this morning's hearing. So if there is a break and someone wants to give her some ideas, I hope you will avail yourself of that opportunity.

We went through some of these same problems with my wife's mother back a few years ago. She is no longer with us, but we went through some of these things about what home care we could get, how much it was going to cost, and nursing home care. We went through these options that all too many people have to face these days. So, we know from first-hand experience what is involved with some of these decisions.

Back to the Cincinnati situation—the particular focus of the Cincinnati hearing was women who are providing care to elderly family in their own communities. Our lead off witness was Dr. Robert Binstock, of Case Western Reserve, who I am sure is well known to many of you.

Ten years ago, Dr. Binstock pointed out the need for private insurance which would enable middle-income people to purchase insurance for non-medical community based care, and suggested that this insurance should be provided to workers to protect against long-term care costs for their parents.

I look forward to the testimony, and getting the testimony from today's witnesses on the private, long-term care policies that are available today, and on the steps the Federal Government can take to help more people plan ahead for their own financial security. At the same time we need to look at both the Medicare and Medicaid programs to determine how they can be made more responsive to the health care needs of the chronically ill elderly and the disabled in ways that are cost effective and humane. It is a big problem.

Mr. Chairman, I compliment you for having the hearing today. It is something that is certainly needed, and for the legislation that you are proposing. I look forward to today's witnesses. We thank them for coming before the committee, and look forward to the advice that they can give us today.

The CHAIRMAN. Thank you very much Senator Glenn.

Senator Pryor.

STATEMENT OF SENATOR DAVID PRYOR

Senator PRYOR. Thank you, Mr. Chairman.

Once again, we appreciate so much your holding this hearing, but when you look at the facts and the figures and the statistics about what is about to happen to our population, it is pretty awesome. I don't think that we are prepared for this in this country. Even though we see the trend line, even though we know the numbers, generally, I don't think, still, it has soaked in on the Congress and maybe even the American conscience as to what is about to happen to us.

For example, the baby boom population is comprised of 76 million people, and it is approaching retirement age. In fact, the first baby boomers are going to retire at about the year 2011. That is not long away. They are going to begin to need at that time, long-term care. We are going to see a massive strain on the infrastructure for caregivers and for providers, for nursing homes, for hospitals, for home health care agencies; something that I don't think we realize yet the significance of.

Three million people are in the group that are 85 or older. That is the fastest growing population age of our time at this time. There are 3 million people today who are 85 or older in the country, and in a few years there are going to be 9 million people who are 85 or older. That gives all of us some hope.

By the way, this is a little remark I hope won't be taken the wrong way, but I'm retiring from the Senate, and I have said it is not because the Republicans have taken over the Senate, it is not because, as some people say, that it has gotten to be a little more mean spirited or whatever, it is simply because not long ago, in the airport in Dallas, a man came up to me and said, "Aren't you Congressman Claude Pepper?" [Laughter.]

I knew then it was time for to get out of here. [Laughter.]

The CHAIRMAN. What did you say?

Senator PRYOR. I said, no, but I knew him very, very well, which I did, and respected him mightily, I will say.

Mr. Chairman, I have a longer statement I would like to put in the record. My staff is going to hit me for getting off of their beautiful, prepared remarks, here.

Some 10 to 40 percent of the retiring population can even afford long-term health care. We are seeing a real emergence of two people who came forward in the health debate last year. I call them the ultimate power couple. It was Harry and Louise. Many of you remember Harry and Louise.

Well, Harry's mother has come into play. I don't know if you have seen some of the ads. This is Harry's mother. There she is. We have blown up an ad there. They are running this in a lot of publications across the country. I am going to read this. It says, "Harry's mother is amazing. At 75 she is financially self-sufficient and plans to stay that way. The purchase of long-term care insurance insures financial independence for many Americans like Harry and his mother."

The truth is that only about one-third of the single women aged 76 to 79 could probably afford any insurance of this sort. The median income for single women at age 75 is less that $10,000 in our country. So, some how or another, Harry's mother has discovered

a secret. She is very happy, and looks like she is going off to go play golf, or do something, living in a fancy retirement center, perhaps. But, that is not the way the real world is. We have to face that.

I think that we all have to face that together. I hope very much that we can find some solutions to this, and all sing out of the same song book.

I look forward to working with the distinguished Chairman and colleagues here on the Committee, and really to trying to find some solutions to the problem that we are faced with.

The CHAIRMAN. Thank you very much, Senator Pryor.

Senator Feingold.

STATEMENT OF SENATOR RUSSELL D. FEINGOLD

Senator FEINGOLD. Thank you, Mr. Chairman. I am always grateful, as a member of this Committee, that both the Chairman and the ranking member have had such a long time commitment, not just to aging issues, but specifically a dedication to the long-term care issue that I have been interested since I have been in public life. I thank you for calling this hearing on the private financing of long-term care.

This hearing is very much consistent with the tradition of this Committee of looking at these sorts of issues, and I look forward to the testimony that we will hear today.

Mr. Chairman, I do want to make a couple of remarks. Private long-term care insurance may be able to play an important role in providing a limited population some financial security, like funding the need for long-term care services. But in my view, for most families that will require long-term care services, the only real solution is fundamental long-care reform centered around a home and community based program that can deliver flexible, consumer oriented, consumer-directed services.

I think Senator Pryor is absolutely right that despite the best efforts of many of the people in this room and across the country, the reality of what is going on in this area has not sunk in, from either a human or fiscal point of view.

It has reached the halls of the legislature and government of my home State of Wisconsin. It is understood there, but it is not yet completely or adequately understood here. There is a learning curve that has not yet been surmounted.

Just last week, the White House Conference on Aging met here in Washington, as the Chairman pointed out. I was able to meet with nearly every delegate to that conference from my own State of Wisconsin. We discussed a number of issues of keen interest to seniors, including the possible Medicare cuts. But, by far the most important issue on their agenda was moving toward a national, Government based, long-term care reform.

The Wisconsin delegates were not alone. Of the so-called 10 percent resolution that was adopted at the conference, and these were resolutions that the delegates offered themselves, they were not offered by staff, I am told that the resolution receiving some of the broadest support was the one calling for a national long-term care program.

Among other things, the resolution called for a program that guarantees long-term care services and supports for all who need them, regardless of age, income, or disability. That is would be financed progressively across generations, and protect families from impoverishment. It would cover persons with physical, cognitive, and other mental impairments. It would specifically emphasize home and community based services. It would assure consumers' choices and the opportunity to direct their own services.

Pursuant to that, because I obviously knew the concerns of many of these folks long before the conference, Mr. Chairman, I introduced on the first day of our session this year, S. 85. S. 85 establishes just such a program. It is based largely on the Wisconsin Community Options Program, the home and community based long-term care program that was introduced and started in Wisconsin in the early 1980's. It is a reform that is not only compassionate, Mr. Chairman, it has saved Wisconsin taxpayers hundreds of millions of dollars.

Because COP and our other reforms in the 1980's, while the rest of the country saw changes in the Medicaid nursing home bed use climb by 24 percent, because of our program in Wisconsin, we actually saw Medicaid nursing home bed use drop by 19 percent, because we had this State program.

Our long-term care reforms have had strong bipartisan support. In fact, our Republican Governor, Tommy Thompson, has cited these reforms as the reason Wisconsin has been able to keep its Medicaid budget under control. This is especially relevant in this week, and even more so next week, as we approach in the U.S. Senate the Budget Resolution, and eventually reconciliation.

If we are serious about finding ways to save money in Medicaid, then this kind of a national, long-term care program has to be part of the answer. It is not part of the problem. It is not something that is going to make things worse. It is part of the answer to solving our deficit problem.

By capping the long-term care program costs to the Federal Government, my bill ensures fiscal control by including a progressive cost sharing mechanism. S. 85 ensures that those who could afford to do so, would pay more, while avoiding the inequities that arise from means tested welfare programs like Medicaid. By including off-setting spending cuts, S. 85 ensures that we do not have to rely on expected Medicaid savings, which I am sure will occur. In fact, the bill is actually a net deficit reducer.

The offsetting spending cuts in S. 85 actually realize $6 billion in net deficit reduction over the first 5 years. So, Mr. Chairman, I recognize that many of today's witnesses will be focusing on the possible role of private long-term care insurance. Though I do not view private long-term care insurance as being the largest part to the answer to the problem, perhaps it will be part of the answer. I am certainly interested in what our witnesses will have to say about the ways in which we can improve access to these policies, as well as any possible protections we ought to include in them.

However, I am firmly committed to reforming our long-term care system to the establishment of a home and community based care program that provides flexible consumer oriented and consumer directed services, without regard to age, income, or disability.

Mr. Chairman, I again thank you. You are the reason that there is a forum here in the U.S. Senate for this issue.

The CHAIRMAN. Thank you, Senator Feingold. Let me make a couple of quick remarks in response to Harry's mother. Right now, many middle income people can't afford long-term care insurance, and no one is suggesting that private insurance is going to be the solution to low income people. But, we do need to encourage a private market so that the pool will get larger and the products will become more affordable for more and more families.

Second, right now many people who could afford to buy insurance with the limited tax incentives that we are currently providing, are not doing so. They are assuming that the Government is going to plan for them, so they are shifting their assets to get on to Medicaid, taking scarce Medicaid dollars away from the truly low income.

Another point that I would make is that for the past 5 years, we have had four national hearings on long-term care insurance programs. There were nine field hearings, plus the four national ones here. Not one hearing has ever been devoted to examining what the private market should offer, and can offer. What we are trying to do is have some balance. We need to have a combination of private and public. So, today marks the first time we will actually have a hearing dealing with the private insurance market. What has happened in the last 10 years from the initial phases of insurance coming into play, and where they are now; what the costs are; whether they are becoming more affordable, more comprehensive, and certainly more understandable to the consuming public.

With that in mind, let me call our first panel. It is not Harry's mother, but we have Mr. John Spear, who has come to us today from Champaign, Illinois, accompanied by his daughter Sarah Spear; and Mrs. Jean Heintz, from Portland, Oregon; who are going to discuss their first-hand experiences with long-term care insurance. Both are going to explain how their policies have protected them from catastrophic costs associated with the care of their spouses.

I think their stories are truly compelling. The Committee is very grateful to have them with us, having traveled this great distance to be with us this morning.

We are also pleased to have with us, Ellen Friedman, who is the manager of benefit planning at Ameritech to discuss what employers are doing to help working families manage their long-term care needs. We look forward to their very important testimony.

STATEMENT OF JOHN SPEAR, PFL LIFE INSURANCE CO. POLICYHOLDER, CHAMPAIGN, IL, ACCOMPANIED BY SARAH SPEAR

Mr. SPEAR. Thank you, Mr. Chairman. I am glad to be here. I am glad to tell you of some of our experiences. This is Sarah, my daughter.

I might start with some of my history, so you will know some of my background. I was born on a farm in the central part of Illinois. I graduated from high school in the depth of the Depression, when corn was 10 cents a bushel, and hogs were 3 cents a pound. There was one thing in my mind—I didn't want to be a farmer. We weren't starving to death, but we didn't have money to pay the in-

terest, pay the taxes, or pay anything else, because we didn't have it.

I finished high school in 1932, and we just didn't have money for me to go to college that fall. By the next fall, we had gotten a little more together, had done a little better. I had a job at the Kroger store, working on Saturdays. I went to work at 7 in the morning; stayed at work until farmers quit coming in to buy groceries, which was about 10:30 Saturday night. I got paid $1 for that.

Then Franklin Roosevelt came along with his wage program. Gosh, my pay went from $1 to $3.50 a day. My time was cut off from 11:30 at night to 7:30 in the evening. So, I lost 4 hours of time, and 2½ more dollars of pay. Pretty good.

Well, I graduated from college in 1937. My first job was $25 a week, with a packing company in Davenport, Iowa. I had a very good title, that of student salesman. Do you know what a student salesman did in 1937? He candled eggs. We had a lot of eggs with bad spots in them, because we didn't have good refrigeration. I helped unload refrigerator cars with beef that came in from slaughter plants in Kansas City. One of the most boring jobs was cleaning moldy wieners. Do you know how to clean a moldy wieners—cheese cloth and vinegar. It makes new ones from them.

Well, it didn't take me long to decide I didn't want to be in the meat packing business. I qualified to teach vocational agriculture, and in the middle of September I got a job as a vo-ag teacher in high school in Jerseyville, Illinois. That is a little town north of Alton about 20 miles. I stayed there until 1944, when I got the kind of job that I really thought I wanted. That was farm management and appraisal work.

I want to tell you about my wife, and our getting to know each other. The luckiest point in my life. I was in the second term of my freshman year at the University of Illinois that I met her. She was 2 years ahead of me. Not 2 years in age, but 2 years in school. She is only 364 days older than me. So one day out of the year, I am as old as she is.

She was a home economic major and had a job that paid her $100 a month for a 9-month year as a home economics teacher for the 2 years before we were married. Like all kids who fall in love, they decide money is not too important. Why would she give up $900 a year to come with me, when I was making $25 a week?

Anyway, I retired from farm management work with Doane Agriculture Service in 1976. I want to throw in too, that when we moved to Champaign, Illinois, our youngest kid started school. Barbara really liked school, so she decided to go back to the University of Illinois and acquire her master's degree in elementary education. She then taught school until we both retired in 1976.

After that time she did a lot of volunteer work at one of our local hospitals. Along about 1988, we were talking one day after we had gotten a folder from the Illinois Teachers Association with a little brochure on long-term care. We talked about it extensively. And one day I said, "Mom, you know, I think we ought to get some long-term care."

So, I investigated the insurance company that sent the literature to us. I came up with a figure for long-term life care in a nursing home, or whatever, wherever we had to be. Gosh, that was going

to cost us $4,000 a year. Mom said we can't afford that. I sat down and I said, look, here is our assets. Here is what we have to spend. We can't afford not to buy some long-term care. And, we did that.

A year later I was talking to a friend who had a license to sell the insurance we now have. His program looked so much better to me. It was long-term; paid us $70 per day, either of us, for the length of our life in a nursing home. We signed up for that. The only thing we did wrong was we had it for 3 years when we had the opportunity to increase our coverage at a fee; we vacillated over that and finally let the time expire and didn't get it increased. That was a big mistake I made on long-term care.

It was in the early 1990's that Barbara, who was a lover of flowers, began to get her flowers mixed up. She couldn't keep track of where she had planted them. After taking plants from the seedling bed out for transplanting in our flower beds she would go back to the seedling bed with her plants. When she came back, I said, "What's the matter?" She replied, "Well, I forgot what to do with them." It wasn't funny, but in retrospect in a way it is. It is damn sad.

A year ago now, it got to where I couldn't take care of her. She obviously didn't want to go to a nursing home, but there wasn't anything left. Sara lived in Columbus, Ohio. She had to take care of her job. I have another son in Cincinnati. He had to take of his work and three little kids. He, by that time, had gotten sick. He was in his internship, advanced study in medicine at Cincinnati University. The other son, who is not married, but does well to take of himself. So, there wasn't anything for us to do but go to the nursing home.

Mom didn't want to go, but she is a heck of a lot happier now, I know, than she was when she was at home, because she got so anxious, and so disturbed. At first they put her in the regular part of the nursing home, then, about a couple of months ago they moved her to Alzheimer's group. It is a more structured type of care. It costs me $10 more a day there, but it cut off some other expenses that I had prior, that I didn't realize were involved in the nursing home. So, it didn't really increase our expenses much more. We are paying about $600 a month, beyond the $2,100-plus the insurance company pays us, which makes it a total of around $30,000 a year for the total cost.

I talked to you about this long-term care. You know I hope you fellows can figure some way to really, really encourage people to buy it. I don't know what the possibilities are. You fellows have the background.

People say, "I can't afford it." If they would start back when they are 60 years old, when the policies cost so much less. They find money to go to the picture show; they find money to do this and do that—but 15 years before you are 75, that premium is not too bad. Maybe a fourth of what it is when you are 75, at the time we bought.

Well, anyway, I want to add just one more thing. I told you I had a son in Cincinnati. He had graduated from the University of Illinois medical school, and was on his way to Cincinnati with his family of three children. They stopped by our house. We had taken this long-term care. I said, "Mark, what if something happened to

you and you couldn't take care of your family? What if you couldn't work?" He said, "I'm going to work. There is no reason why I shouldn't keep working." I said, "Before you go to Cincinnati we are going over to talk to Eisner Murphy and see what they can give you for disability insurance." His stipend was $2,000 per month at school. They signed up on a disability with a $2,000 a month payment. His program was a 5-year program. He completed 4 years of it. He got up one morning, and could not go back to work. He just went to pieces. What would have happened to that poor family if he had not had that $2,000 per month to help him out.

That is beside the point of long-term care, I realize, but it is parallel to it. You know, it is my judgment that if we somehow could educate our people to do it, and cut out some of the frills they think they can't get along without, and spend a little money each month on a good insurance program, long-term care or even disability. I think we should do everything we can to encourage that. I gather from things that have been said here this morning, plans are, hopes are, to make long-term care premiums tax free, or so that you would not have to pay taxes on those. How many people in this country are in the 28 percent tax bracket? I don't know, but there are lot of them. Not very many of them have insurance. If they could deduct the premium before they pay their tax, that would be giving them a 28 percent reduction in their insurance premium.

It sounds like I'm trying to sell insurance. I am trying to figure out some way that people can be more responsible for what they are doing, and taking care of themselves.

Thank you for your kindness.

[The prepared statement of Mr. Spear follows:]

TESTIMONY OF JOHN SPEAR, PFL LIFE INSURANCE CO. POLICYHOLDER

Mr. Chairman, members of the committee, good morning, and thank you for giving me this opportunity to testify before you today. My name is John Spear and my wife Barbara and I live in Champaign, Illinois. We have three grown children and our daughter Sarah has accompanied me here today.

I am here today to tell you about the importance of private insurance, particularly private long-term care insurance. I would like to tell you a little about my wife and my family and our personal experience with long-term care insurance.

I was born on a farm in Illinois. My father was not wealthy by any means but we still managed to survive the depression. Somehow my father was able to help me with college expenses and I am very fortunate to say that I was able to work and attend college at the same time. I worked at various jobs, including working at the first Kroger Grocery store earning $1.00 per day. When the NRA was passed I thought I had become rich as my earnings increased to $3.50 per day.

After college I went to work for a meat packing plant and quickly learned that this was not to be my calling in life. I finally become an Agricultural Teacher and remained in that job until 1944. My earnings were $25 per week. I have since retired as a supervisor in farm management and farm appraisal. I had responsibility for a three state area.

Barbara, my wife, and I met in 1934. Barbara was a home economics teacher at the time. When we had our children we decided it was best for Barbara to stay home and raise them. In 1963, Barbara decided to go back to school and she earned a Masters degree in Elementary Education from the University of Illinois. Both Barbara and I retired in 1976. We have had a great life together.

In 1989 Barbara and I talked about buying a long-term care insurance policy. Barbara did not want to buy the policy, she thought that it was too expensive and that we couldn't afford it. I told her that we couldn't afford not to buy a long-term care insurance policy, that we couldn't afford to pay for several years of care in a nursing home without some financial help from somewhere other than our savings. We finally did buy the policy, and about 2 years ago I noticed the first signs of Alz-

heimer's Disease. Barbara began forgetting things until finally I was just unable to care for her. A nursing home was the only alternative that I had.

Now Barbara receives the best of care. The young men and women that provide care to Barbara just love all of the people in the nursing home. Two of them told me that they were going to adopt Barbara as her own Grandma. Barbara is in a special Alzheimer's unit and no one could complain about the care that she is receiving. I get a great deal of satisfaction about the care that Barbara is receiving.

But without our long-term care policy we could not afford to pay for the care that Barbara is now receiving. The cost for Barbara's care is over $90 per day, that's over $30,000 per year. We just couldn't afford the catastrophic risk and cost of nursing home coverage without an insurance policy to help pay for those bills.

My personal feelings are that people should purchase insurance policies to protect themselves against the catastrophic risks that we all face. The government cannot afford to take care of all of us, and we can't afford the tax increases that would be necessary to provide care for everyone. We also should keep government involvement to a minimum—individuals should take responsibility for their own lives and expenses.

However, the government must encourage people to plan in advance and to take responsibility for their own long-term care expenses. The best way to do this is to give a tax deduction for the premiums that we pay for long-term care insurance. By giving a tax deduction for long-term care premiums the government will be sending two big signals to citizens. First, the government will be warning people that with the exception of Medicaid there is no government program that will pay for long-term care expenses. Second, the tax deduction is something that everyone understands and is the government's way of encouraging people to plan to pay for their own long-term care expenses.

I am a firm believer in good insurance products. Without good insurance products my son's family would be financially devastated. Five years ago my son, Mark, became totally disabled and without his disability insurance policy there is no way his family could have survived financially. Without a good long-term care policy my retirement savings would have been spent on Barbara's nursing home expenses. Barbara originally said that we couldn't afford the premiums. The truth is we were able to afford the premiums and we couldn't have afforded not to have good insurance coverage.

The CHAIRMAN. Thank you, Mr. Spear, very much. We know that you didn't want to be a farmer; you had good reason why you didn't want to be a farmer; you didn't want to be a meat inspector, or deal with meat. We know you don't want to be an insurance salesman either, but we thank you very much for your testimony. We are going to come back to you with some questions after we complete the panel.

Ms. Heintz would you care proceed?

STATEMENT OF JEAN HEINTZ, PORTLAND, OR

Ms. HEINTZ. Good morning, Mr. Chairman, and members of the Committee. My name is Jean Heintz. I am a 70-year-old retired school teacher from Portland, Oregon. My husband, Chuck, is 75. He retired in 1982 from his position as an executive with a warehousing firm. I want to thank you for having me here to share my story.

I retired from the public school system in 1990, having taught 30 years. My husband and I were looking forward to our retirement years together, and we thought it best to plan ahead. My husband contacted Health Choice for Seniors, a very reputable local firm specializing in retirement planning.

A young lady representing Health Choice came to our home with brochures which explained a wide variety of HMO offerings. We discussed these and made a decision. When I retired, I had to leave the group plan, and enter an individual plan.

She then asked if we had thought about a retirement community. It was obvious our hillside home was not ideal for the elderly. We told her we had made arrangements years ago, after becoming familiar with my mother's choice, a place called Rose Villa.

At Rose Villa seniors live independently in their own apartments. College classes, lectures, trips, and a wide variety of interesting activities are offered regularly. Health care is also available for those who need it in their apartments.

Mother said she chose Rose Villa because it had an excellent skilled nursing facility, and if she ever had a stroke or needed custodial care, she did not want me to give up my profession to care for her. Mother had led an extremely happy life at Rose Villa, and we also saw the expert care she received after a hip replacement in her 80's, and then again when her body began its brief decline in her 90's.

This discussion about mother and Rose Villa prompted the next question. Have you thought about a long-term care policy? Frankly, we had given little thought to the possibility of a severe personal health problem. We had been so healthy, and we knew we practiced good health habits. But we also knew from experience that long-term care needs could present problems for any family, and that meeting those can take quite a financial and emotional toll.

You see, during World War II, my father who had always been healthy, suffered a massive heart attack. He survived, went back to work, and then suffered another disabling heart attack, and was confined to our home for the next 14 years. My mother cared for him there herself, while also teaching in a local high school. She paid for his medications, as well as for the pleasant day companion that he needed. At times, mother would be so tired she couldn't dress herself. But her effort allowed me to attend a fine college, Reed College, and prepare for my profession.

Although we hadn't really thought about it before, my husband and I both agreed that long-term care insurance would be a good idea. We planned an active retirement, including travel abroad, and wanted to make sure that we would be taken care of in the event of a debilitating accident. We particularly wanted our two sons to have the peace of mind that we were covered, should anything happen to us.

The representative from Health Choice for Seniors suggested a long-term care policy called ProtectCare, provided by John Hancock. We studied the policy, which was very clear and straightforward, and decided that the cost was reasonable and it provided for a variety of possible care options, including both home and nursing care. We both signed up for a policy that paid $70 a day toward nursing care and $35 a day toward home care. At the time we signed up, I was 65. The policy costs me $950 a year. Chuck was 70 and the policy cost about $1,500.

Chuck and I enjoyed retirement together, but later I noticed minor but persistent changes in his driving skill. He had been a bomber pilot in World War II and was an exceptionally capable driver, so I was concerned. After his annual physical, I talked to the doctor, and he suggested a neurologist. An MRI revealed no tumor, but the doctor's diagnosis was Parkinson's disease.

He responded well to the medication at first, so life went pleasantly on. Unfortunately, his mind began to show signs of impairment. He fell frequently, was occasionally confused, and suffered frightening hallucinations at night. I began to think seriously about moving to Rose Villa earlier than we had planned. My husband agreed to visit, we selected a pleasant apartment and moved. I experienced a great sense of relief knowing help was only a minute or 2 away.

Although I had become a constant caregiver, I think we could have managed together for years if his mind had not continued to deteriorate so rapidly. I knew my insurance policy would pay for home care, but I preferred to care for him myself. He had always been a pleasure to live with, and as long as he could help me help him, we could have managed his physical limitations and enjoyed life together in our apartment.

Ever so slowly his needs increased until they reached a point where I was getting so little sleep that I became ill and had to call for help. The staff brought Chuck to the skilled nursing facility within 15 minutes. Later in the week, I watched two very strong young aides doing what I had been trying to do alone. I knew there was no way that I could continue to provide the personal care he now needed day and night. As I evaluated the situation, I realized that he also needed more frequent skilled nursing care. Later, I found out that, when admitted, he was dependent in five out of six standard activities of daily living. In other words, classified as severely disabled.

Chuck has lived in Rose Villa's skilled nursing facility since August 1993. His dementia has become more severe and the Parkinson's disease has taken a great physical toll. He often does not recognize me or his surroundings, but does enjoy his meals and the friendly aides. One of the benefits of living at Rose Villa is that I can easily participate in his daily care—helping him with meals, wheelchair outings, and remaining a part of his life.

I've been so grateful to have the long-term care insurance because all that was presented in the policy has been promptly fulfilled. The policy pays for his entire nursing home bill, and will pay for up to 6 years. The insurance claims staff even took care of most of the nursing home arrangements for me. Most importantly, it has allowed my sons and me to continue our lives without the frightening financial and emotional drain long-term care needs present families.

Some people are in and out of a nursing facility in a matter of a few days or weeks, but we also have those with failing minds and fairly healthy bodies. These people can live years with proper care. Because medical advances have made it possible for us to live longer, I believe an even larger number of Americans will need help with long-term care needs far beyond what family members can provide. Private insurance has certainly made arranging and paying for this kind of help a lot easier for me. I hope you will actively encourage Americans to purchase private long-term care insurance because affordable long-term care insurance can really make a difference in people's lives, as my family's experience so clearly demonstrates.

Thank you.

The CHAIRMAN. Thank you very much, Mrs. Heintz. Before calling on Ms. Friedman, I am going to yield to our colleague from Montana to celebrate the virtues of being a farmer, or being associated with farming, or any other comment he would like to make.

STATEMENT OF SENATOR CONRAD BURNS

Senator BURNS. I'm just thrilled to meet Mr. Spear. He makes me want to go home. I was raised in Missouri.

Mr. SPEAR. You are my neighbor.

Senator BURNS. That is right. I candled some of them eggs, and packaged some of that beef, and farmed a little ole bitty 160 acres of two rocks and one dirt, and I wish everybody would take FFA. I want everybody to take FFA. If you are going to be a vocational agricultural teacher, you just keep on expounding that.

Mr. SPEAR. I haven't fooled with that since 1944.

Senator BURNS. Well, they have taken it out of schools now because they think they have to cut something. It is the greatest youth organization there is in the world, bar none.

Mr. SPEAR. I agree with you.

Senator BURNS. Here we are, we have all the people who think they are going to do something for the world, when they ought to be taking a look at 30,000 blue jackets in downtown Kansas City, and never, ever hire an extra cop, and then wonder where our country is going.

So, we are happy you are here. I am going to make my statement a part of the record. I have another hearing to go to.

Thank you very much. We are happy you are here.

[The prepared statement of Senator Burns follows along with the prepared statements of Senators Alan K. Simpson and Larry E. Craig:]

PREPARED STATEMENT OF SENATOR CONRAD BURNS

Mr. Chairman, I thank you for holding this hearing today. I am sorry I am not going to be able to stay for the whole hearing but, as is more common than ever, I've got another committee hearing that I need to attend.

I did, however, want to say that I think exploring ways to mix public and private financing for long-term care is an idea whose time is overdue. For too long, folks have not planned well for what should be their golden years. And in not doing so, finding a way to afford long-term care can bankrupt the one who needs it and their family.

The Senate is focusing these days on Medicare and though Medicare is not a big player in long-term care, I think it is important that we review it at the same time. I think both programs are facing similar challenges—the way it is financed, the way people view it, and the way it is delivered.

I hope I will have time to hear our first panel because I think its folks like you who can teach us the most. So many people have the attitude that the government will take care of them, and I am glad to see, in your testimony, Mr. Spear, that you and your wife believe in individual responsibility. I honestly believe that's an attitude we need to get back to in our society.

Yes, it is hard to save. And now that we are living longer, healthier lives, our needs for retirement are greater. Add to that any catastrophic costs and the financial demand, in our waning years can be outrageous.

I am interested in learning the cost of long-term care insurance, since both Mr. Spear and Mrs. Heintz appeared to have purchased policy late in life. And I am interested in the choice Mrs. Spear made to care for her husband at home even though the policy would have paid for home care. My parents did the same thing—but I think, these days, you and my folks are the exception, not the rule.

Mr. Chairman, thought I have to run, I will look forward to reading the hearing report and would like to work closely with you in addressing this need. At a time when we are looking at ways to tighten the budget and keep Americans healthier

longer, both physically and financially, I believe we need to get to work on building a public-private relationship in long-term care. And I am anxious to hear our panelists thoughts on how best to do that.

Thank you again for bringing this issue before our Committee, Mr. Chairman.

PREPARED STATEMENT OF SENATOR ALAN K. SIMPSON

I commend my old friend Senator Cohen for convening this hearing regarding the role of the private sector in long-term care. This is a very timely and appropriate topic. As Congress searches valiantly for a fiscal course that will lead us to a balanced budget, each of us is keenly aware that our success depends largely on whether or not we are able to control the extraordinary growth of Federal spending on Medicare and Medicaid. Any plan to control these expenditures must include a strategy for dealing with long-term care costs.

My dear brother Pete and I are personally familiar with the realities of long-term care. Our wonderful father resided for several years in the West Park Long-Term Care Center in Cody, Wyoming before he died in 1993 at the age of 95. And our lovely mother received "around-the-clock" continuous care right in her own home until she passed away on January 24 at the age of 94. It was truly a blessing to have our parents with us for so many years.

The expense of this long-term care was staggering. We paid it personally—and every penny was well worth it—but our parents were both covered with private insurance that covered ~~long-term care.~~ They used their own personal resources to meet these expenses.

Unfortunately, many Americans simply could never afford to fully pay the costs that are associated with nursing home care or home health care. Instead, they then turn to Medicaid. I am pleased that Congress has closed the loopholes that allowed people to "game the system" in the past by "hiding" their assets or using other gimmicks. However, even with eligibility limited only to those who have truly depleted their resources, the reality is that Medicaid expenditures on long-term care will only continue to soar in the foreseeable future. And they are substantial!

In order to stop this trend, I believe we must find ways to bring more people under private long-term care insurance coverage. This will not be easy, especially when people know that they can always fall back on Medicaid as an option of last resort. However, we must find ways to make people understand that it is in their best interests to take personal responsibility for their future care.

Those who can afford to purchase private coverage should be encouraged to do so, either through tax incentives or by other means. If we take steps now to stimulate private insurance coverage of long-term care, I am absolutely convinced that we will save huge Federal dollars over the long haul. I trust this hearing will help to shed some light on possible solutions to this perplexing and extremely costly problem.

STATEMENT OF LARRY E. CRAIG

Mr. Chairman, I would like to thank you for your leadership on the issue of long-term care and for holding these hearings today to discuss future directions in private financing of long-term care. I have briefly looked over the outline of you legislation, Mr. Chairman, "The private long-term care protection act of 1995," and found it to contain come very timely and important provisions. I look forward to hearing more about the ways we can solve the problems we face with the financing of long-term care.

In the past, I have cosponsored legislation that would help spur the growth of private sector long-term care insurance. I have long believed that in order to meet the long-term care needs of our aging population, that we need to have a mix of both private and public financing of long-term care. In order to encourage the purchase of private policies, there need to be incentives for planning ahead for the future.

Mr. Chairman, I look forward to listening to the witnesses today and gaining from their insight on changes in the private long-term insurance market. I am interested in knowing their thoughts about the incentives—or lack of incentives—to promote the private financing of long-term care.

As I mentioned, there needs to be a mix of both private and public coverage available. Since the growing cost of public programs like Medicare and Medicaid are out of control, it is doubly important that the Congress look at ways to expand private financing for long-term care. In addition, it is apparent that changes are needed, because most long-tern care is currently covered by Medicaid, which has strained many State budgets under the burden of growing needs and costs.

Mr. Chairman, I think it is important to gain an understanding of how the current choices in private long-term insurance either work or fail. I look forward to hearing from the witnesses today about their personal experiences with long-term care insurance. Whenever we look at ways to change access to a program, it is important to know how these changes will affect each of us as consumers of care.

Mr. Chairman, I would also like to ask the witnesses today for their opinion on the use of medical savings accounts as a means of saving for future long-term care costs. I am a strong proponent of MSA's, and believe that they may also help to provide yet another way to help prepare for the future and provide private financing for long-term care.

Again, Mr. Chairman, thank you for this timely hearing. This is a tough issue, but it must be addressed, and I appreciate your leadership on it.

The CHAIRMAN. Thank you, Senator Burns.

Ms. Friedman.

STATEMENT OF ELLEN FRIEDMAN, MANAGER OF BENEFITS PLANNING, AMERITECH

Ms. FRIEDMAN. Mr. Chairman, thank you for the opportunity to tell the Special Committee on Aging about Ameritech's Long-Term Care Insurance Plan. I am Ellen Friedman, Manager of Benefits Planning.

Ameritech is one of a growing number of employers which offers its employees and retirees an opportunity to purchase group long-term care insurance through a program of the Company's own design. Long-term care insurance is a relatively new benefit and as of yet is not as widely understood or recognized as other benefits, but as the population ages, and more and more people have exposure to the need for long-term care, it is emerging as an employee benefit.

While providing for long-term care may be viewed as a necessary evil—because people certainly don't want to find themselves in need of it—the fact is that nearly one in two people will require this care after reaching the age of 65. Individuals are living longer and longer, and families are finding it increasingly difficult to provide this care without outside help.

Ameritech's long-term care plan is quite new. We implemented it in July 1993 for our active employees, and shortly before that, for our retirees. We presently have over 3,000 enrollees, and the plan is insured by the CNA Insurance Companies.

Why did Ameritech put in a long-term care plan? Frankly, our retirees expressed interest in Ameritech's sponsoring a plan, and we felt it fit in well with our overall benefit program. Philosophically, we have been moving more and more toward encouraging our employees to take individual responsibility for managing their overall financial security. For example, in the past few years we've added medical and dependent care flexible spending accounts and more investment options in our savings plan. This equates to more employee choice-making in benefits.

Also, long-term care coverage provides an important safety net to protect a family's assets, which can sometimes take a lifetime to build up. So, it fits in well as a family benefit like other programs Ameritech offers in the way of work and family benefits, such as resource and referral services for child or elder care. This is one program that we offer, a family connections program. It is completely unrelated to our long-term care program, whereby an employee can call a toll free number and get help from an elder care

expert on subjects such as local housing options, in home or medical services, or transportation arrangements for an elderly relative.

As you know, long-term care insurance provides an important benefit to meet an important need, and it can be expensive, especially at older ages. One of the values of employer sponsored programs is that we can go to the market place and competitively bid the program in order to get the best pricing, and otherwise act as an advocate for our employees. Because companies also generally use consultants who are experts on these programs, as Ameritech did, we are assured that the plan design includes provisions which are state of the art, such as an emphasis on home care and a program to receive price discounts on home health care equipment and emergency response systems.

Ameritech's long-term care plan offers three different options. There two different benefit levels: $100 and $150 a day. Of course, when home care which is less costly is used the benefit dollars go further. The three options include nursing home only (of course, it is the least expensive, and it has the greatest appeal to retirees); a mid-level plan which covers home care; and the high level plan which offers a 25-year paid-in-full provision designed to appeal to younger employees; and, of course, the younger you are when you buy this coverage, the more affordable it is.

How have Ameritech employees benefitted from this plan? As I indicated, our plan is relatively new, and thankfully, to date we have not had many enrollees who have needed long-term care. But I thought you would be interested in hearing how the plan has helped our people. One of our retirees received several months of long-term care benefits while he recovered in a nursing home from shingles, a neurological disease which can cause severe pain. Medicare benefits were not available, because skilled nursing care was not required. Because this individual also suffers from dementia, it is likely he will need nursing home care again, perhaps on a permanent basis, as his dementia worsens. Our plan only has one waiting period, so if he does need this care, his benefits will begin immediately.

Another case involved a 44-year-old employee with cancer. He was enrolled in one of our options with home care, and was able to receive care at home until his death. The plan paid $9,000 in benefits over an 8-month period. A third case involved a 68-year-old retiree who was perfectly healthy when he enrolled in January 1993. He became paraplegic due to a car accident the following month. Until his death in June 1994, our plan paid $12,000, coordinating with Medicare for the periods of time when he needed custodial care, and Medicare did not pay.

At Ameritech, we think of ourselves as well positioned for the future and, likewise, we believe Congress should develop policies today which position the country for several decades to come. Tax clarification for long-term care will enable employers to assist employees with retirement planning needs, and can potentially help stem the growth of public health care spending. Although we proceeded to implement a plan absent final guidelines, we were optimistic that when clarification came, it would grant these benefits the same tax status as a medical plan when benefits are paid out to the beneficiary. And, although Ameritech does not contribute to

the long-term care plan, or have a full flexible benefit plan at this time, allowing tax deductible employer contributions to long-term care insurance would go a long way toward encouraging the growth of long-term care plans in the private sector.

In a flexible benefits environment, where the choice making and individual responsibility values we want to promote really come into play, employees could be given a chance to select a long-term care option by trading off another coverage they may not need or want like dental or vision.

In conclusion, employers can assist their employees by educating them about the need for long-term care coverage. They can make the coverage easily accessible through payroll deduction, and partnering with private insurance companies to ensure a quality product at a competitive cost through group purchasing power. And, as in Ameritech's case, group plans can make sure enrollees benefit from as many value added services as possible, such as complete case management to act as an advocate for the patient and family, and help them access and maximize resources to assure appropriate, high quality care.

Mr. Chairman, Ameritech appreciates the opportunity to appear before you today, and commends your leadership on this important issue.

Thank you.

The CHAIRMAN. Thank you very much, Ms. Friedman.

Let me first begin by telling you, contrary to a case of mistaken identity as Senator Pryor suffers from, whenever I walk through airports, be it in Washington, Maine, or where ever, people will run up to me and say, "Aren't you Jerry West?" To which I immediately say, "Yes." [Laughter.]

Because it gets a much more positive response, than if I say, "No. I happen to be the Senator from Maine."

But as I was listening to Mr. Spear and Ms. Heintz' very moving stories, I was thinking of the observation by Oscar Wilde. He said at one point, the soul is born old, but it grows young; that is the comedy of life. The body is born young and grows old; that is life's tragedy.

I think all of us during the course of our lives will have to face the combination of the comedy and the tragedy. I think both of you have demonstrated that through the telling of your stories with respect to your spouses.

Let me tell you, Mr. Spear, that you were much more successful in talking to your son, Mark, than I have been in talking to my father. My father is now 86. He works 18 hours a day, 6 days a week. He is not a farmer. He isn't involved with meat. He is a baker. He likes to claim that he is always in the dough. [Laughter.]

I tell you, that is one of the reasons I got out of the baking business. That is why I am a politician, because I saw the kind of hours, and the kind of work involved, and I decided at a very early age that I was never going to be a baker.

In any event, let me come back and talk to both of you a little bit. You indicated, Mr. Spear, that it was your wife's association that first brought the idea of long-term-care to you?

Mr. SPEAR. Yes. CNN Insurance Company, I think. I don't know. I don't remember who. I don't remember our first policy. I think it

was CNN, if there is a CNN Insurance Company. Anyway, that is where we got our first insurance. When CFL agent, a friend of mine, visited. I realized he had a better deal than I had where I was.

The CHAIRMAN. Can I ask you whether or not you ever shared this kind of information with your friends, or neighbors, or colleagues? All of us up here have said not many people know about this. When I say I am not successful with my father, for example, I have tried to persuade him about the need for health care coverage. He throws up his hands, and says, "Look. I am well. I am still physically able. I don't need it, besides I got Medicare."

Now, fortunately, I have my mother, who has a great deal more sense. I can deal with her. She will listen to me much more than my father.

Do you ever talk to your neighbors or your friends? Most people are completely unaware that Medicare does not cover long-term-care costs. It does not cover it. In order to get any kind of coverage, you have to go down to Medicaid, which means you have to expend your life savings and assets to impoverish yourself. Most people are not aware of this. So, I am wondering if either you or Mrs. Heintz have had any dialogue with your neighbors in an effort to start an educational dialogue at the kitchen table level of our society in order to make more people aware. We will get to you, Ms. Friedman, in terms of what the industry is doing.

Mr. Spear, or Ms. Heintz, have either of you had that experience of talking with friends and neighbors and saying this is something you have to look into because it has produced positive results for you, Mr. Spear, and you Ms. Heintz, because this is something that saved me and us from ruin, and protected the quality of our lives to the extent that it has?

Ms. Heintz.

Ms. HEINTZ. As a teacher, our organization, the Public Employees Retirement System, provides us with workshops. They start long before you are thinking seriously about retirement, so that you have some idea of how to plan. The HealthChoice for Seniors was one of those who could be contacted to come and talk to you individually so you could work through whatever package you wanted.

In talking to my friends about this, I now found out about who has John Hancock, and who has Teacher's Union, and who are saying that this sounds better than what I have, or I am more interested now than I have been before because I have a friend who is having to spend down at a frightening rate, and it worries me. Yes, but it is just a little drop, and a little drop there. It is not the broad important presentation that I think people need to recognize what Medicare doesn't do. I believe they think there is more offered, and more available, than there really is.

Nobody wants to think about this. We didn't think about this from the point of view of a debilitating illness. We thought we could be driving abroad and be in a terrible accident in a country where we might not be able to get any help, and wanted to be sure that we could make decisions without having to have our children decide what we would sell first, and how to handle this, and so on.

The CHAIRMAN. I think both of you also had something in common. I believe that you did not take advantage of the inflation factor.

Ms. HEINTZ. No. Mine is still so reasonable because in this retirement village, we all have many opportunities to help the health care center keep costs down. So, I turned down the increase because I didn't need it. I will have a chance again, and if we have had an increase, and I think I want to pay the difference, then I will do that.

The CHAIRMAN. With respect to your coverage, you did not start drawing upon the coverage while your husband was at home, is that correct?

Ms. HEINTZ. That is right. We were in Rose Villa, off our 68 steps, and the various problems that our hillside home presented, and I thought we were going to have years there.

The CHAIRMAN. Did your policy cover home care?

Ms. HEINTZ. Oh, yes. But I didn't need it, because as long as he could help me help him, we got along fine.

The CHAIRMAN. But the fact is you could have had two strapping young men, who you said helped at the nursing home as such, and could have been available, not necessarily men, but women or others who could have given you the kind of assistance at home that might have alleviated your burden under your policy at that time?

Ms. HEINTZ. The burden is the lack of sleep and stress. I could help him with his shower; I could help him get dressed. The things that are a part of daily life were the problem. It is quite different if you have a person who has had a serious injury, and you need a therapist to come, and you need what I think of as specialized help. But what I needed was not what I would want to pay $35 a day.

The CHAIRMAN. The point was that you had the coverage, you didn't use it, and didn't feel you needed to use it.

Ms. HEINTZ. Yes. It was there.

The CHAIRMAN. Mr. Spear, I want to ask another quick question about your talking with neighbors. Have you had these conversations with other friends or neighbors? Like the conversations you have had with your son?

Mr. SPEAR. Sure. I don't get very far. I think most people think, by gosh, we have our money committed. They don't have; they just think they have. There's always room for one more. But I don't know how we can convince them of that.

The CHAIRMAN. We hope through hearings such as this. We are going to try and educational process that will point to people like yourself.

Mr. SPEAR. I hope you can find one, because people have just so many things that they want, and they go out and get them. Tomorrow they have forgotten about them. How are we going to break that chain of thought?

The CHAIRMAN. We hope that with people like yourself, and Mrs. Heintz, coming forward, that it will start an educational program. A dialogue on this issue has to take place. Senator Pryor and Senator Feingold have pointed out only roughly 3 percent of the American people have any long-term-care coverage.

Mr. SPEAR. If you could convince those people, by the time they are 60 years old, to get the protection, it wouldn't cost any of them about a third of what it would cost them if they wait until they are getting close to time they need it.

The CHAIRMAN. I am going to yield to Senator Pryor for some questions.

Senator PRYOR. Thank you, Mr. Chairman. Mr. Chairman, you hit on something earlier in this hearing that I think speaks volumes about the mind-set of the American people today. That is when the average American thinks about going into a nursing home, they dismiss it from their mind just as quickly as they can. We don't want to even think about it, and we don't want to, certainly, part with any of our so-called hard earned money to apply to that principle.

The other mind-set that Senator Cohen has hit upon is if you took a poll today, I believe we could predict what the results might be. If you took a poll, and asked, "Do you think the Government will take care of you through Medicare, or whatever, when you get to be 65, and you have to perhaps go to a nursing home?" I'll bet you that 85 percent of the American people would say, "Yes, my Government is going to take care of me. I don't have to buy any insurance, because Medicare is going to take care of me."

I think there is something that Senator Cohen in talking about the educational aspect of what we are doing, is certainly one thing that we have to realize. Another thing that I think haunts American people when we start looking at options for an insurance company, or an insurance policy, we don't if that insurance company is going to be there when we get ready to go into a nursing home. There is a lot of—I don't want to say distrust of insurance companies—but there is a lot of concern that these policies may not be what they are purported to be.

For example, I hope that if any of our insurance commissioners around the 50 States are listening to us this morning, or have their aides tuned in, most States in our country have yet to pass some form of law or regulations that deal with the consumer protection angle of long-term care policies. Now, this is not to say that some States haven't passed some, but most States have not passed anything. I think our States have to be more involved with insuring that consumer protection is there.

Let me ask you a question, Ms. Friedman. What is the average age, do you think, of a person in the work activity range when they start purchasing a long-term insurance coverage? What is the average age?

Ms. FRIEDMAN. I actually don't have statistical data, but anecdotally I would say it is about age 40. I would say it is about the time that individuals experience through their own family, or friend's families, the need for long-term care, and are in a situation where they have an opportunity in a private plan, then they might look at the rates. They are attractive at 40.

Senator PRYOR. Do you have any statistics, figures, on what the average salary might be of that worker, and that potential retiree, as to when they feel like they can start purchasing long-term health care?

Ms. FRIEDMAN. There is no question that it is down at the bottom of the list, in terms of disposable income. Individuals who enroll in this program, unquestionably, are the individuals who have the most disposable income. I will say our enrollment is about even between our management and our nonmanagement people, even though our nonmanagement people do earn less. It is definitely below something like life insurance, but probably above something like a savings bond, or something like that.

Senator PRYOR. What would be, do you think, the average cost of a policy, say for a 40-year-old, in fairly good health, and who was looking to buy insurance coverage for long-term care? What would be the average cost?

Ms. FRIEDMAN. Our cost for a 40-year-old, for nursing home only, for a month is $11. If an individual wanted to buy our comprehensive plan with home care, it is $25 a month.

Senator PRYOR. So, that is $25 a month. That is if you are 40 years of age?

Ms. FRIEDMAN. That is correct.

Senator PRYOR. Frankly, Mr. Chairman, that is not as much as I thought it would be.

As that worker gets older, do the premiums increase?

Ms. FRIEDMAN. It is $20 at age 50 for the nursing home only; $47 for the comprehensive plan. At age 60 it jumps up to $43 a month for the nursing home only benefit, and $96 for the comprehensive.

Senator PRYOR. Mr. Spear? I think, Mr. Spear, you are around 80? Is this correct?

Mr. SPEAR. I will soon be 81. You are a good judge.

Senator PRYOR. You mentioned when you graduated from high school, and I just calculated a little bit. You gave us a good hint, or a good clue. [Laughter.]

Can Mr. Spear, if he never had any coverage, buy some nursing home coverage? And if so, what would the cost of that be?

Ms. FRIEDMAN. For all our retirees and individuals, if we had individuals actively at work at that age, coming into the program late, they would have to meet underwriting criteria. But if they were healthy, they could come in.

Senator PRYOR. Do you have any idea of the cost of that?

Ms. FRIEDMAN. For a 70-year-old, it would be $200 a month for the comprehensive, and $104 for the nursing home only. I don't have a rate for age 80.

Senator PRYOR. This has been very educational for me. Once again, I applaud the Chairman for holding this hearing.

Thank you, Mr. Chairman.

The CHAIRMAN. Would there be exclusions for pre-existing conditions? You say a healthy individual, do you mean there would be exclusions if there was a pre-existing condition?

Ms. FRIEDMAN. Yes. Individuals who have pre-existing conditions are not underwritten under these programs.

Senator PRYOR. Excuse me, what about the 40-year-old? Would there be any exclusion for him?

Ms. FRIEDMAN. A 40-year-old who is actively at work can enroll without any underwriting. The premise there is they are actively at work. If they are well enough to be at work, even if they have

cancer, if they are well enough to be at work, there is no underwriting.

The CHAIRMAN. Let me commend Ameritech for the job that you are doing. I would inquire as to what kind of a promotional effort is being made by your company?

Ms. FRIEDMAN. We implemented this at a time in our recent history when we were undergoing a lot of corporate reorganization, and consolidation of business units. So, we would like to go back, and we are planning to do that. We are going to work with CNA later this year to go back and re-solicit and do another enrollment.

The CHAIRMAN. One of the chief criticisms of the past, at least, has been—and I address it to both you Ms. Friedman and Mrs. Heintz or Mr. Spear—is that these policies are complicated, they are misunderstood, they may be even misrepresented in terms of their coverage. Has there really been a dedicated effort on the part of the industry itself to make them as easily understood as need be, and to explain the coverage? Senator Pryor and I know from past experience when years ago we talked about MediGap policies that didn't quite cover what the beneficiaries thought they might cover; that people found they were paying for the policies but not getting the coverage. That is perhaps part of the underlying, suspicion or distrust of the industry itself, which has taken great strides in the past 10 years to correct that. Has the industry, from your perspective, really undertaken to correct those kind of feelings of distrust?

Ms. FRIEDMAN. I see it from the carrier that we are working with. As more and more employer sponsored plans come on board, too, it is a question of it becoming an employee benefit. And, as such, more widely discussed and treated in terms of educating our employees.

The CHAIRMAN. So, you are in a better position if you are in an employer/employee situation, as opposed to if you are a single individual out there looking around for disability or a long-term care policy. Number one, you don't have the kind of buying or purchasing power to get the premiums that you might get in a group.

Ms. FRIEDMAN. I think that is true. It is also a question of convenience. Since the company has researched the financial stability of the carrier, as someone mentioned, will they be around to pay benefits in 50 years, and how well funded are they.

The CHAIRMAN. I agree with what Senator Pryor said. As we encourage our population to purchase long-term care insurance policies, we also have to have a great deal more consumer protection at the State level, to make sure to get the premiums down, and to get the coverage expanded, so we don't place the kind of burdens on the Medicare and Medicaid programs that we now see looming like a tidal wave in the not-too-distant future.

Ms. Heintz, I want to conclude with this observation. You raised the issue about Parkinson's Disease. This is something that I am personally concerned about exploring. We are working now with Dr. Arthur Ullian and others on a hearing later next month. We want to find out how more funding for research in the particular field of brain diseases, can actually produce dramatically lower costs for long-term care. Because, if we can in fact fund some of these programs to do the kind of research that is necessary, we

may in fact relieve the Federal Treasury and State treasuries of a great deal of the burden that would be placed on them by a proliferation of Parkinson's and Alzheimer's. and others. So we are looking at that now.

The difficulty is what we call scoring. We can't go to the Congressional Budget Office and say if we invest $200 million more in research and development, will that produce $x millions, or tens of millions in savings? We can't get a calculating or scoring of that in our budgetary process. That is what makes it so difficult. But we know, almost intuitively, that if we put more into research and development and science, that we will have long-term savings on some of these diseases if in fact we correct and help mitigate them. That is another hearing that we have coming up at the end of next month. Hopefully, that will be beneficial as well.

One final comment, Mr. Spear. We have two more panels, and I want to, would like to make this brief.

Mr. SPEAR. I would like to make this comment. It is possible for an insurance company to write their policy in regular typewriter type letters, so you can see them, and so you can tell what they are going to do for you. That is what this BLF does. That is one of them, but I am sure many of them are doing it. That can be done.

Ms. HEINTZ. It certainly can.

The CHAIRMAN. No microscopic print. In other words, you want nice, large letters that everybody can see and understand.

Mr. SPEAR. Everybody can see it, and it is simple for guys like me.

Ms. HEINTZ. Mine was so clear and so easy to read. Every term was defined so I could understand the definition, that I didn't feel the need to call my good friend, the lawyer, to take a look at it. Of course, then I was not at all surprised when they came through with everything that was promised. I felt they said they would, and they did. I understood it. I had enough time if I had any question about it, there was nice piece of leeway there to decide if you were having second thoughts for some reason.

The CHAIRMAN. The point I wanted to make with you by pointing out that you did not call upon home care benefits when you didn't need them, even though they were available to you at the time, was to point you out as a model example of a really great citizen of the country. We have so many who come forward, that we are learning about, who do take advantage of a system. We are finding amazing levels of abuse in Medicare and Medicaid, fraud that has permeated our whole system, costing us billions.

As a matter of fact, we have done a study now. The GAO has indicated that we are losing roughly $100 billion a year in our health care system through fraud, $44 billion a year is coming out of Medicare and Medicaid. That is why we are so concerned now. We are looking at Medicare. Something has to be done. It is going bankrupt. In 7 years there will be no money left to pay. So, we have two choices. We can either reduce the benefits, or we can increase the taxes. There is no way out of this dilemma, in terms of making sure that Medicare and Medicaid remain solvent for the future.

We also have to reduce the level of fraud and that is taking place, because it is depriving many people of needed coverage. We are seeing fraud and abuse throughout our health care system, from providers to consumers to organized crime, across the board, who are exploiting these programs, driving up the cost, making them unaffordable, not only for private citizens, but for the public treasuries. I wanted to point you out as an example of someone who had coverage but didn't need it, and didn't call upon the policy coverage to help you out when you didn't need the help.

Let me thank all of you for coming. I know you have come from great distances to be here. I believe, Mr. Spear and Mrs. Heintz and Ms. Friedman, that beginning a dialog on long-term care starts right here in the Nation's Capital. Hopefully, by virtue of the coverage that we will get today, and hopefully, in the future, we can start this debate and dialog so that we can recognize that there is no panacea for long-term care. It can't be all private health insurance, because not everybody will be able to afford it. It can't be all public because the Treasury is being depleted at a level that will not allow us to do that. It has to be a partnership, and hopefully, we can formulate that partnership by virtue of help by citizens like yourselves. Thank you very much for coming.

Ms. HEINTZ. Thank you very much for having us.

Mr. SPEAR. Thank you. I want to wish you all a lot of luck. It's tough going.

Ms. FRIEDMAN. Thank you.

The CHAIRMAN. Next we have several witnesses who will share their expert knowledge on these issues, and will share what they believe to be the role of the private sector in financing long-term care for the elderly.

The Committee welcomes Stanley Wallack, the Chairman for the Coalition for Long-Term Care Financing; Marilyn Moon, the Senior Fellow with the Urban Institute; Dr. Mark Battista, Vice President of Marketing and Products of Long-Term Care with UNUM Life Insurance Company of America; and finally we will have the opportunity to hear from Gail Holubinka, the Director of the New York State Partnership for Long-Term Care.

Dr. Wallack, we are going to start with you.

Senator PRYOR. Mr. Chairman, may I ask a point of privilege here? I am going to have to go to the Finance Committee downstairs. I think a while ago, I misspoke myself. I want to clarify that, because I think I stated something to the effect that most States have not adopted a plan to protect consumers in the long-term care area. That is not quite right, I have been told by my very fine staff. What has happened is that we have not gone far enough in many of the States. For example, I think 12 States have no home care coverage provisions or protection spelled out in statute. I just wanted to clarify that. Thank you, Mr. Chairman. Maybe Dr. Wallack is going to address himself to that.

The CHAIRMAN. Thank you, Senator Pryor.

Dr. Wallack.

STATEMENT OF STANLEY WALLACK, CHAIRMAN OF THE COALITION ON LONG-TERM CARE FINANCING

Mr. WALLACK. Thank you. I appreciate the opportunity to speak before the Committee today. I wear a number of hats. I am on the faculty of Brandeis University at the Heller Graduate School, where I also direct the Institute for Health Policy. I am the founder of a private company called LifePlans, which I began on my sabbatical from Brandeis, which is in long-term care risk management. I am also chairman of the Coalition on Long-Term Care Financing. I am speaking in that role today.

I wear these three hats, and I wear them all the time. So, I guess once a teacher, always a teacher. I do appreciate this opportunity. After hearing your comments as well as Senator Pryor's, I am not sure teaching is what I need to do for you two Senators.

The CHAIRMAN. Would you like to engage in politics? Is that what you are saying?

Mr. WALLACK. That is not my chosen field. [Laughter.]

I do appreciate all the work this Committee has done, and all the previous hearings you have had. I also appreciate this opportunity to discuss the private long-term care insurance market and its potential.

I have three points I am going to try to make in the 5 minutes I have with regard to the Federal Government's support for private long-term care insurance. First, you have talked about the fact that there isn't a very big private market. I do not believe there can be a significant private market without Federal Government support. I'll explain why.

Second, with regard to a public/private partnership, I will talk about what a better balance is, and what should be the role of the Federal Government to bring it about.

The third point is related to these first two. I think the Federal Government can find innovative solutions which aren't very expensive, very small investments today will have tremendously big payoffs if the future. I think that is what Federal leadership in this area can do.

You talked in the last session about the current environment. The problems with Medicare, Medicaid, and the need for a Balanced Budget Act. But clearly, the problem is much bigger than that. You also talked about the aging of the population, particularly the baby boomers entering retirement after 2010.

We need new public solutions to social problems. We should also recognize, and some of the people testifying today are illustrative of another dramatic thing that has happened: today's elderly have more financial resources. I don't think we should look to all the elderly to pay for their long-term care by themselves. But the elderly as a group are much better off financially than they were 20 and 30 years ago.

The other major change is the growth of the private market, which you have mentioned and what this hearing is all about. It is very important for this discussion. There are well over 100 companies today that offer private long-term care insurance products.

As you know, the insurance products over the last 10 years have improved a great deal. About 60 percent of the policies sold today

have home care benefits. The value of these products has clearly improved.

And the insurability issues that you were pursuing in the last session have changed. The average purchaser today is an older individual, aged 68. Roughly 10 to 15 percent of those applying don't pass the health screens. But as the growth in group policies occurs, underwriting restrictions such as these will no longer occur.

So in effect, as the group market grows, and I think that it has great potential in the future, a high proportion of people will be eligible for long-term care policies. The typical policy today is bought by a 68-year-old, for $100 or so a month. They get 5 years of very comprehensive benefits, which will cover with a very high degree of probability all long-term care expenses.

We are talking about a $100 premium, which is close to the cost of a MediGap policy. The question is how many elderly can afford it? Quite a few, it seems to me.

I think the big disappointment is that so few individuals have purchased a policy. I think the explanation is very simple. The older population looks to the Federal Government for social programs, given Medicare and Social Security, and says, what are you going to do for us next. This is a major issue, the expectations of the elderly, which we have built up. We have to address it.

To address it, we have to ask ourselves what is our philosophy? There is a very basic question; whether or not today we as Americans think the private sector should go as far as possible, and then look to the Government to fill in; or whether, as we have for a number of years now, say how many dollars does the Federal Government have, and when we run out of them, we will have the private sector gap fill in.

Do you lead with the private or public sector in solving a social problem? The Coalition believes it should be the private sector. But we also believe to have a responsible private market, you have to have the Government involved at the outset. The Government has to provide leadership. The Government has to set standards and appropriate regulations, and the Government has to be willing to support those who can't afford to buy private insurance.

We need a new perspective. One of the things that Mark Twain said, comparing us to the British, is the British always invent a new innovation from looking at their last one. What is different about Americans is that we develop new solutions to new problems. It is that philosophy or perspective that we need in order to make progress.

One issue you mentioned was public education. Today, this occurs with an insurance agent at the kitchen table. It needs to be done by the Federal Government, because that is who the older population looks to. The Government needs to assume a leadership role if we are to move to this new form of public/private partnership.

I believe we need Federal standards. I believe that you can't have these different State laws. I think we need Federal regulations of insurance. The big issue is Federal preemption. If you are going to have Federal standards, you have to have Federal standards that are meaningful.

We have to have some incentives for individuals to purchase insurance. We don't have any now. Tax clarification does that. Here, for relatively few dollars you can have a very significant impact. This is what happened with health insurance in this country in the 1950's. The Government sent a signal through tax law changes in the 1950's that basically said we want to encourage the private market, and employers, in particular, were incented.

I want to compliment you on your previous tax bills. By including things such as cafeteria plans and per diem payments, you are building in the flexibility to develop innovative products in the future.

Mr. Spear talked about individual disability policies for younger individuals. Then there is long-term care; which is disability for older individuals. Perhaps, these will be merged. But, we shouldn't try to predict how this is going to occur. It is a new industry. We are going to have innovations out there. We should establish Federal policies, and tax policies in particular, that are as flexible as possible.

Finally, I would like to talk a little about what I see as the biggest competitor to the private market. Sometimes I think we should have restraints of trade against the biggest competitors. They are Government programs. Medicaid is often mentioned in this regard. I have spoken at meetings of lawyers where all they talk about is setting up trust funds to avoid having to pay for your nursing home bills.

A new competitor is Medicare. This may not be well known, but Medicare has really changed. In 1988, there were administrative changes in Medicare's home health care program, not done by legislation, but by people at HCFA, that made it possible for the chronically ill who are the long-term care population to get Medicare benefits, if they have a skilled case manager.

When you look at the growth in Medicare home health from 1988 to 1993, it has gone from $2 billion to $12 billion, a six-fold increase. It is predicted to increase to maybe $35 billion by the year 2000. The fastest increase is for people that have very long stays or over 100 visits in a year. If you look at that population with over 100 or 150 visits in a year, they turn out to be people with three or more ADLs for the most part. We are in fact serving a pure chronically ill population under the Medicare program.

That, as I heard you say, was not the intention of Medicare. One of the things we must address if the Federal Government wants to have a strong private market, and not squeeze that private market out, is Federal Medicaid and Medicare policy.

When it comes to how to pay for tax clarification, I want to mention that the cost of a tax bill, although I don't exactly know how they got the figure, $6 billion is relatively small. The potential savings in Medicaid from the purchase of private insurance is very substantial. The purchasers of long-term care policies are middle income people, and that is who needs the protection. They are the ones that spend down to Medicaid. Private insurance will drop the spend-down rate, according to the study by LifePlans that was published, by about 40 percent. And there will be Medicare savings as well.

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The bottom line is what can the private market do? Somebody quoted my research that potentially 40 percent of the elderly could purchase a policy. This study pertained to an older market. Once you start to bring the employer into this market in large numbers which is where we have had the greatest recent growth, and innovative products, I don't believe 40 percent is the maximum number. It is higher, maybe it is 50 percent. It isn't everybody we know. There are still people who can't afford it, or won't buy it.

The basic question that Members of Congress are going to have to ask is: If I had 50 percent of the population covered by private insurance would I be happy? Those that like social or public programs would say, no, it is not 100 percent. We need to have a social program. Those of us that look at restricted public dollars, and the need for a public and private partnership would say, that's great. Now, that we have 50 percent of people taking care of themselves, it is the other 50 percent of the population that the Government needs to concentrate on.

We have to answer that question. The private market has great potential. Personally, I think that is way we have to go, given the limited resources of this country.

[The prepared statement of Mr. Wallack follows:]

COALITION FOR LONG TERM CARE FINANCING

TESTIMONY OF

STANLEY WALLACK

I. INTRODUCTION

Good morning, Mr. Chairman and Members of the Special Committee on Aging. My name is Stanley Wallack and I am Chairman of the Coalition on Long-Term Care Financing. I also am the Director of the Institute for Health Policy at Brandeis University and a faculty member of the Heller Graduate School at Brandeis. In 1987, I founded LifePlans, Inc., a long-term care risk management company.

I am here today on behalf of the Coalition on Long-Term Care Financing which represents a diverse group of researchers, leading insurance companies offering long-term care insurance coverage and providers of long-term care services. Coalition members are united by a common commitment to the establishment of a strong partnership between the public and private sectors in financing long-term care services.

The Coalition appreciates the opportunity to testify on a matter of critical importance to consumers, providers and insurers of LTC services: to identify the most appropriate and fiscally responsible roles for the public and private sectors in financing LTC services and creating the incentives necessary to promote these roles and responsibilities. To this end, we very much appreciate the leadership you have demonstrated for many years by offering a variety of legislative proposals to promote public/private partnerships through such incentives as tax clarification and reasonable federal standards for LTC policies, educational programs to expand consumer awareness of LTC risk, and enhanced asset protection for purchasers of LTC products, to name a few of the many measures you have crafted during your tenure in the Senate. The Coalition believes that such an actions will significantly enhance the marketability of LTC insurance policies by: (1) creating financial incentives to purchase LTC policies; (2) sending a strong signal to the marketplace that the government considers this a legitimate approach to financing LTC services; and (3) increasing consumer confidence in private LTC policies.

Mr. Chairman, the Coalition strongly believes that 1995 presents an unparalleled opportunity to implement legislation which establishes a positive environment for the development of public/private partnerships in long-term care financing. Consider the following priorities on the agenda of the 104th Congress:

- ***Deficit Reduction and Entitlement Reform:*** We understand that the Congress intends to devote as much time to deficit reduction during the 104th Congress as they devoted to health care reform during the 103rd. Given that Medicare and Medicaid represent the fastest growing entitlement programs in the Federal budget, proposals to reduce spending or the growth rate of these programs is likely. Reductions in Medicaid resources will underscore the need for private sector long-term care financing alternatives.

- ***Medicare Restructuring:*** Medicare has become one of the most politically volatile issues before Congress in recent weeks. The Medicare Trustees report issued last month indicates that the HI trust fund will be bankrupt in less than 7 years if no steps are taken to avert this crisis. Both parties know that Medicare expenditures must be controlled if the goal of a balanced budget by 2002 is to be realized. While Congress is exploring ways to rein in costs and save the trust fund through program restructuring under a managed care approach, other steps also can be taken to control short-run and long-run costs which will require a reexamination of public and private sector responsibilities.

- *Medicaid Block Grants*: While few official proposals for block-granting Medicaid have appeared to date, many states seem willing to accept a block grant approach in exchange for additional flexibility and freedom from federal prescriptions. Block grants or annual growth caps on Medicaid spending, however, could severely strain states' ability to continue serving the same number of individuals at the same service levels. States should be more open than ever to innovative proposals for public/private partnerships which would reduce state responsibility for LTC expenses.

The unparalleled pressure brought to bear on deficit reduction through measures such as the unfunded mandates legislation, the balanced budget amendment and the line-item veto -- coupled with a renewed commitment to individual responsibility -- set the stage for serious consideration of public/private partnership programs. Never has there been a greater chance for enactment of responsible long-term care financing legislation since long-term care insurance bills first were introduced almost a decade ago. As a case in point, the House passage of the tax bill represents the first time a LTC insurance tax clarification measure passed either House of Congress.

Mr. Chairman, my written testimony addresses several critical issues related to the establishment of a solid public-private partnership in LTC financing. These include:

- clarifying the tax status of LTC policies to encourage individual responsibility;

- enacting federal standards governing private LTC insurance policies to assure consumers value in such policies;

- clarifying the role of the federal government in covering acute and long-term care services and identifying more rationale alternatives for government involvement in the financing of LTC services than that represented by the current Medicare and Medicaid programs.

II. BACKGROUND

A. The Problem and Need for Federal Involvement

I want to begin my testimony by emphasizing the importance of a meaningful public/private sector approach in the financing of LTC. This debate is not occurring in a vacuum. Great strides already are being made with respect to innovations in the private market. Little more than ten years ago, many LTC insurance policies were limited primarily to skilled nursing facility services following a hospital stay. In response to consumers' demands for broader coverage of a variety of benefits, however, today's products provide comprehensive coverage of the full range of LTC benefits from home and community-based services through institutional care. Further, virtually all products offered by leading carriers have eliminated provisions limiting access to coverage, such as prior hospitalization and level of care requirements.

All too often, those supporting a public/private partnership are only providing lip service to this idea. We are not far from 2010, when the baby boom generation will reach retirement age and the number of disabled accelerates rapidly. LTC expenditures will increase exponentially when this happens. Without addressing the issue of public and private sector roles today, there will be pressure for more government assistance in the future.

In 1993, national LTC expenditures totalled $108 billion. About 65% was paid by the Federal and state governments and about 35%, out-of-pocket. If current LTC spending patterns persist, LTC expenditures will more than double in the next 25 years. Entitlement programs account for about 55% of all Federal spending. The Medicare and Medicaid programs represent the two fastest growing entitlement programs in the Federal budget and currently constitute 32% of mandatory spending. GAO reported that Federal spending for Medicare reached almost $163 billion in 1994 and the Federal portion of Medicaid spending grew to $82 billion.

Although the elderly accounted for only 11.5% of the Medicaid case load in 1993, expenditures for this group totalled 28.4% of spending. Likewise, while the disabled accounted for 15.5% of Medicaid beneficiaries, close to 40% of Medicaid dollars were spent on their care. The disproportionate share of Medicaid dollars spent on the elderly and disabled will only continue to increase as the elderly population grows. Between 1992 and 1993, the number of Medicaid beneficiaries grew by 8.8%, but two-thirds of the increase in Medicaid spending during this period was attributed to the growth in enrollment. Per capita spending grew only 2%.

Currently, the fastest rising budget expenditures for both Medicare and Medicaid involve home care and skilled nursing facility services. In the next six years, expenditures on home care are expected to double, even in the absence of any major programmatic changes. This growth reflects an increasing need for services as well as an inability to manage acute and chronic populations and to accurately define service norms. If the record growth in Medicare home health care expenditures were to continue, they could exceed Medicare physician payments in the next ten to fifteen years.

For these and other reasons, the Coalition believes that the Federal government must be clear about the services it will and will not pay for and what it expects of individuals in terms of personal and private responsibilities. We should not overlook the opportunity and importance of encouraging private sector involvement in the financing and managing of LTC services. Older people look to the Federal government for signals on financing LTC needs. At no time was this more evident than in 1993 and 1994 when Congress was debating health care reform. Members considered a series of options for LTC from a non-means tested home care program for the severely disabled to a public insurance program for nursing home services. During this time, interest in LTC insurance dropped noticeably. Following the end of the formal debate in 1994, interest in exploring product options and sales began to rise again. Only if the Federal government is supportive and sends the proper signals will the private market approach its full potential. It must take the lead in recognizing the viability of private LTC insurance and establish incentives that will promote the evolution of this market such as tax clarification and federal standards for policies.

B. Private Market Potential

The private market consistently has spearheaded efforts to enhance financial protection against LTC risk in the past decade. Data collected by the Health Insurance Association of America (HIAA) for policies sold in 1993 reflect the growth in the private market place. Currently, 118 companies offer LTC insurance coverage. Since 1987, the number of policies sold has increased from 815,000 to almost 3.4 million at the end of 1993. The number of policies sold has grown an average of almost 27% annually. The majority of LTC insurance policies, about 80%, have been sold to individuals or through group associations.

Sales through the employer and life insurance markets, while a smaller percentage of total sales, also have increased dramatically. In the past five years, the number of policies sold in the employer market has grown from 20,000 in 1988 to over 400,000 policies offered across 968 employers in 1993. This represents an average annual growth of 88%. Employer policies comprised over 12% of the market at the end of 1993. During the same period, the number of LTC riders to life insurance policies increased to over 280,00 policies, representing an average annual growth of over 270%. Life riders now represent over 8% of the LTC insurance market.

Coalition members believe that these markets hold great promise for the future expansion of private LTC insurance coverage since the average age of purchasers is much lower than in the individual market and premiums are much lower as a result of younger aged purchasers. The average age of buyers in the individual market was 67.5 in 1993, down from age 72 in 1990. The average age of purchasers in the employer and life insurance markets was 42.5 and 34.5, respectively, also representing a decrease in the past several years.

LTC insurance coverage has continued to expand in response to consumer demand. HIAA analyzed policies of the top 13 LTC writers representing 80% of the market of all individual and group association policies sold in 1993. All products analyzed offered coverage for skilled, intermediate and custodial nursing home care, home health care and inflation and nonforfeiture protection. In addition, 92% of the policies covered adult day care and alternate care services and 85% covered respite care. Daily benefit offers ranged from $40 to $200 per day for nursing home care and $20 to $100 per day for home care services.

In its 1993 market survey, HIAA collected for the first time data related to the distribution of LTC policies across the U.S. The survey revealed that Florida, Pennsylvania, Illinois, California, Texas, Ohio, Michigan and Indiana had the most sales. Seven of these states are in the top 8 states relative to the size of their elderly populations. States with the greatest ratio of LTC policies to their elderly populations included North Dakota, Nebraska, South Dakota, Iowa, Washington, Indiana, Kansas, Missouri and Arizona. Each of these states had a market penetration of at least 8%. Only two of these states, Iowa and South Dakota, rank in the top 10 states with respect to the percentage of elderly people in the entire state's population. These figures suggest that, despite the impressive growth rates in the individual and group LTC insurance markets over the past five years, more must be done to increase the penetration of LTC policies across all markets.

HIAA also surveyed state compliance with the NAIC Model Act and Regulation. Effective October 1994, all 50 states had adopted long-term care insurance laws and regulations. About 78% of states had adopted at least half of the NAIC recommended provisions. Compliance with the various provisions is strongly correlated with the date of adoption; i.e., more states have had the opportunity to comply with the older provisions of the act, while fewer states have implemented more recent changes in the Model. The variance in compliance is reflective of a major challenge faced by both states and insurance companies in maintaining currency with each iteration of the Model Act. This model has been changed at least annually since its inception in 1985. The Coalition believes that both state and individual compliance would be easier to enforce under a uniform set of Federal standards.

C. Congressional Agenda for 104th Congress

Coalition members are extremely concerned that the pressure for deficit reduction could lead to short-sighted approaches to reducing or decreasing the growth rate of programs such as Medicaid and Medicare. We believe that the actions taken by the 104th Congress must position the country to address our fiscal problems not just in the next five year budget cycle, but literally several decades into the future. Coalition members believe that there are several important actions Congress could take to stem the growth rate of Medicaid and Medicare expenditures for years to come.

1. Medicaid Expenditures

Several proposals for block-granting Medicaid or capping the annual rate of Federal contributions to states under Medicaid have begun to surface. Either approach could lead to reductions in the number and/or type of LTC services available to low-income consumers and cuts in provider reimbursement rates for such services.

Block grant approaches present serious challenges to the Federal and state governments, as well as the recipients of Medicaid dollars. Experience under the OBRA 1981 block grants which combined approximately 50 different categorical programs into 9 block grants illustrates some of these challenges. For example, while states have generally been open to block grant approaches as a strategy for obtaining greater flexibility in the way they spend Federal dollars, under the OBRA 1981 experience, the flexibility initially accorded states was gradually reined in.

Coalition members are concerned that the lower-income states who will be hardest hit under either block grants or spending caps will not have the fiscal capacity to increase state spending enough to offset the lose in federal dollars. The obvious choice such states would then be faced with would include eliminating optional services, tightening eligibility requirements for access to Medicaid benefits, reducing service levels per beneficiary and/or freezing or cutting provider payment rates.

Whether or not Congress enacts Medicaid block-grants or other measures for reducing Medicaid expenditure growth, states will be looking for ways to ease the burden of Medicaid costs. The expansion of private LTC insurance offers one promising solution to the Medicaid dilemma. Research conducted by LifePlans, Inc. reveals that LTC insurance coverage reduces the probability of individuals spending down their assets and qualifying for Medicaid LTC benefits by almost 40%. Further, the average lifetime savings accruing to the Medicaid program per LTC insurance policyholder ranges from $3,500 to $7,000, depending on the average length of stay in a nursing home. If only half of the 2.4 million elderly who have purchased LTC policies maintain their coverage, Medicaid will save between $4.2 billion and $8.2 billion over the next 25 years. Taking steps such as clarifying the tax status of LTC policies would stimulate significant new sales of LTC policies and dramatically reduce future Medicaid expenditures.

2. Medicare Expenditures

The Coalition firmly believes that tax clarification of LTC products and the establishment of federal standards will significantly enhance the growth of this market. As I mentioned above, however, to realize the full potential of this market, it is critical that the Federal government clearly and unequivocally define its role in this market. Medicare coverage of home health care benefits provides a good example of why this is so important.

Medicare coverage of home health care benefits originally was conceived as a short-term benefit. To be eligible for coverage, an individual had to have been hospitalized prior to receiving home care and be in need of skilled nursing services. Had the Medicare program continued to operate under these rules, the consumer's responsibility for covering longer term services related to chronic conditions -- as opposed to short-term services of a recuperative nature -- would be fairly clear. Similarly, the type of coverage needed under private LTC insurance policies to pay for home health care services in excess of the Medicare benefit would be clear.

Over the last five years, however, the Medicare home health benefit has been transformed through Administrative rules, from a program paying for the post-acute care needs of senior citizens, to a program that covers a population characterized by chronic long-term care needs. The result of these modifications has been a rapid expansion in all facets of Medicare home care and a dramatic escalation in spending. Medicare home care spending grew from about $2.1 billion in 1988 to $7 billion in 1991 to $11.7 billion in 1993.

Another result of this change in coverage is that the Medicare home health benefit now, in essence, competes with the private LTC insurance market. And as more providers and consumers become aware that Medicare will pay for their nonskilled as well as skilled home health care services, the disincentive to purchase private LTC insurance will grow. Maintaining the current Medicare home care program works at cross-purposes with the goal of federal standards and tax clarification.

In 1980, Congress liberalized the Medicare home health benefit by eliminating 100 visit limit and 20% copayments. Now, home health care is the only Medicare benefit that does not require a copayment or include coverage limits. Reinstitution of these limitations represents one method by which Congress could control the growth in the benefit as well as target benefits to the population requiring post-acute rather than long-term care. Further, while copayments would affect all Medicare beneficiaries who are not dually eligible for Medicaid, research conducted by LifePlans, Inc. shows that a visit limit of 100 or 150 visits would affect only 1.2% to 2.2% of beneficiaries receiving home care benefits.

The cost-savings potential of either option is significant. In 1996, a 20% copayment would reduce Medicare program expenditures by 25% and a 100 visit limit would reduce expenditures by 30%. Over the five years between 1996 and 2000, the copayment option would reduce Medicare expenditures by $30.5 billion and the 100 visit limit would reduce spending by $42.4 billion. Even with such substantial reductions, home health care spending still would exceed $20 billion in 2000.

If Congress is serious about getting federal spending under control, it needs to revisit the original intent of the Medicare program to determine if this program should continue to provide coverage for acute and recuperative services or if the program should be expanded to cover long-term chronic illness. This is a critical public policy decision since coverage of LTC services would mean even greater expenditures for home health care and, in effect, would result in a federal LTC insurance for the elderly and disabled. The financial implications of creating a new Federal entitlement for LTC services are enormous and would require a significant shift in current spending priorities.

Coalition members believe that a more rationale policy would be to continue relying on Medicare for acute and recuperative stays of a short term nature and on private financing and Medicaid for longer term illness of a chronic nature. A wide range of innovative private LTC products are available and the number of individuals purchasing coverage of home and community-based services has grown dramatically in the past five years. Appropriate public and private sector coverage of home care services will require clarifying existing coverage rules under Medicare.

Mr. Chairman, the Coalition will be conducting additional research regarding this issue and identifying more specific recommendations on how to solve these problems over the next few months. We will be happy to share these recommendations with you and other Members of Congress.

III. COALITION POSITION

A. In General

The Coalition supports four key strategies for promoting public-private partnerships in LTC financing:

- aggressive strategies to educate consumers about LTC risk and options for financial protection;
- tax clarification of LTC insurance policies to provide incentives for consumers to plan for their LTC needs in advance through the purchase of private coverage;
- federal consumer protection standards to ensure that policies provide value to consumers and that this value is maintained over time; and
- improved public assistance programs for those who cannot afford to protect themselves against LTC risk through private means.

Based on our principles regarding LTC financing reform, Coalition members are pleased to note that your bill, S. 423, includes provisions to clarify the tax status of LTC insurance products and that other Senators will be including similar provisions in 1995 health care legislation. Such actions suggest that Congress recognizes the market potential for private LTC insurance. This recognition clearly is warranted by the growth of this market in recent years and the continued refinement of products with a view toward meeting the diverse needs of consumers.

B. Tax Clarification

1. Why Tax Clarification?

The Internal Revenue Service has yet to rule on the treatment of premiums paid for LTC insurance policies and benefits paid out by such policies. The Coalition believes that clarification of the tax status of LTC insurance would significantly enhance the LTC market and is important for the following reasons:

- **Enhance Product Legitimacy:** It would enhance product legitimacy by treating this benefit the same as all accident and health insurance coverage. From a consumer's perspective, if LTC insurance is as important as other insurance coverage such as health, life and disability products, why hasn't the government ruled on its tax status?

- **Expanded Market Penetration:** It would increase consumer interest in purchasing products and employer interest in offering coverage.

- **Reduce Public Spending:** It would reduce the drain on public sector programs, most notably Medicaid and Medicare, through enhanced private sector coverage.

- **Catastrophic Coverage:** LTC is a catastrophic event; those who need LTC services for an extended period of time incur enormous financial expenses. While the government has a responsibility to help consumers determine how to protect themselves against this risk, this does not mean that the government actually has to pay for this risk. Instead, the public sector can encourage individuals to self-finance this risk through insurance mechanisms by providing a financial incentive in the form of a tax benefit.

- **Reduce Costs to Consumers:** Tax clarification of LTC policies will reduce the effective cost of policies to consumers by allowing them to deduct premium expenses as legitimate medical expenses.

We believe the impact on consumer interest would be particularly significant in the group market since most consumers are used to purchasing health insurance benefits through their employer. Based on surveys conducted by the Washington Business Group on Health, the Health Insurance Association of American and others, we believe that tax clarification would increase employer interest in offering LTC coverage and, in some cases, making a premium contribution to this coverage. Employees also would be more likely to purchase policies if their premium contributions were tax free.

2. Potential Impact on Consumer Behavior

During World War II, many employers began offering group health insurance as an employee benefit as a "substitute" for higher wages since there was a wage freeze. Market penetration increased even more dramatically when health insurance coverage was granted favorable tax treatment. By the end of 1991, fully 85% of the civilian noninstitutionalized population was covered under a plan. The Coalition believes tax clarification would have a similar impact on the LTC market. The studies identified below provide evidence supporting this belief.

Washington Business Group on Health

The Washington Business Group on Health conducted a survey during the summer of 1991 to determine employer views toward private LTC insurance as a potential employee benefit. Responses were collected from Fortune 500 companies and members of the National Business Coalition Forum on Health, a membership of state, local and regional business coalitions. The two main reasons for offering private LTC insurance cited by survey respondents included: (1) protecting employee/retiree financial security and (2) encouraging greater employee responsibility for benefit planning.

Among the barriers to sponsoring a LTC insurance plan cited by potential plan sponsors were the following:

- Unfavorable tax treatment

- Fear of government mandates for employer contributions

- Feeling that LTC would be added to Medicare or other government programs.

The survey also asked employers about appropriate roles for the Federal government relative to LTC financing. Survey results indicate far more support for Federal roles which promote private sector coverage and individual responsibility than for the expansion of public benefits:

ROLE	PERCENT FAVORING
Tax incentives for personal savings for LTC	86%
Qualification of LTC for flexible benefits plan	70%
Treatment of LTC on same tax basis as medical care	59%
Tax incentives for employer financing of LTC	44%
LTC coverage through Medicare or federal program	23%
LTC coverage through Medicaid	12%

Conference Board

According to a study on employer offerings of LTC insurance protection by the Conference Board in 1991, most sponsors and carriers believe that the provision of a tax credit or deduction to plan participants and/or sponsors will increase both the number of plans offered and participation rates by employees and their families. Employers indicated that the lack of tax clarification "continues to impede their decision making on the best methods to design, administer and upgrade their plans."

Sponsors recommended several approaches for tax clarification of LTC policies:

- Allow employees to pay for all or part of their premiums on a pre-tax basis;
- Develop LTC Income Retirement Accounts and 401(k) plans;
- Provide tax deductions to employers who contribute to LTC benefits.

Employers interviewed for the Conference Board study also stressed two other important roles for the Federal government. First, they felt that the Federal government has a responsibility to increase public awareness about LTC risk and the need to protect themselves. Employers indicated that this would lead to higher participation in employer LTC benefit plans and a consequent reduction in public spending for LTC through Medicaid. Second, employers felt it was critical for the government to define its position on LTC solutions. For example, sponsors suggested that the government focus on the long-term costs of not taking actions to increase private coverage instead of the short-term revenue loss associated with the granting of tax deductions. Sponsors also warned against government responses to LTC financing that would penalize employers who have had the foresight to offer this coverage, such as new entitlement programs.

Buyer-Non Buyer Survey

LifePlans conducted a study on behalf of the Health Insurance Association of America in 1990 to determine who purchases LTC insurance policies, what motivates them to buy such policies and what kind of policies they purchase. LifePlans simultaneously collected data from a group of individuals who elected not to purchase coverage to identify similarities and differences between the purchasers and nonpurchasers.

Respondents who elected not to purchase private coverage were likely to reject coverage based on cost (too expensive), their inability or unwillingness to spend more money on additional insurance coverages or the belief that policies needed to be improved. Further, nonpurchasers were far more likely than purchasers to believe that the federal government should provide universal coverage of LTC benefits.

These findings underscore the critical importance of the government's role in public education about LTC insurance products for several reasons. First, research conducted by LifePlans indicates that about 30 to 40% of those 65 and above could afford a private LTC policy that would cover the majority of their expected lifetime expenditures on LTC services. The typical policy purchased by the over 65 population in 1991 provided over five years of nursing home care with benefits of $70 per day and one third of purchasers selected inflation protection. This typical policy cost about $100 per month. The benefits provided under this policy would cover the entire duration of service utilization for 85-90% of those purchasing coverage.

Almost 70% of Medicare beneficiaries 65 and older purchase Medigap coverage which costs roughly the same price as an average LTC policy. The affordability of this coverage is even more dramatic for the under 65 population, particularly employees who have the added benefit of receiving a group discount. Therefore, we strongly believe that the affordability issue so often raised is really a matter willingness to pay for LTC coverage, not financial ability to purchase such coverage.

Second, consumers might be more willing to purchase private LTC coverage if they understood the risk they face without insurance. With the tremendous amount of press this issue has received in recent years, it is difficult to conceive of the number of consumers who still believe that their LTC needs will be met by Medicare, private health insurance or other government programs. Public education about this risk is essential to dispelling these misconceptions.

Third, consumers need better information about how to evaluate the quality of products. As mentioned above, products have improved light years since the first generation policies were released. Because the market has received such negative press from advocates of government-sponsored insurance programs, however, consumers are often distrustful of these products. In this regard, the Coalition acknowledges that the insurance industry has to do a better job of promoting the value of these products as well. In addition, we believe that federal product standards would enhance consumer confidence in LTC policies.

Non purchasers indicated that the following government actions would make them more likely to purchase coverage:

ACTION	PERCENT FAVORING
• If the government would give them a tax break for purchasing a policy.	80%
• If the government would give a seal of approval to certain products.	64%
• If the government provided information on how to choose an insurance policy.	59%

Consistent with the WBGH and Conference Board surveys, the LifePlans study demonstrated that tax clarification of LTC products would increase consumers' interest in purchasing policies. The study also underscores the importance of a "government seal of approval" vis-a-via product standards and a role in public education about LTC risk.

3. *Specific Recommendations for Tax Clarification*

Mr. Chairman, the Coalition appreciates your long-standing support of tax clarification for LTC insurance policies. We believe that such clarification will promote the private market in two important ways. First, it effectively will lower the cost of LTC policies by allowing employees to pay for premiums with pre-tax dollars and by allowing retired consumers to deduct the cost of their premiums as a legitimate medical expense to the extent that their total annual medical expenditures exceed 7.5% of their annual income. Second, by giving LTC policies the same standing as other accident and health insurance policies, it will send a strong signal to the market that the government considers private LTC insurance a legitimate financial vehicle for covering LTC expenses.

The Coalition supports the majority of tax clarification provisions you have included in S. 423. We do request consideration of changes in a few areas. Below are key points we would like to make regarding the tax clarification provisions in your bill.

Tax Reserves: The Coalition appreciates the inclusion of a provision to conform the tax treatment of LTC reserves with the statutory reserving requirements. All other insurance lines are permitted to take a deduction for reserves when they are established. Currently, the federal tax code in unclear as to when companies are allowed the deduction for LTC insurance. This clarification is of critical importance to the growth of this market.

Per Diem Policies: We appreciate your recognition of per diem policies as legitimate LTC products. Per diem policies pay a fixed amount when the beneficiary meets the eligibility requirements without regard to the use of specific services. We believe that more insurance companies will move toward the per diem approach in the future to accommodate the changing labor market. We expect employers and employees to look for ways to integrate LTC insurance with other employee benefits such as life and disability insurance and pension programs. Per diem policies offer greater flexibility that service benefit policies do not.

Cafeteria Plans: Your legislation specifically provides tax preferred treatment for LTC policies sold through cafeteria plans and recognizes that policies purchased under such arrangements are not to be considered deferred compensation. We believe that such clarifications are critical to the future development of the long-term care insurance market since the greatest market potential lies in the employer sector. Through such arrangements, employers can act as advocates on behalf of their employees by obtaining policies tailored to their employees' needs and negotiating the best price for LTC policies.

Maximum Benefits: The Coalition appreciates the inclusion of a maximum daily benefit of $200 since it recognizes the high cost of LTC in certain parts of the country. Previous legislation set this limit much lower and would have penalized those who live in high cost areas. We also believe that your legislation would tax as income only those benefits that exceed the limit, but would like the regulation to clarify this point. Prior legislation would have disqualified all benefits under a policy that exceeded the daily limit (or policies that, when combined, exceeded the limit).

Effective Date: We would appreciate a modification of the effective date to recognize the time needed by carriers to refile policies to be consistent with the requirements of this Act and to receive approval for such policies. To address this problem and allow tax-favored treatment for policies issued during the new approval process, we recommend amending the language in the effective date sections to provide consumers and insurers an 18 month transition period for new policy approval. Policies sold for up to 18 months after the effective date would be eligible for tax-preferred treatment.

Transition Period: We also request a transition rule which would provide tax-favored status for policies sold prior to the enactment of this Act so long as the policy met the LTC insurance requirements in the State in which the policy was sitused at the time it was issued. This transition is needed to prevent penalizing individuals who took responsibility for their LTC needs by purchasing a policy before the tax status of such policies was clarified.

Payment Rules: Your legislation would prohibit an individual from paying premiums in excess of what the premium level would be under a level funded contract. We request that this prohibition be eliminated to allow individuals either to purchase paid-up policies which could be paid off at age 65 or to prefund part of their policies to reduce the monthly premium costs. We believe that carriers will continue to find innovative ways to make LTC insurance payment mechanisms more attractive and wish to plan for this contingency. In fact, some companies already have begun to offer paid-up policy options.

C. Federal LTC Insurance Standards

The Coalition supports appropriate federal standards for consumer protection to ensure that LTC insurance policies have initial and continued value. To ensure access to affordable protection, however, any federal legislation must strike an appropriate balance between the extent of policy requirements and affordability. The Coalition supports the provisions contained in the 1993 NAIC Model Act and Regulation.

The Coalition also supports most of the LTC insurance standards requirements contained in S. 423 and believe that most of these provisions will help assure high quality products and enhance consumer confidence in these products. In addition to many of the requirements taken from the 1993 Model Act and Regulation, the Coalition is supportive of several other aspects of S. 423 including the establishment of a national long-term care insurance advisory council. This council, composed of experts in the LTC field, would play a valuable role in advising Congress regarding the need for changes in LTC insurance laws and regulations, once implemented under this Act. In addition, we believe that the data analysis and information dissemination functions and provisions to develop education models would contribute significantly to the public's understanding of LTC risk and vehicles for protecting against such risk.

Notwithstanding our general support for the standards provisions in S. 423, the Coalition does have concerns with a few provisions. We respectfully request your reconsideration of the following provisions:

State Preemption - Sec. 203: The Coalition strongly urges you to reconsider this requirement which would enable states to require policies to exceed Federal standards. We believe that state preemption of federal standards is inconsistent with the intent of federal standards which have been designed, in part, to create greater uniformity across products. Further, we are concerned that State pre-emption of Federal standards only will perpetuate existing regulatory burdens and limit consumers' choices regarding LTC coverage by stifling competition in the LTC market place. Current variation in state regulations forces insurance companies to comply with up to 50 different state regulations, adding substantially to administrative costs. These costs are passed on to consumers in the form of higher premiums.

We understand that outright Federal preemption of state authority is a difficult concept to support at this time, given Congress' interest in regulatory reform, including the expansion of state flexibility in decision-making regarding programs funded with Federal dollars. Accordingly, we would support a state's right to require additional standards in order to receive <u>state</u> certification of LTC policies. Carriers whose policies comply with Federal regulations, however, should not be prohibited from selling their policies in any state.

Rate Stabilization - Sec. 102(b)(9): S. 423 includes a series of requirements regarding rate stabilization which the LTC industry has supported in the past as an alternative to more onerous regulations ultimately approved by the NAIC. Given the change in Congressional and state leadership to a more conservative viewpoint, and this leadership's interest in regulatory reform, the Coalition requests that this section be deleted from your bill.

We believe that insurance companies should be held accountable for reasonable and justifiable premiums and that consumers should be protected against unwarranted and unreasonable premium increases. However, we have several concerns with rate caps. First, there is no evidence that LTC insurance carriers as a class have engaged in inappropriate pricing practices. Second, LTC insurance pricing practices already are regulated. States have the right to approval initial rates and to deny requests for rate increases they deem to be unfair, discriminatory or unreasonable in relation to benefits. Also, due to loss ratio requirements, premium adjustments must be actuarially justified by the states.

Third, we believe that there are more effective vehicles for providing consumers such assurances. Premium caps will not assure that rates are established correctly at the outset. Actuarial guidelines for evaluating the adequacy of premiums based on assumptions regarding utilization, lapse rates, etc. would be more effective in this regard. Fourth, it is important to note that the LTC industry still is young compared to the life and health markets, from a experience perspective. Rate caps actually coup jeopardize carriers' solvency and claims paying ability which certainly is not in the best interest of consumers.

Penalties for Non-Compliance - Sec. 202: The Coalition supports civil monetary penalties as a strategy for enforcing compliance with LTC insurance regulations. We believe that the penalties included in S. 423, however, are unnecessarily punitive. We request that you consider substituting this provision with Sec. 11 of the NAIC Model Act which imposes a penalty of the greater of $10,000 per violation or three times the commission earned on the sale of a policy that does not comply with the regulations.

IV. CONCLUSION

The Coalition believes that S. 423 represents an important step toward promoting a public/private partnership in LTC financing by creating strong incentives for the purchase of private policies. We also believe that additional steps must be taken both to enhance consumer confidence in this market and to clarify consumers' understanding and expectations regarding the level of support and protection they can anticipate from the government versus the amount of coverage they will be responsible for themselves.

The Coalition believes that the most efficient way to divide public and private sector responsibilities and minimize confusion regarding coverage is to: (1) relate eligibility for public LTC benefits to financial need; and (2) provide strong incentives for those who can afford to self-insure to do so through savings, private insurance, medical IRAs, etc. Financial incentives will promote wider penetration of private insurance and savings vehicles for those with the financial ability to protect themselves.

Coalition members appreciate the opportunity to address these important issues. We stand ready to assist the Subcommittee in any way we can.

The CHAIRMAN. Thank you very much, Dr. Wallack.
Ms. Moon.

STATEMENT OF MARILYN MOON, SENIOR FELLOW, THE URBAN INSTITUTE, WASHINGTON, DC

Ms. MOON. Thank you very much, Mr. Chairman, for the opportunity to be here today. I believe my role here is also to discuss balance between the public and the private sector, with a different emphasis than what Stan Wallack raised.

The need for balance is clearly there. Private insurance can play an important role, and it is moving increasingly in that direction. But I also believe that such insurance needs to be improved to assure that people get the benefits that they need, and that should be a primary role for the Federal Government for oversight or State governments if the Federal Government does not take responsibility. Like Stan, I believe there is a Federal role here.

I also believe that private insurance cannot fill in all the gaps without either substantial subsidies or expansion of the public side of a long-term care strategy. Making the public and private sides fit together well is difficult to achieve, however.

I will avoid talking very much about the important needs in the area of long-term care since that has been laid out pretty well. And the problem is going to continue to be well known.

I also agree with Stan Wallack when he emphasized that Medicare is now playing a more important role that we have recognized in the past, both for home care services and for skilled nursing care. Legitimate questions arise concerning whether that expansion has gone too far, but what has happened is Medicare filling in an important unmet need for many people. Before we talk about rolling back Medicare's contributions, we should consider very carefully about what else should be done in the public sector and in what ways.

Similarly, I don't think anyone is very happy with the way the Medicaid spend-down rules work, and the games that get played over that program. But we need to think carefully about making sure that we don't throw the baby out with the bath water by making Medicaid even more restrictive. If we move too much in that direction, we will eliminate protection for people for whom private insurance is not a good option, and who should not be purchasing private insurance. It is just as important to educate people on who should buy private coverage as well as who shouldn't buy such insurance.

Good insurance in the long-term care market is going to be relatively expensive, and it should be expensive in order to assure that it does the things necessary to help people get something out of the system. Inflation protection should be made clearly available to people, and people should be encouraged to take that inflation protection. Only then will benefits be sufficiently large to meet their needs, particularly, for those who buy insurance when they are younger. The younger the population, the more important many of these protections become.

Similarly, I believe that nonforfeiture benefits are very important. One barrier to a lot of young people buying insurance is the fear that if they do not pay every single month for 30 years, they

won't get anything out of the system. And in fact, the irony is that is what keeps the price of long-term care insurance low for younger people in many cases; the very assumption that many of them will lapse those policies means they effectively subsidize others who keep up the payments. I don't believe that such subsidies are an appropriate way to set up an insurance system to encourage people to buy when they are younger. Certainly, I would not buy a policy that did not have non-forfeiture clauses in it.

There is also a dilemma of buying early and having to pay into a system where private insurance appropriately must be very conservative. If I am going to buy private insurance, I want make sure that the rates are high enough so that the company does not simply cancel the policy when they realize they don't have enough money to pay the benefits when I get to the age where I need them. I want the insurance company to be conservative, but that means the prices are going to be higher.

There are other ways in which ways standards should be improved, and these are pretty typical of what others propose. Establishing standards will actually be a major selling point to many people who are reluctant to buy insurance until they feel there is some kind of stamp of approval and better standards. Again this is particularly a Federal issue, given the mobility of an aging population, where regulations in one State may not satisfy needs when people change residences over time.

Finally, there is a need to keep an eye on the public sector as well. An imbalance in terms of support for basic protections is likely to arise if we are not careful. The enthusiasm to cut back on the Medicare and Medicaid programs is understandable, and if I believed there were only going to be cuts in terms of fraud, waste, and abuse, I would not be concerned. But we are going to cut into some of the bone and meat, as well as the fat in the system given the size of the changes under debate. We need to be very careful about that, and in considering any tax benefits that might be provided to encourage private activity. There should be a balance between those two, and we should not get so enthusiastic about providing tax benefits that we go overboard in that direction while cutting public programs for the most vulnerable.

What should we do? I would stress strong educational efforts as being particularly important. I think we can only gain by telling the pros and cons of insurance. That is only for everyone's benefit. We need standards and protections. We need strong inflation and nonforfeiture protection, and a careful weighing of how to target any subsidies that the Federal Government is going to provide in this area.

Thank you.

[The prepared statement of Ms. Moon follows:]

THE ROLE OF THE PRIVATE SECTOR IN LONG TERM CARE

Statement of
Marilyn Moon[1]

Hearing before the
Special Committee on Aging
United States Senate
May 11, 1995

Thank you for the opportunity to testify on the issue of the role of the private sector in improving access to long term care services for older Americans and their families. My testimony focuses on the issue of the appropriate mix and relationship between public and private spending for long term care.

I make three basic points:

- Private insurance is expanding and can certainly play a role for older Americans. But it will take a long time for significant expansion and it will always be limited without substantial subsidies for the purchase of insurance.
- Nonetheless, there are a number of things that could be done to improve such insurance and the value it offers older Americans.
- Without some additional expansions in public programs, however, there will continue to be major gaps in long term care services. Too much emphasis on expanding private insurance while cutting back on public spending will create a serious imbalance in approaching this problem.

The Nature of the Problem

Long term care needs affect a substantial number of older Americans. Currently, 1.6 million older Americans reside in nursing homes and another 2.3 million severely disabled persons remain in the community. Older persons face a variety of needs, making it difficult to define exactly what an ideal long term care system should look like. Institutional (nursing home) services for those who cannot remain at home and community-based services that offer a variety of options for persons who remain in their homes are both crucial components of a long term care system. Institutional care may be needed not just for the level of skill required, but the constancy of care, such as round-the-clock supervision for those with Alzheimers' disease or dementia. But long term care is not just nursing home care. Community-based services include skilled and unskilled services in the home and programs such as adult day care or congregate meal services. Such personal services require flexibility and choice for the recipients.

Whatever the specific setting, such services are likely to represent relatively permanent arrangements, stretching over months if not years. Thus, they need to reflect quality of life concerns and the living environment of the disabled. In this way, long term care differs substantially from the acute care setting, which is designed for the convenience of the providers and to which patients are only briefly exposed.

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[1]Senior Fellow, The Urban Institute, Washington, D.C. The views expressed in this statement are those of the author and do not necessarily represent those of the Urban Institute, its trustees, or its sponsors.

Moreover, such services are expensive and it is difficult to find ways to minimize the costs. Those in the community who use home health services and have serious disabilities spend on average over $4000 per year on home care. And for persons in nursing homes, these expenses can overwhelm the family since costs of housing someone in the nursing home start at about $35,000 per year and can be much higher.

Because of this expense, when people need care, they often do not have the means to provide it for themselves. Among the elderly, for example, those with disabilities are older on average and have fewer resources than does that group as a whole. The most likely group to need long term care services, unmarried women over the age of 85, have rates of poverty in excess of 20 percent. And many more of them have incomes just above the official poverty levels.

The Medicaid program constitutes the major source of public support--mostly for nursing home services. But Medicaid is a welfare program, designed to protect those with low incomes and minimal assets. Thus, only when the families' resources are exhausted--or if they have none to begin with--can individuals rely on Medicaid for support. And even then, they must continue to devote substantial amounts of their incomes each year for nursing home care before Medicaid's contribution begins. Unlike insurance, which protects people against financial catastrophe, our current system provides people protection only after catastrophe occurs. There is also considerable variability across the states in terms of the quality and size of their long term care programs.

Medicaid is not an insurance program; it is a welfare program for those who have impoverished themselves. And even after becoming eligible, families must devote most of their incomes toward the cost of that care. This eligibility requires that individuals spend an enormous amount of resources before becoming eligible leading to dissatisfaction with Medicaid. In turn, such dissatisfaction has helped to rationalize the elaborate behaviors of some financially better-off seniors seeking to hide or transfer assets to avoid the stringent eligibility requirements.

A further interesting trend in recent years is the increasing importance that the Medicare program is playing in financing long term care. In 1980, for example, Medicare accounted for only 2% of the costs of nursing home care; by 1993, the share had risen to 8.8%. And Medicare has long been the dominant public payer for home health care, which has been rising very rapidly in recent years.

Together, Medicare and Medicaid finance three out of every five dollars of long term care services; hence projected cuts in these programs are very likely to be crucial for long term care services. Just one year ago, there was serious discussion by both

Democrats and Republicans about expanding public support for long term care. Now this is apparently no longer a viable option; in its place are proposals to stimulate the growth of the private sector. And while private insurance policies have been increasing, such insurance still only pays for about 2.4% of nursing home services in the United States. As yet, it is still a trivial payer.

Expansion of Private Insurance Coverage

The good news is that private long term care insurance is expanding. Today, over 3.4 million Americans have private long term care insurance policies of various types. This is up from 2.9 million the previous year. Most of these policies remain individual plans, although the number of employer-based plans is reportedly on the rise as well. And policies sold as riders to life insurance policies are also on the rise. Interest in finding private protection against the cost of care is likely related to the failure of health care reform to offer expanded benefits, so it is likely that growth will continue for the foreseeable future as any promise of expanded public coverage continues to be unlikely.

But it is also important to consider how quickly such insurance will expand and for whom. Before we become too optimistic about insurance, it is important to keep in mind what the overall numbers look like. First, for those over the age of 75 who do not now have insurance, it is highly likely that few would be able to purchase it both because of high premium costs relative to incomes of those in this age group or the health conditions they already have that would make them poor risks to companies issuing such policies. This means about 13.8 million Americans are currently at risk--and many of them will live for at least 10 more years. The most likely purchases of insurance are those between age 55 and age 75--or about 39.4 million people. (And if we include younger persons aged 45 to 54, that would add another 27.4 million.) If we assume that most of the 3.4 million enrollees in private health insurance are between the ages of 55 and 75, less than one in ten Americans now has insurance protection. And in all likelihood, the number is even smaller than that.

To examine how much further expansion is likely we should ask why so few people currently buy long term care insurance. Availability of policies should not be a barrier since over 100 companies offer such insurance. Many older persons are relatively uninformed about the prospects for public coverage and what is necessary to do to qualify for Medicaid coverage. Thus, emphasis on better education and information could likely have an impact on encouraging further growth.

But foremost, insurance, particularly good insurance, is expensive. The Health Insurance Association of America reports that while plans can be purchased for as little as $898 per year for persons aged 65 and over, good quality plans (that allow for at least some inflation and nonforfeiture of benefit clauses, which are discussed below) would cost persons aged 65 $2,525 per year. And for someone aged 50, the expense would be $1080; 79 year olds would expect to pay $6,033 (without nonforfeiture, which is likely to be less crucial for this age group).

Although insurance is more affordable if purchased at a younger age, that still means individuals must pay into the system for many years before seeing any benefits. Families still meeting the costs of children's education and just beginning to think about retirement are likely to place long term care insurance far down the list of purchases. Since evidence indicates that tax advantages have not yet spurred on substantial savings for retirement--the good years--how likely will we be able to encourage younger persons to set aside resources for a problem they are likely not to want to face?

And when people do begin to focus on the need for such protection, it is quite expensive. In 1992, for example, only a small percentage of elderly persons could afford to purchase such insurance at age 65. For example, median per capita income for persons aged 65 to 69 was only $12,551. Certainly over half of all elderly could not spend $2500 for insurance. Moreover, not until we reach the top 20 percent of the population do such policies begin to fall below 10% of income.

Thus, private long term care insurance is not likely to ever "solve" the problems of the unaffordability of long term care for many Americans. It is unlikely to attract enough individuals, and many of those it does attract are likely to be able to afford to pay for their own long term care needs if they did not have such protection. Almost by definition, private insurance is most attractive to those who have a lot of assets to protect, and hence are seeking to avoid spending down even though they could do so.

Improving Private Insurance Standards and Protections

A number of important controls and restraints need to be put on private insurance to assure Americans that this is a worthy investment. At a minimum a number of reforms are needed to protect consumers and those insurance companies that seek to provide responsible coverage.

A first step for making insurance a viable option for those who can afford it would be to establish federal standards to protect consumers. These would include outlawing high pressure tactics in marketing, and standardizing definitions of benefits and restrictions so that it is possible to compare plans and make good choices. Further, there need to be protections for renewals and upgrading to new products. People who

buy private insurance are generally going to be paying for many years before benefits are received and they need assurance that the value of the package they have purchased will keep up with the times.

Another important issue raised by the long time horizon involved in this insurance relates to nonforfeiture of benefits. If products are to be made attractive to younger persons, there need to be guarantees that someone who pays in for many years but then lapses can withdraw some portion of the payments. Insurance companies price insurance premiums low for younger persons precisely because they believe many will fail to keep their premiums current until they need the care. Indeed, it is very telling to look at the difference in premiums between policies with and without such protections. HIAA finds that such protection increases premiums by over 40%. (Life insurance policies have such nonforfeiture protections, so this is not an unusual protection.)

Another needed protection that also adds to the costs of premiums is an adjustment for inflation. Without such protection, a guarantee today of $100 a day in nursing home coverage will rapidly become worth much less. A standard protection would offer a 5% compounded rate of growth in the protected levels over time. This increases the cost of a policy for a 65 year old by about 75%, although even this constitutes a lower level of inflation protection than what would have been needed over the last decade, for example.

Many of these needed improvements will raise the costs of insurance over time, but it is far better for persons to buy an expensive but useful product than to pay substantial amounts of money over time and fail to get the help they need when they are ready to collect benefits. And by discouraging artificially low premiums, those who should not buy such insurance will be less tempted to do so. Such protections are an essential element of any greater reliance on private insurance and themselves might help stimulate some growth by certifying the quality of such products.

Improving Public As Well As Private Coverage

As recently as the mid 1980s, serious discussions of a comprehensive program of social insurance for long term care took place. Such a program would guarantee to all disabled persons access to nursing home, and home and community-based services as needed. But the high and escalating price tags for long term care, coupled with the enormous growth in the acute care portions of Medicare and Medicaid, moved the discussion away from such solutions to more modest initial steps. And after the collapse

of the health care reform debate last year, even modest expansions of public programs seem much less likely. Indeed, the pendulum has swung so far that we are more likely to consider cuts in public funding rather than expansions. Unfortunately, this will result in an imbalance between public and private efforts if we truly wish to see a "partnership" approach to solving the problems of long term care.

Expected cuts in Medicaid will likely preclude even modest expansions in this means-tested program. While some states might take advantage of increased flexibility to experiment in various areas, holding the line or even contractions of services seem more likely. Further, those services under Medicare with the highest rates of growth for the last five years are home health and skilled nursing care--both areas where there is considerable overlap between acute and long term care services. These services, which have provided some relief for many seniors in need of long term care, are likely to be areas particularly targeted for cuts.

Thus, the public sector picture for many Americans is likely to become bleaker over time, creating a further imbalance between those who can afford long term care (or private insurance) and those who must rely on government services. That is,e even optimistic projections of private insurance growth suggest that 30 years from now, no more than half the nation's senior citizens are likely to have long-term care protection. As a result, the demands on the welfare-based Medicaid program will rise with the growth in the elderly population. Projections are that even to keep pace with current levels of service--deemed inadequate by consumers, providers, and experts--expenditures on long-term care, net of general inflation, would be triple today's levels.

In an effort to help expand coverage for long term care beyond what a public expansion would offer, direct efforts to encourage families and individuals to purchase long term care insurance could be undertaken. But what will it take to expand this line of business enough to provide serious relief? If substantial tax benefits or offering those with insurance some expedited eligibility for Medicaid as a back-up are considered, new federal resources would be needed as well for this part of the effort.

However, such a strategy also poses many problems. Even with preferential tax treatment and subsidies, private insurance would remain too expensive for most elderly to purchase without substantial financial sacrifice. Subsidies would therefore disproportionately benefit the better-off relative to the moderate income elderly unless very specifically targeted. Alternatively, a few states are now experimenting with

promoting private insurance by expediting Medicaid eligibility for those who purchase such policies. The private policies are kept more affordable by covering only a limited time period. After that period, individuals could become eligible for Medicaid without spending down all of their assets. This preferential public coverage, added at the "back end" of a stay would mean that for purchase of more modest insurance, individuals would get full protection for a long nursing home stay. Variations of this approach are being tried in several states, particularly New York and Connecticut. Proponents argue that in the long run this should save Medicaid costs as people will remain off the roles for longer. Detractors worry that this approach is also more likely to appeal to those with higher incomes and still remain unaffordable for those with more modest resources. But either of these strategies will not be adequate to provide universal protection against long-term care risks--unless the subsidies were very large and Medicaid expanded substantially.

Conclusion

Providing older Americans with reasonable access to long term care services is not a problem likely to solve itself. The aging of the population implies increased demand for such services. The larger share of women working outside the home portends a diminished supply of informal caregivers. Prospects for breakthroughs in disabling conditions or treatment of disability are not very promising. Prospects for cutbacks in medicare and Medicaid will further limit access. It is difficult to imagine how private lon term care insurance could fill all thse gaps. Unmet long term care needs are likely to remain with us for the foreseeable future.

The CHAIRMAN. Thank you, Ms. Moon.
Dr. Battista.

STATEMENT OF MARK E. BATTISTA, M.D., VICE PRESIDENT, LONG-TERM CARE, UNUM LIFE INSURANCE COMPANY OF AMERICA

Dr. BATTISTA. Mr. Chairman, good morning. I appreciate the chance to be here today.

UNUM markets long-term care both in the individual and the group markets, as well as to residents of the continuing care retirement communities. We believe that the largest unfunded liability facing Americans today is long-term care. There is an urgent need for a coherent national policy. The Nation can neither afford to drift into a virtually unlimited public liability, or turn its back on the very real problems facing those who simply can't afford to assume their own financial responsibility.

I'd like to outline five key points today. First, why is long-term care such a major financial burden? Clearly, this is the triple whammy that we have heard of talked before. That is, demographics, the great need, and the high cost.

Second, there are two pillars to a sound, national long-term care policy. First, those who can take responsibility for themselves by purchasing private long-term care insurance must be encouraged and expected to do so. Second, we need to spread the risk over large numbers, and over time.

The third point is that private long-term care insurance truly is affordable for many, and more so at younger ages. We've talk about various rates at different ages. UNUM estimates that between 60 and 75 percent of Americans who are between 30 and 50 years old can afford private long-term care insurance, and perhaps 40 percent of those over 65 can afford private long-term care insurance.

Another point I want to emphasize is that generally speaking in long-term care, these rates are what are called level rates. If a person buys at age 40 at say $300 or $350 for a good policy, they continue to pay that rate, year after year after year. If they start at 50, they might have to pay $475, and pay that year over year over year. The only time an insurance company can raise those rates in a level premium structure in a guaranteed renewable context, which this is, is if the entire class of all people at that age group for that company has such adverse experience that was so far off what was priced for it that it put the insurance carrier's ability to pay future claims at great risk; and only then with the approval of the insurance commissioner of a particular State.

I think waiting until 65 to buy life insurance makes that a very costly proposition. Anybody would be surprised if anyone were to suggest that we wait until 65 to begin to fund our retirement plans. I think we must assert the same common sense view of the facts to encourage Americans to cover themselves for long-term care early when it really is easily affordable.

The fourth point is that current products are of high quality. We have a way to go, but we have come an awfully long way in 10 years. I won't go into that here.

The final point is that there truly are viable and growing individual and group long-term care markets with 118 insurers selling.

But as Dr. Wallack said, and I really agree with this, with 3.5 million policies, which is not very many, considering the potential penetration of this market, we really do need the Federal Government to take the leadership role in helping to expand the market, particularly in the employer group market, which at this point is very small, having just about 1,000 employers that have put in a long-term care plan, with maybe 400,000 employees actually covered.

Mr. Chairman, we applaud you for carefully crafting a comprehensive, effective, and sensible strategy for long-term care in your Private Long-Term Care Protection Act of 1995. We feel the following concepts are vital.

First, a level playing field for all types of long-term care policies, both reimbursement and per diem, or indemnity policies. Second, the bill takes the critical step of encouraging the growth of the employer group market by clarifying the tax treatment of benefits and premiums, and permitting long-term care benefits to be part of a cafeteria plan. This is a great opportunity to expand the number of people covered at those more affordable ages.

Third, there will be Federal minimum standards established to balance consumer protection with affordability, product innovation, and very much, consumer choice. I think that is critical in the mandated nonforfeiture debate that has really hit the industry.

Finally the bill takes a very, very important step of educating the public about the risk of incurring catastrophic long-term care costs, and the importance of planning for such costs.

Mr. Chairman, given that long-term care represents the largest unfunded liability facing Americans today, we urge the development of a coherent national policy on long-term care that combines viable and responsible roles for both the public and private sectors.

Thanks again very much for the chance to present these views.

[The prepared statement of Dr. Battista follows:]

TESTIMONY BY
UNUM LIFE INSURANCE COMPANY OF AMERICA
BEFORE THE
SENATE SELECT COMMITTEE ON AGING
– U.S. CONGRESS –

on

"The Role of the Private Sector in Long Term Care"

Presented by:

Mark E. Battista, M.D., J.D.
Vice President, Long Term Care
UNUM Life Insurance Company of America

Good morning, Mr. Chairman, and members of the Senate Select Committee on Aging. My name is Mark Battista; I am Vice President for Long Term Care of UNUM Life Insurance Company of America, headquartered in Portland, Maine. UNUM is America's leading Disability insurer, and a leading provider of other employee benefits, long term care insurance, and retirement security products. We operate internationally, and were honored in 1994 to be the first insurer, domestic or foreign, to be licensed by the Japanese Ministry of Finance to write long term disability insurance in Japan. In long term care specifically, we are active in both the individual and the employer group markets, as well as marketing directly to residents of continuing care retirement communities under the exclusive endorsement of the American Association of Homes and Services for the Aging. I am honored and pleased to be able to speak with you this morning about how the private sector fits within a sound national policy on Long Term Care.

UNUM believes that long term care represents the largest unfunded liability facing the American family today. We believe there is an urgent need for a coherent national policy on long term care. The nation can neither afford to drift ahead willy nilly into a virtually unlimited public liability, nor turn its back on the very real problems facing older Americans – particularly those who simply cannot financially assume responsibility for their own care.

Mr. Chairman, the United States is facing a confluence of historic societal forces. These forces add both urgency and risk to the decisions you will make in crafting a sound public policy on long term care. First, the baby boom generation in the demographic profile is

rapidly approaching senior citizen status. To a truly unprecedented degree, our population will be older, and aging, with one renowned scholar of aging in America noting that, for the first time in history, the average American family will have more parents than children. (Dychtwald).

Second, and simultaneously, we are individually experiencing radically extended lifespans, with the national average now topping 76 years. In fact, the average American reaching age 65 today can look forward to another 17 years of life. How dramatically this contrasts to the situation in which your predecessors enacted Social Security back in 1935, when the average life expectancy was a mere 61 years! Then, it was revolutionary to enact a modest safety net program for the very old. Eligibility began 4 years above the average life expectancy, and many workers were paying into the system for every retiree collecting benefits.

Today, we approach the unpleasant reality of each working couple supporting one retiree. If we were to reset the Social Security retirement eligibility age to be in the same relationship to average life expectancy, as it was originally, citizens would not qualify for Social Security until age 82!

This historic double whammy of demographic bulge plus extended longevity also challenges Medicare's solvency, and Congress will have to deal with this problem in short order -- an undertaking that will not be without substantial political and economic pain. So what does all of this have to do with Long Term Care? It presents the factual backdrop against which the emerging long term care problem must be evaluated. With long term care, not only are we dealing with enormous numbers of seniors living longer, we are also pondering how to address the need for basic custodial, support, and maintenance services for a broad range of an aging population.

As we confront long term care, we have the opportunity to address the issue in the full light of our learnings from the past. The challenge will be to develop a public policy approach that produces tangible benefits without exposing the public treasury to a virtually limitless liability.

The two critical pillars of sound policy should be (1) that those who can take responsibility for themselves are encouraged and expected to do so, and (2) that with long term care, we must not only spread the risk over large numbers, we must also spread the risk over time.

UNUM estimates that between 60-75% of Americans aged 30-50 can afford private long term care insurance, and another significant percentage can make some contribution toward their own protection. A good long term care policy from my company for a 40 year old -- including home care and uncapped inflation protection -- costs less than $300 per year on a level premium basis. For someone age 50, that same coverage would cost only about $475 per year. This verifies the second pillar of spreading the risk over time as well as numbers -- long term care insurance is affordable.

It also highlights the public value of encouraging the growth of long term care insurance coverage at younger ages, as an employee benefit, offered on a group basis to employee-aged citizens. Few would be surprised if we pointed out that waiting until one is 65 to buy life insurance makes that a very costly proposition; all would be surprised if someone were to suggest that we wait until age 65 to begin to fund our retirement plan. We must assert the same exact common sense view of the facts to encourage Americans to cover themselves for the risks of long term care early -- when it is easily affordable.

Group long term care insurance itself is showing promising signs of growth even with a cloudy tax status and an employer population that has been wary of adding new benefits due to the uncertainty brought about by the national health care reform debate. According to the most recent study published by LIMRA -- the Life Insurance Marketing Research Association -- more employers have chosen my company to carry their group long term care coverage than any other. Yet, the most current data from the Health Insurance Association of America (HIAA) shows that, nationwide, only 400,000 people are covered under fewer than 1000 group insurance policies. This represents a tremendous opportunity that should be a key focus of Congress. It underscores why enactment of Senator Cohen's Private Long Term Care Family Protection Act of 1995 would be so powerful: the tax clarification which it provides will leverage private coverage through the group insurance market and rapidly expand the number of people covered at those early affordable ages -- and, in turn, ultimately reduce the financial obligations/burdens of this and future generations of taxpayers.

Now to return to the first pillar of a sound public policy, what are the ideal roles of the public and private sectors in encouraging those who can assume responsibility for themselves to do so? Again, a thoughtful analysis of the economic, social, and demographic trends leads one to conclude that the private sector should be expected to pull the laboring oar in this effort, with the public sector providing guidance, groundrules, and incentives. There currently exists a vibrant private market for long term care insurance that will form the ideal foundation. As of December 1993, according to HIAA data, about 118 insurers were active in the long term care insurance market, and they saw that market expand by over 27% year over year. Importantly, average policy premium actually decreased by an average of 8% since 1992. This latest HIAA Study analyzed 13 policy forms representing about 80% of all policies sold in the individual and group association market in 1993, and found that they had in common all of the following quality features:

- All plans offer nursing home and home health care. In addition, twelve plans also offer adult day care and an alternate care benefit and eleven provide a respite care benefit.

- None of the top sellers use a *medical necessity only* benefit trigger. Plans either use medical necessity or ADL impairment or cognitive impairment; or only ADL impairment or cognitive impairment.

- All but one offer an unlimited lifetime nursing home maximum.

- All plans are guaranteed renewable, have a 30-day free-look period, have a pre-existing condition limitation of less than 6 months, and cover Alzheimer's disease.

- Twelve plans offer the NAIC Model Act and Regulation inflation protection requirement of benefits increasing at an annual 5% compounded rate funded with a level premium. One insurer offered periodic benefit upgrades to all policyholders.

- All plans offer a nonforfeiture benefit to their policy holders, with a return of premium and/or reduced paid-up as the most common types offered.

These and other available facts clearly demonstrate that we have an active, growing, and functional private market for long term care insurance. These facts also support the public approach of guidance and incentive as the most appropriate strategy for Congress. Such a strategy assures Congress the biggest gains in protecting the largest number of Americans from this looming risk.

Mr. Chairman, we applaud you for carefully crafting a comprehensive, effective, and sensible strategy on long term care in your Private Long Term Care Family Protection Act of 1995. We endorse the general concepts outlined in the bill. In particular, I note several concepts that are vital to any public approval on long term care: 1) A level playing field for all types of LTC policies, such as reimbursement and per diem models; it is essential that all policies be treated equally; 2) the bill encourages the growth of the employer group market by clarifying the treatment of benefits and premiums and by permitting LTC benefits to be included in cafeteria plans; 3) LTC reserves for tax purposes are brought in line with statutory reserves; 4) federal minimum standards are established which appropriately balance consumer protection with affordability and product innovation; and 5) the bill takes a very important step of educating the public about the risk of incurring catastrophic long term care costs and the importance of planning for such costs. This proposal addresses a primary impediment to the development of the LTC market: the public's general lack of knowledge that there is no government program that will cover their long term care needs unless they are destitute and that there are options available to help plan for such costs. We believe the Federal Government can play its most useful role with a public information program.

Mr. Chairman, given that long term care represents the largest unfunded liability facing Americans today, we urge the development of a coherent national policy on long term care that combines viable and responsible roles for both public and private sectors. We are proud to be founding members of the Coalition on Long Term Care Financing, which has been working for several years to find honest, workable answers to these difficult problems. We pledge our continuing efforts to work in good faith with all parties seeking constructive answers. Again, Mr. Chairman, and members of this Committee, on behalf of myself and UNUM, I thank you for the opportunity to present my views to you.

The CHAIRMAN. Thank you very much, Dr. Battista. I should point out that UNUM, in fact, is a Maine-based company, but is global in reach, in terms of the business it does, not only nationwide, but well into other countries. There are many other long-term care policies issued by a number of other companies. I happen to know the work of UNUM, and applaud what it is doing, and the high standards it sets. That is the reason why UNUM was invited, but there are many other companies out there as well.

We will go on, but I will come back to you, Dr. Battista, in a moment.

Ms. Holubinka.

STATEMENT OF GAIL HOLUBINKA, DIRECTOR, NEW YORK STATE PARTNERSHIP FOR LONG-TERM CARE, NEW YORK, NY

Ms. HOLUBINKA. Thank you. Good morning, Mr. Chairman.

Long-term care financing rarely elicits the concern and passionate advocacy reserved for new services or delivery systems. That should change. For to me, and to anyone who has ever had to care for an aged loved, services, no matter how excellent or varied, without the means to purchase them is akin to watching a feast while starving outside. To families attempting to pay for care needed today, that care that all of us may need, finding the money is not an intellectual exercise.

As a health care professional, I am well aware of the budgetary limitations that Government is facing. Therefore, while pleas for Government action are usually accompanied by appeals for more public expenditure, this request is different.

I represent a State that has recognized the problem, has made an effort, and does not anticipate increasing its spending to complete that effort. New York is one of four States; California, Connecticut, and Indiana being the others; with operational partnership programs funded under grants from the Robert Wood Johnson Foundation.

All partnership programs combine private insurance with Medicaid to provide residents an affordable, attractive alternative to poverty caused by spend down, or the artificial poverty of divestiture. While the exact model used in the partnership States varies, each State offers its residents a way to avoid impoverishment through the purchase of special insurance coverage, and it offers participating insurers assistance in reaching their target market, provided that they meet standards beyond those required when selling regular long-term care insurance.

In New York, purchasers who buy, maintain, and subsequently exhaust their private coverage, are permitted to apply for Medicaid without regard to the type or amount of assets they may have. However, Medicaid income rules do apply.

Substituting private insurance dollars for public tax dollars saves State Medicaid funds. But, the partnership also means that many elderly will be able to maintain financial independence throughout their lives without the threat of losing their life savings and their dignity. Let me explain.

In the New York, the cost of nursing home care ranges from around $60,000 to over $75,000 per year; the average length of stay is 2.5 to 3 years. Even New Yorkers with $200,000 in assets run

the risk of Medicaid dependency. Although it may seem odd to consider those with such high assets as potential Medicaid recipients, poverty is relative. If all our assets and income do not cover what we need in order to survive, then we are poor, regardless of how much we may have started with.

Clearly, Medicaid's concerns can not be limited to the day the formerly middle and upper middle class individual applied for assistance; that is a day too late. Attention must be paid to delaying or avoiding that day.

In 1988, New York State began its work on this program. The problem could not be solved by the State alone, and New York turned to the private insurance market. Although, initially the public and private sectors were somewhat leery of each other, the decision, we feel, has proven to be sound for both parties.

Quality was assured through requiring Partnership policies to provide extensive consumer benefits. Affordability was addressed by limiting the duration of coverage needed. The Partnership's success depended on, first, convincing consumers there was a problem, and second, that insurance was a positive solution. Most people are in denial about the risks of long-term care, and frankly suspicious of insurer motives of informing of these risks.

Working as partners, the State and insurers created a solution that addressed everyone's needs. The State undertook an extensive education and publicity campaign that advised the public of a need of long-term care planning, and the advantages and limitations of the Partnership in meeting that need.

How is the program doing, Mr. Chairman? The sale of long-term care insurance has increased by over 60 percent, with Partnership policies now constituting almost 40 percent of new long-term care insurance sales in the State of New York. Individuals have shown that given a reasonable alternative that makes sense, they are willing to share the responsibility for their future needs.

Consumers now have information and confidence to make the decisions that are right for them. And more importantly, they know that growing older with the possibility of long-term care does not have to mean poverty, real or artificial.

The Partnerships are not the total answer to financing our long-term care needs. They are an answer, and a start. Demographics and time are not on our side. States and individuals are in crises now. The question is not whether Congress should encourage the States and the public to seek private solutions, but how.

The first step is to recognize that insurance protection against the cost of long-term care has as much benefit to individuals and society as health insurance and should be promoted with the same tax advantages. The second is to allow States the latitude to try alternative methods of financing long-term care by rescinding the OBRA '93 restrictions on the expansion of Partnership programs.

Long-term care is the issue of the 1990's and beyond. The Governments of New York and the other Partnership States are meeting that challenge. Can Washington do less?

Thank you.

[The statement of Ms. Holubinka follows:]

TESTIMONY PRESENTED BY

GAIL HOLUBINKA
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Good morning. Mr. Chairman. Members of the Committee. I am Gail Holubinka, Director of the New York State Partnership for Long Term Care. I wish to thank you for the opportunity to speak before this committee on the issue of financing long term care.

Long term care has become one of the most written about and debated issues in health care today. Financing issues, however, are not usually considered as interesting as other areas and rarely elicit the concern and passionate advocacy seemingly reserved for new services or delivery systems. That should change. For to me and to anyone who has struggled to care for an aged loved one, services, no matter how good or varied, without the means to purchase them is akin to viewing a feast through a window while starving outside. To families attempting to pay for care needed today and care that might be needed tomorrow - the care nearly all of us will need - finding the money is not an intellectual exercise. It is a personal social/fiscal crisis that must be acknowledged and acted on now. That being said, I must also note that as a professional in health care financing, I am well aware of the budgetary limitations government is facing. Therefore, while pleas for government action such as I just made are usually accompanied by appeals for more public expenditure, this request is different. I am here as a representative of a state that has recognized the problem, acted on it, and doesn't anticipate expanding public programs to finance its efforts. How is New York doing it: the Partnership for Long Term Care program.

New York is one of four states - California, Connecticut, and Indiana being the others - with operational Partnership programs. All Partnership programs combine private insurance with Medicaid in order to offer state residents an affordable, attractive alternative to poverty caused by spenddown or the artificial poverty of divestiture. While the exact model used in the Partnership states varies, the essence of each state's program is that the state offers residents a way to avoid impoverishment provided that they purchase special insurance coverage. Concurrently, the state offers insurers who wish to participate assistance in reaching the market provided the insurer meets standards beyond those expected when selling regular long term care insurance. In New York, the special insurance is a policy that covers three nursing home equivalent years of care (two home care days equals one nursing home day). Purchasers who buy, maintain, and subsequently exhaust this private coverage are permitted to apply for Medicaid without regard to the type or amount of assets they may have. However, Medicaid income rules do apply.

Substituting private dollars for public dollars saves limited Medicaid funding. But, the Partnership also means that many elderly will be able to maintain financial independence throughout their lives without the threat of losing their life savings and their dignity. Let me explain.

In New York, the cost of nursing home care ranges from around $60,000 to over $75,000 per year; the average length of stay is 2.5 to 3 years. Multiplying the expected cost of care by the expected length of stay, the fact emerges that even New Yorkers with $200,000 in assets run the risk of Medicaid dependency. Although it seems odd to consider those with such high assets as potential Medicaid recipients, poverty is relative. If all our income and assets do not cover what we need in order to survive, we are poor, regardless of how much we may have started with.

New York realized that the cost of long term care was driving otherwise financially independent persons onto Medicaid. The effect was reflected in state expenditures. In 1994, the cost of long term care under the Medicaid program was over $7 billion; over 80 per cent of all nursing home days in the state were paid by Medicaid; and nearly 60 per cent of patients entering nursing homes were Medicaid at admission. If the state was to reverse this trend, it was necessary to re-examine the state's vision of its role in administering Medicaid. Clearly, Medicaid's concerns could not and should not be limited to the day the formerly middle- and upper middle-class individual applied for assistance; that was too late. If Medicaid dollars were to be spent in the most cost

effective way, attention had to be paid to delaying or avoiding that day. Under a grant from the Robert Wood Johnson Foundation, New York began researching ways to achieve that goal.

Work on the New York State Partnership began in 1988. From the beginning, it was evident that the problem could not be solved by the state alone. Consumers needed a more affordable means of financing their long term care needs and as, the state could not contribute more funding to help them, New York turned to the private insurance market. After all, nearly all other fiscally catastrophic events are handled privately through insurance: why not long term care?

Although initially the public and private sectors were somewhat leery of each other, the decision proved sound for both parties. Governed by Partnership staff research regarding costs, lengths of stay, and spenddown to Medicaid, together the public and private representatives negotiated and designed a program that would provide state residents the most affordable and highest quality insurance possible. Quality was assured through requiring Partnership policies to provide extensive consumer benefits and protection including the unprecedented right of the state's Partnership staff to review all denied claims and the right of the patient to elect binding arbitration (to be paid for by the insurer) if such review indicated the claim may have been denied in error. Affordability was addressed by limiting the duration of coverage needed. That is, the consumer was asked to buy only three nursing home equivalent years of coverage rather than lifetime (a savings of approximately 40 per cent in premium) in order to obtain total asset protection.

With a viable design in hand, the program still faced several obstacles. The Partnership's success depended first on convincing consumers that there was a problem, and second, that insurance was a positive solution. Most people are in denial about the risks of long term care and frankly, suspicious of insurer motives in informing them of those risks. Compounding the problem was the state's concern that only the target population, healthy, middle-class, residents, participate.

Working as partners, the state and insurers created a solution that met everyone's needs. The state would promote the idea: insurers the product. The state and insurers shared the expense of developing uniform, neutral informational material to be used by both sectors. Additionally, the state undertook an extensive education and marketing campaign that advised the public of the need for long term care planning and the advantages and limitations of the Partnership program in meeting that need.

The logical question to ask at this point would how is the program doing? The sale of long term care insurance has increased by over 60 per cent with Partnership policies now constituting almost 40 percent of new long term care insurance sales. New Yorkers are beginning to understand the problem and accept the fact that, for those who can afford to do so, the solution is in their hands. Individuals have shown that, given a reasonable alternative that makes sense, they are more than willing to take personal responsibility for their future needs. Under its Partnership effort, New York has witnessed a minor miracle. With the change in public perception regarding the importance of planning for long term care, the state can look forward to Medicaid savings. Participating insurers have experienced an expended market that is better informed and more accepting of quality coverage. Consumers now have the information and confidence to make the decisions that are right for them, and more importantly, they know that growing older and the possibility of long term care does not have to mean poverty - real or artificial.

Partnerships are not THE answer to financing our long term care needs; they are AN answer and a start. Demographics and time are not on our side. States and individuals are in crises now. The question is not be WHETHER Congress should encourage states and the public to seek private solutions, but WHEN. How? The first step is to recognize that insurance protection against the costs of long term care has as much benefit to individuals and society as health insurance and should promoted through the same tax advantages. The second step is to allow states the latitude to try alternative methods of long term care financing - recind the OBRA 93 restrictions on the expansion of Partnership programs.

Long term care is the issue of the 90's and beyond. The governments of New York and the other Partnership states are meeting the challenge. Can Washington do less? Thank you.

THE

New York State Partnership for Long Term Care

1994 Statistical Report

CUMULATIVE SALES AND PURCHASER INFORMATION
April 1, 1993 - December 31, 1994

March 1, 1995

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Director

Prepared By:
Jacqueline Powell
Steve Nussbaum
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Gregory Belardi

Participating Insurers

AMEX Assurance Companies
Finger Lakes Long Term Care Insurance
The Travelers Insurance
Mutual of Omaha
Teachers Insurance and Annuity Association
AFLAC - NY
CNA Insurance Companies
John Hancock Life Insurance
Metropolitan Life Insurance
New York Life Insurance
John Alden Insurance Company of New York

EXECUTIVE SUMMARY

INTRODUCTION

This is the *Annual Statistical Report* of The New York State Partnership for Long Term Care. The NYSPLTC is a unique program to finance long term care based on the concept of a public-private partnership, linking private insurance to Medicaid. The program became operational on March 1, 1993 when the first group of five insurance companies was approved by the New York State Department of Insurance to market Partnership policies. As of the end of 1994, 11 insurance companies were approved to sell Partnership policies, including two group offerings. Program participation requires insurance companies to submit quarterly data on Partnership policy sales activity. This statistical report is based on an analysis of these data. A more comprehensive analytic paper, the *NYSPLTC Annual Report*, is scheduled for completion later in 1995.

This report provides a statistical overview on cumulative Partnership policy sales from April 1993 through December 1994. Eleven companies marketed Partnership policies during the period: **AFLAC-NY, AMEX Assurance Companies, CNA Insurance Companies, Finger Lakes Long Term Care Insurance Company, John Alden Insurance Company of New York, John Hancock Life Insurance Company, Metropolitan Life Insurance Company, Mutual of Omaha Insurance Company, New York Life Insurance Company, Teachers Insurance and Annuity Association, and The Travelers Insurance Company.**

APPLICATIONS, ISSUES, AND DROPPED POLICIES

From April 1993 through December 1994, the 11 participating carriers received 7,813 applications for Partnership policies. Since the initial quarter of activity, the number of applications received each quarter has remained relatively constant, varying from about 1,000 - 1,500 per quarter. Of the 6,503 applications which were fully processed (i.e., resulted in an underwriting decision) 5,379 (82%) were approved for coverage while 1,128 (18%) were denied, usually for health reasons. Since the initial quarter of activity, the number of approvals (i.e., new policies issued) each quarter has remained relatively constant, varying from 705 - 1,052 per quarter.

Overall, 761 approved policyholders dropped their policies, most commonly during the free-look period (523). Policies dropped during the free-look period generally entail a full refund of all premiums paid. It is estimated that about one-quarter of approved policyholders who dropped their policies during the free-look period (known as NTOs) took out another company's Partnership policy, while another 20 percent of NTO's took out a non-Partnership policy.

ACTIVE POLICYHOLDERS: POLICYHOLDER DEMOGRAPHICS

The number of in-force policies has increased steadily each quarter. As of December 31, 1993 there were 2,165 active Partnership policyholders; as of December 31, 1994 the number of Partnership policyholders rose to 4,618. Of these, 79 percent were first time purchasers, while the remainder consisted of prior policyholders who either replaced their old policies from a different company or converted to a Partnership policy within the same company. The majority of purchasers was female (60%) and married (65%). The age of policyholders at purchase ranged from 25 to 88, with a mean age of 67 years. Nine out of ten policies were sold through the individual market, while the remainder consisted of group contracts (6%) and individual policies marketed through organizations/associations (3%). Geographically, 69 percent of purchasers were from upstate counties; the remainder were from NYC (12%) or one of five Metropolitan counties (19%).

ACTIVE POLICYHOLDERS: POLICY FEATURES AND BENEFITS

The average annual premium cost for all policyholders was $2,183; the average premium for policyholders aged 65-69 who purchased *basic* policies was $1,487. All Partnership policies specify a daily benefit amount (DBA) for nursing home and home care services. Nursing home DBAs were sold ranging from $100/day to $263/day; home care DBAs ranged from $50/day to $263/day. On average, the DBA level selected by purchasers reflects the relative cost of care in their areas of residence.

All Partnership policies waive premium payments when nursing home care is used; about half waive premium payments when home care is used. Almost six out of ten policyholders selected a 100-day deductible; 37 percent chose a deductible of 30 days or less. While most policyholders selected the standard coverage term (3 years of nursing home care/6 years of home care), 100 bought a longer coverage term, including 33 insureds who purchased lifetime coverage. Only 87 persons (2%) bought a non-forfeiture benefit; of these, one-quarter included a *return of premium on death* component. Of the 321 policyholders whose purchase age was 80 or over, 91 (28%) bought optional inflation protection.

NEW YORK STATE PARTNERSHIP FOR LONG TERM CARE

SUMMARY CUMULATIVE STATISTICS ON PARTNERSHIP ACTIVITY SINCE APRIL 1993

APPLICATIONS RECEIVED[a]	7,813
APPLICATIONS PROCESSED	6,503
APPLICATIONS APPROVED	5,379 (82%)
APPLICATIONS DENIED	1,128 (18%) 888 Health/Medical 240 Other
ACTIVE POLICYHOLDERS[b]	4,618
MALE FEMALE	1,830 (40%) 2,788 (60%)
MARRIED NOT MARRIED UNKNOWN	3,016 (65%) 1,430 (31%) 172 (4%)
AGE	67 (Mean) 67 (Median) 25 (Minimum) 88 (Maximum)
1st TIME PURCHASERS CONVERSIONS REPLACEMENTS	3,654 (79%) 791 (17%) 173 (5%)
INDIVIDUAL GROUP ORG. SPONSORED	4,213 (91%) 285 (6%) 120 (3%)
NYC UPSTATE[c]	560 (12%) 4,058 (88%)
POLICIES DROPPED[d]	761 523 Not Taken Up 16 Died 222 Other

a. Includes applications which were withdrawn or are currently pending.
b. Excludes purchasers who dropped their policies as of 12/31/94.
c. Includes 13 policyholders living outside N.Y. State
d. Adjusted for reinstatements

NEW YORK STATE PARTNERSHIP FOR LONG TERM CARE
CUMULATIVE STATISTICS OF APPROVED POLICYHOLDERS (N=4,618) 4

APRIL 1, 1993 TO DECEMBER 31, 1994

DEMOGRAPHICS

AGE RANGE: 25-88

AGE DISTRIBUTION

<=35	36-45	46-55	56-60	61-65	66-70	71-75	76-80	81-85	86+
8	57 (1%)	314 (7%)	461 (10%)	1,069 (23%)	1,256 (27%)	781 (17%)	422 (9%)	242 (5%)	8

DEMOGRAPHIC CATEGORY	COMPOSITION #	Pct.	MEAN AGE
ALL POLICYHOLDERS	4,618	100	67
POLICY CATEGORY			
INDIVIDUAL	4,213	91	68
GROUP	285	6	60
ORGANIZATION-SPONSORED	120	3	64
GENDER			
MALES	1,830	40	67
FEMALES	2,788	60	67
MARITAL STATUS			
NOT MARRIED	1,430	31	69
MARRIED	3,016	65	66
UNKNOWN	172	4	68
PURCHASE TYPE			
UPGRADES (Internal Replacements)	791	17	69
REPLACEMENTS (External)	173	4	66
NEW PURCHASERS	3,654	79	67
GEOGRPAHIC REGIONS			
NEW YORK CITY[a]	560	12	67
DOWNSTATE COUNTIES[b]	886	19	67
UPSTATE COUNTIES[c]	3,172	69	67

a. The five boroughs of New York
b. Metropolitan PMSA counties: Nassau, Putnam, Rockland, Suffolk, Westchester
c. All other counties in New York state.

NEW YORK STATE PARTNERSHIP
FOR LONG TERM CARE

CUMULATIVE STATISTICS OF APPROVED POLICYHOLDERS (N=4,618)

APRIL 1, 1993 TO DECEMBER 31, 1994

POLICY FEATURES

MAXIMUM LENGTH OF NURSING HOME AND HOME CARE COVERAGE

COVERAGE TERM	POLICYHOLDERS #	Pct.
3 Years (Nursing Home)/ 6 Years (Home Care)	4,518	98
5 Years (Nursing home)/ 6 Years (Home Care)	4	0
5 Years (Nursing home)/ 10 Years (Home Care)	51	1
6 Years (Nursing Home)/ 12 Years (Home Care)	12	0
Lifetime	33	1

ELIMINATION PERIOD

DAYS	POLICYHOLDERS #	Pct.
0	233	5
20	1,074	23
30	404	9
60	167	4
100	2,740	59

WAIVER OF PREMIUM

PREMIUM WAIVED	POLICYHOLDERS #	Pct.
Nursing Home	4,618	100
Home Care	2,280	49

NEW YORK STATE PARTNERSHIP FOR LONG TERM CARE

CUMULATIVE STATISTICS OF APPROVED POLICYHOLDERS (N=4,618)

APRIL 1, 1993 TO DECEMBER 31, 1994

POLICY FEATURES

NON-FORFEITURE BENEFIT

NON-FORFEITURE OPTION	POLICYHOLDERS #	Pct.
None	4,538	98
Shortened Benefit Period	6	0
Benefit Bank	41	1
Reduced Paid-Up	21	0
Extended Term	0	0
Return of Premium on Death	19	0

PREMIUM PAYMENT MODE

PAYMENT MODE	POLICYHOLDERS #	Pct.
Monthly	471	10
Quarterly	733	16
Semi-Annual	689	15
Annual	2,725	59

INFLATION PROTECTION STATUS FOR AGE 80 AND OVER*

INFLATION STATUS	POLICYHOLDERS #	Pct.
None	230	72
5% Compounded	91	28

* New York State Partnership for Long Term Care requires a minimum rate of inflation protection of 5% compounded annually for all Program participants under age 80.

NEW YORK STATE PARTNERSHIP FOR LONG TERM CARE

CUMULATIVE STATISTICS OF APPROVED POLICYHOLDERS (N=4,618)

APRIL 1, 1993 TO DECEMBER 31, 1994

POLICY FEATURES

MAXIMUM NURSING HOME DAILY BENEFIT

RANGE: $100–$263
MEAN: $128
MEDIAN: $110

MAXIMUM DAILY BENEFIT* ($)	POLICYHOLDERS (#)	Pct.
$100-$105	1,784	39
$110-$115	621	13
$120-$125	413	9
$130-$135	201	4
$140-$145	167	4
$150-$155	685	15
$160	320	7
$170-$175	59	1
$180	50	1
$190	21	0
$200	130	3
$210-$225	129	3
$230-$240	12	0
$250-$265	26	1

* New York State Partnership for Long Term Care requires a minimum Nursing Home Daily Benefit Amount of $105 in 1994 and $110 in 1995.

NEW YORK STATE PARTNERSHIP
FOR LONG TERM CARE

8

CUMULATIVE STATISTICS OF APPROVED POLICYHOLDERS (N=4,618)

APRIL 1, 1993 TO DECEMBER 31, 1994

POLICY FEATURES

MAXIMUM HOME CARE DAILY BENEFIT

RANGE: $50–$263
MEAN: $68
MEDIAN: $60

MAXIMUM DAILY BENEFIT* ($)	POLICYHOLDERS (#)	Pct.
$50-$53	1,728	37
$55-$58	442	10
$60	379	8
$65	232	5
$70	153	3
$75	665	14
$80-$99	458	10
$100-$105	409	9
$110-$263	152	3

* New York State Partnership for Long Term Care requires a minimum Home Care Daily Benefit Amount of $52.50 in 1994 and $55 in 1995.

NEW YORK STATE PARTNERSHIP FOR LONG TERM CARE
CUMULATIVE STATISTICS OF APPROVED POLICYHOLDERS (N=4,618) 9

APRIL 1, 1993 TO DECEMBER 31, 1994

AVERAGE (MEAN) POLICY PREMIUMS

AGE RANGE	ALL	#	BASIC	#	POLICY TYPE OPTIONAL	#	BASIC+	#
ALL AGES	$2,183	4,618	$1,960	999	$2,237	3,519	$2,483	100
25-34	$420	7			$420	7		
35-39	$355	8	$236	4	$474	4		
40-44	$659	37	$542	3	$639	32	$1,158	2
45-49	$853	70	$472	7	$805	58	$1,951	5
50-54	$956	190	$658	26	$961	149	$1,415	15
55-59	$1,074	396	$794	63	$1,122	325	$1,318	8
60-64	$1,430	919	$1,143	184	$1,492	710	$1,788	25
65-69	$1,841	1,303	$1,487	280	$1,921	997	$2,583	26
70-74	$2,670	888	$2,177	193	$2,773	682	$4,584	13
75-79	$3,879	479	$3,228	133	$4,125	345	$5,528	1
80+	$4,486	321	$3,862	106	$4,777	210	$5,498	5

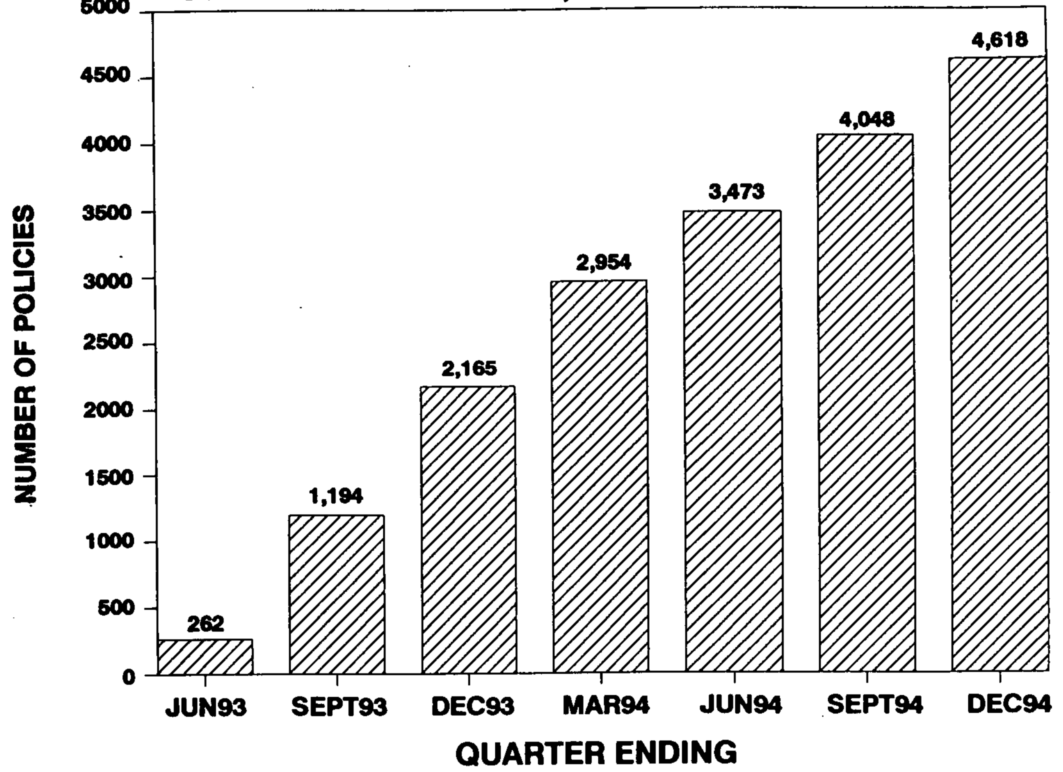
BASIC: Basic policy includes the following policy features:

1) 3 years of nursing home care ($100 daily benefit for 1993, $105 for 1994, 110 for 1995);
2) 6 years of home care ($50 daily benefit for 1993, $52.50 for 1994, $55 for 1995);
3) inflation protection at the annual rate of 5% compounded;
4) 100 day elimination period;
5) no non-forfeiture benefit; and
6) all other benefit standards defined in New York State Insurance Department Regulation No. 144 (11 NYCRR 39). Enriched benefit coverage may be provided if there is no or minimal (2% or less) premium impact from the premium cost without such enriched benefits.

OPTIONAL: Optional policy includes the following policy features:

1) 3 years of nursing home (minimally $100 DBA for 1993, $105 for 1994, $110 for 1995);
2) 6 years of home care (minimally $50 DBA for 1993, $52.50 for 1994, $55 for 1995);
3) inflation protection minimally at the annual rate of 5% compounded;
4) up to 100 day elimination period; and
5) at minimum, all other benefit standards defined in New York Insurance Department Regulation No. 144 (11 NYCRR 39).

BASIC+: Basic+ policy is defined as policies offering benefit coverage beyond those provided by Basic and Optional policies.


TOTAL POLICIES IN-FORCE,
CUMULATIVE BY QUARTER, APRIL 1993 - DECEMBER 1994
NUMBER OF POLICIES
5000
4500
4000
3500
3000
2500
2000
1500
1000
500
0
262
1,194
2,165
2,954
3,473
4,048
4,618
JUN93
SEPT93
DEC93
MAR94
JUN94
SEPT94
DEC94
QUARTER ENDING

Number of Policies Purchased, By County* (as of 12-31-94),

New York State Counties

* Counts exclude lapsed policies

Total number of policyholders living in N.Y. state=4,605

Total number of policyholders living out-of-state= 13

The CHAIRMAN. Thank you very much. I have just a few questions to ask the panel.

Dr. Wallack, you suggested a number of things. Number one, when you said leadership coming at the Federal level, namely I assume you meant in the financing aspect as well, not only educational, that Medicare does not and should not provide certain types of benefits, cannot afford to do so, but it must provide financing of these tax incentives, I would assume, to treat them like health care policies, deductibility and so forth. That would be part of the leadership, I assume.

Mr. WALLACK. Yes.

The CHAIRMAN. Along with establishing Federal regulations. Dr. Moon raised the issue of mandatory non-forfeiture provisions. Is there a cost factor that would make it more expensive and therefore less of an incentive for people to acquire. I'll ask you, Dr. Wallack, and then Dr. Battista, and then so on.

Mr. WALLACK. Clearly, the first issue to address is that people have different needs. Marilyn said she would buy a policy with different criteria. I would personally buy a policy with other kinds of criteria. Marilyn, for example, said inflation is very important. I do not believe it is. Long-term care insurance has these two components. It has this insurance part, it also has a savings part.

I would rather invest in other assets. You get a higher rate of return, and have the money. To insure against inflation, raises significantly the price of the product. So, you have to make a decision that is a very personal decision based on your financial planning.

With regards to nonforfeiture, I would buy a policy that had nonforfeiture. I agree with Marilyn. But I think the important point is that it would raise the price. The price would increase more for younger ages because there are more savings involved. As you get older, the cost of nonforfeiture is less.

The note that was given to me is that on average it is 30 percent increase in premiums for including nonforfeiture, because you are saving more. On average it would add 30 percent to the price. But for a younger person, it may add 200 percent. It goes back to what you want. A benefit of the private market is choice. Insurance is only one way to save for your retirement. We believe in the Coalition that inflation should be a mandatory offer; nonforfeiture should be a mandatory offer. Whether people want them is a personal decision.

We have to recognize that people can make good choices for themselves. We have heard it today. My in-laws tell me what to do all the time. They can make good decisions, but they have to be able to do that.

The CHAIRMAN. Dr. Moon, I think you indicated, or at least implied, that in order for a good insurance policy, it would have to be quite expensive. I didn't gather that from the prior panel. They felt it was quite reasonable. Mrs. Heintz did not take advantage of the inflation factor. I don't believe Mr. Spear did either. I don't believe there were any mandatory nonforfeiture provisions in either of their policies, and yet they seemed quite happy.

I gather from your statement, that you would think that these two key provisions have to be in there, and that would necessarily make them more expensive, and then that raises another issue. If

that makes it more expensive, how attractive does it become. You find yourself in one of these Catch-22, or if I get back into mythology, Priscilla and Carubdus. We get caught between the two rocks in trying to navigate our way through, in trying to encourage people to actually purchase more insurance. Yet, we raise the price so high that we have a disincentive for them to do it. Therefore, we shift the burden back to the Federal system, which is being depleted of its resources as we speak.

Do these two key provisions have to be there in order for it to be a good policy? Or, is it simply as Dr. Wallack is suggesting, you have to at least offer them the choices, then it is up to the purchaser at that point?

Ms. MOON. At a minimum there should be a mandatory offering of those adjustments. First, there have to be some standards for the marketing. My major fear is that people will see these products, in some cases, as too inexpensive, and be encouraged to buy them, when it may be foolish for them to do so. If someone is aged 50, and purchases a plan that has no inflation protection, and no nonforfeiture protection, and then their spouse develops a major acute illness which causes them to give up on their long-term care insurance after 15 years, they will have lost any protection despite paying in for many years.

Similarly, if there is a lot of inflation, they will end up being unable to take advantage of this particular benefit. If the insurance won't pay the cost of their nursing home protection and they don't have enough other resources to supplement it, they will still end up on Medicaid.

One of my concerns is that we not go so far in trying to encourage people to buy insurance that we get them to foolishly buy a cheap plan. I would like to see moderate income people not buy these policies if it is going to be unwise for them to do so.

There should be a balance. But in the enthusiasm to push these products we may encourage those who probably aren't the right people to buy insurance. If you spend money now on buying long-term care insurance, and you never end up saving any assets to protect later on, then this is not a valuable benefit for you.

The CHAIRMAN. Well, in the bill that I have introduced, I would make it mandatory for the insurance companies to offer the nonforfeiture, and to offer inflation protection. It would then be up to the individual to choose whether he or she wanted it. It also allows for the States to determine whether or not it should be included on a mandatory basis. So, it gives the option for both the individual and the States to make that determination, in terms of the policies being marketed in that particular State.

Dr. Wallack.

Mr. WALLACK. I just want to provide a fact that I think supports what you just said about the effectiveness of offering choices. Roughly 50 percent of the people buy inflation protection today. Half of them do, and half of them don't. It is the kind of a decision being made out there. People do differ, even when they are educated and faced with choices.

The other point is that the average person spends $100, and that is what they are spending a month for a policy—I mean the 68-year-old spends $1,200 a year—they look at their budget and de-

cide what they are willing to spend. If, in fact, they have $100 to spend, and they have to buy inflation, they will end up with less benefits of protection for the next 10 years. It is really this calculation that is very personal, what people have, what their assets are. You have to look at trade-offs. It isn't like you are just going to add inflation in. You are going to reduce something else, which may have more value.

The CHAIRMAN. Dr. Battista, could you explain UNUM's per diem? Tell me how that differs from the per diem from either a reimbursement policy or an annuity. Why is this different or better?

Dr. BATTISTA. The real discussion has been between the so-called reimbursement model and the per diem, which is also called the indemnity model in a lot of circles. The comment that you made that sometimes the indemnity model or the per diem model could be thought of as an annuity, I'll just start with that.

Any of these policies have a disability trigger. Long-term care is a disability risk, by its nature. The trigger is lost functional capacity. Every carrier uses a disability assessment process to determine whether the person is eligble for benefits. They have to lose two out of six activities of daily living before they can even be eligible for these policies. That is a lot of functional loss. You have to be sick. So, it is not like people are going to buy these kinds of policies and use it as a savings plan. It just doesn't happen.

In terms of the difference between the two models, UNUM does use a per diem, or an indemnity, approach. Here is how they work, basically, compared to the reimbursement model. Assume the coverage is $3,000 per month, as an average policy, for being in a nursing home. That means that if a person is disabled in two out of six ADLs, and they are in a nursing home, and they file under a per diem or indemnity policy; they get $3,000 a month. They then take that $3,000 and they go to the nursing home, and ask, "What is the charge for the month?" The nursing homes says, "It is $2,700." They give the nursing home $2,700, and they keep $300, which they can then use to pay for medications, or other personal care needs, that might be covered, or might be out-of-pocket costs not covered by other programs.

Under a reimbursement policy—and remember, all we are talking about is how the benefits are paid—the difference is that they would get $2,700, even if the policy amount was still $3,000. They would only get $2,700, which is the actual charge. The reimbursement model would pay the face amount or the actual charge, whichever is less. The other relatively less important difference is simply that there is probably less administrative hassle for the individual under the indemnity, or so-called disability model, or the per diem model, because literally they just have to prove their eligibility, and they get their check. They don't have to go with vouchers, and show that they have received specific services, and we don't have to track those services.

The CHAIRMAN. Ms. Holubinka, could you tell me, what were the expectations for the State when you entered into this Partnership in terms of savings? What were the expectations, and what were the realizations?

Ms. HOLUBINKA. In terms of the realization, we have only been selling for 2 years. We are going here by common sense. When we

did studies of who was on Medicaid, we found that 60 percent of the people entering nursing homes were Medicaid at admission. That is not rational. We've been accused of using anecdotal evidence, but I think you can use your common sense about this. Five years ago there were eight elder law attorneys in the State of New York. Today there are 2,000. I can pick up any newspaper in the State of New York, and find myself a seminar on Medicaid planning.

But to tell you how many people are divesting, that is almost impossible. I know that there was a contract with Brian Burwell to study that. But we do know there is a problem.

We are looking forward to minimally, at least cutting, really conservatively, 1 percent from our budget. Since long-tern care in New York State is over $7 billion, now, and growing at a rate of 10 percent a year, even 1 percent looks very good to us.

The CHAIRMAN. I am not sure you are aware of it, but you mentioned that we have to have some relief from OBRA 1993, and the bill that I have introduced allows that.

Ms. HOLUBINKA. Yes, I know.

The CHAIRMAN. We are on the same track in terms of allowing these kind of strong partnerships between the State and the private sector.

We could go on with this, but I have to keep my eye on the clock. All your testimony, your printed remarks will be entered in the record. It becomes clear from this panel and the previous one, that we do have to strike a balance. We do have to have Federal leadership in this area. It has been absent. There has been virtually no discussion.

Even when we talked about last year's health care plan, offered by President and Mrs. Clinton in the Senate, most of the debate focused upon health care coverage, but very little of that attention was focused on long-term care. When we look at the proposals that have been introduced for long-term care coverage at the Federal level, which I believe, Dr. Wallack, you would see is one of the major impediments to the private sector, really getting actively and aggressively involved, the minimum figures are roughly $45 billion over a 5 year period of time. I expect the costs will go up substantially beyond that.

That is not likely to take place, given the environment in which we live. So we have to find a way in which we can structure some kind of a balance, where in fact the Federal Government does take the lead, does take a leadership role in educating our populace, of encouraging the private sector to get involved, but also to make sure that people who cannot afford to purchase long-term care insurance no matter how low it comes are still provided with good comprehensive coverage. We have to strike that balance and make sure there is financing available to care for those who won't be in that position.

I thank all of you for coming. This is the first of what I hope will be a series of hearings. The health care debate may be off the radar screen temporarily but it cannot remain there very long. We have to get back, and discuss in a very active and aggressive way changing our health care system, because more and more people are still

going without coverage. The numbers are increasing each year, and the impact upon society is dramatic.

So we have to deal with health care reform, and we have to include long-term care as an integral part of that health care reform. It has to start taking place now, and not wait until next year, or after the next election. We ought to be doing it right now. Hopefully, this hearing will stimulate some debate and some concerted interest. I thank all of you for coming.

We now have our final panel. Our last panel includes Paul Willging, executive director of the American Health Care Association; and Val Halamandaris, president of the National Association for Home Care, who will discuss how service providers view the potential of the private market to finance long-term care expenses. Finally, we will hear from Stephen McConnell, who is chairman of the Long-Term Care Campaign. He represents a coalition of over 100 national organizations with interests in long-term care, and will discuss his membership's view of the crisis in the long-term care system.

We look forward to having all of you with us today to provide your testimony. Whatever you don't finish in the way of the 5 minute mark, be assured that your complete statements will be included in the record.

Dr. Willging.

STATEMENT OF PAUL WILLGING, EXECUTIVE VICE PRESIDENT, AMERICAN HEALTH CARE ASSOCIATION, WASHINGTON, DC

Mr. WILLGING. Thank you, Mr. Chairman. It is a pleasure to be with you today. I am the executive vice president of the American Health Care Association, which represents 70 percent of the Nation's institutional long-term care facilities.

I gather I am here because I do represent an industry that is, one, heavily dependent on public funding, and two, doesn't want to be. Therefore, we commend you for your own personal interest in stimulating private involvement and private resources in the area of long-term care, particularly as reflected in the Private Long-Term Care Family Protection Act of 1995. Almost all of which we support very strongly.

I don't have to repeat what you know so very well, Mr. Chairman, as does everyone in this town, dealing with long-term care and the Medicaid program. It is moving rapidly toward fiscal meltdown. It cannot be sustained as it is currently growing, at 10 percent per year. It is impoverishing States. It is impoverishing those who need the services provided under Medicaid. It is impoverishing providers as they attempt to furnish quality services to their residents, and to their patients.

My concern, however, is that the solution to this problem being discussed for the most part today in Washington, D.C., is more an attempt to dismiss it, to devolve it on the States, rather that to deal with the problem. I am speaking, of course, of block grants.

We tend to forget sometimes that there is not one Medicaid program, but two Medicaid programs. They happen both to be housed under Title 19 of the Social Security Act, but they deal with separate services, provided to separate populations.

We have on the one hand, the population of AFDC families, mothers, and children receiving for the most part ambulatory and acute care services in the health care arena. On the other hand, we have a totally different population, the elderly and the disabled, receiving a different type of service for the most part, namely long-term care services, be it nursing facilities, be it home care, or be it ICFCMR.

We suggest it is a terrible mistake to block grant both of those programs. There may indeed be the efficiencies possible through greater flexibility with respect to managed care in the acute care sector, but we doubt very much that those same efficiencies are available in the long-term care setting. Indeed, of the States that have received waivers to experiment with just those types of flexibilities, none of them have brought long-term care into it, because we don't know if those managed care concepts work, or if they are even applicable.

There is a more serious problem with block granting the long-term care portion of Medicaid. It further fragments an already fragmented long-term care system in this country, a system that should be one of the three major pillars of support for the elderly, along with Social Security and Medicare. Long-term care—as a previous witness suggested—is one of the basic unfunded liabilities in terms of the needs of America's senior citizens. I think we want to coordinate those three pillars better, not fragment them.

AHCA would suggest a different approach. We would suggest that we not ship the long-term care portion of Medicaid off to the States. We would suggest it be better coordinated with those other two pillars of support in Washington, D.C., but with a major, major difference. I will use the word, and I will use it without any concern; we would means test the program.

There is no question that we have to do a better job of bringing into a public/private long-term care partnership the private sector, people's own resources, their own responsibilities. This program we are talking about, if it is pulled out of a block grant, would clearly be means tested. We would be very rigorous in the area of asset transfer. I found interesting the recent report by the Heritage Foundation, which suggested, also agreeing with us, one should not block grant long-term care portion of the Medicaid program, and also that there were major savings to accrued from a much more rigorous approach to asset transfer. They suggested $5 billion per year, which even in Washington, gets beyond small change.

I think also we have to look at much more in the way of individual family responsibility in this program. We are talking, obviously, about cost sharing, perhaps even family supplementation, where that can be worked out appropriately.

Finally, and I think most critical, on long-term care insurance—I agree wholeheartedly with Stan Wallack, we need to exert some leadership, as you already have exerted in this field. We have to push it.

I am always amazed at those who suggest there has really not been such a phenomenal growth rate in long-term care insurance. How can anything be such a phenomenal growth rate when we, at the Federal level, have done nothing to stimulate it? I am amazed that still today, if you believe the figures put together by the Em-

ployee Benefits Research Institute, that 44 percent of Americans thing Medicare will provide a long-term care coverage. I mean Medicare, which really provide any coverage at all to speak of in a long-term care institution.

Clearly, education is one thing the Federal Government could do at no additional cost. Education is important. I wonder what we would see happen in the area of long-term care insurance, if with those Social Security checks, an indicator went out to the recipient saying, "Did you know that you have a basic unfunded liability."

I think consumer protection is important. We as an association have long supported a basic consumer protection as a part of long-term care insurance legislation. I agree again with Dr. Wallack that you can protect people to the point that the policy is no longer affordable. I strongly believe that inflation protection and nonforfeiture should be a mandated offer, but I agree with Stan; why do we choose to let the Government make the decisions as to whether we eventually accept that offer? We do all have personal views. We should be allowed to express them in our own personal choices.

Finally, tax clarifications. Again, I am being very repetitive, because so much has been said by those who spoke before me, but I think what we are talking about in terms of tax clarifications is an insignificant amount of money, compared to the potential savings.

In a nutshell, yes, we have to deal with this catastrophe that is facing us in terms of the fiscal meltdown of Medicaid, but it can be done. It can be done to the best interests of the elderly, while at the same time preserving scarce Federal and State funding for those who truly need it.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Willging follows:]

AMERICAN HEALTH CARE ASSOCIATION

Planning Ahead: Future Directions in Private Financing of Long Term Care

Testimony

before the

Senate Special Committee on Aging

May 11, 1995

Paul Willging, Ph. D.
Executive Vice President

Mr. Chairman, Members of the Committee, I am Paul Willging, Executive Vice President of the American Health Care Association (AHCA). AHCA is a federation of 51 affiliated associations that represent more than 11,000 for-profit and non-profit nursing facility, assisted living, and subacute care providers nationwide. Our members care for more than one million elderly, frail, and/or disabled residents. On behalf of AHCA's members, and the residents of our member facilities, thank you for the opportunity to speak at this important hearing.

AHCA has long supported private long term care insurance as a means to increase the proportion of nursing facility residents not dependent on Medicaid. For the past several years, AHCA has worked as part of a coalition of long term care insurers and providers, the Coalition for Long Term Care Financing, to promote appropriate federal standards for long term care insurance; for legislation that would clarify the federal tax status of private long term care insurance; and for other steps to begin to shift the long term care cost burden from Medicaid to private insurance.

AHCA supports the provisions of the Chairman's "Private Long-Term Care Family Protection Act of 1995" that would help Americans plan for and prepare to meet the costs of long term care. We look forward to working with you, Mr. Chairman, and others to secure the enactment of its key provisions.

My testimony will emphasize AHCA's position that:

- the private sector must play a much more significant role in supporting long term care;
- private long term care insurance can be the cornerstone of strong private/public partnership; and
- legislation to clarify the federal tax treatment of long term care insurance -- and other legislative steps -- will help establish a significant role for private long term care insurance in financing long term care.

THE NEED FOR CHANGE IN LONG TERM CARE FINANCING

Our society has not made adequate provision for financing the costs of long term care. Individuals and families are not saving for, or insuring themselves against, the costs of long term care. The federal/state Medicaid program is stretched to the breaking point. Families and governments are going broke.

Without action to address these problems, our growing elderly population will come to rely much more heavily on Medicaid to pay for long term care. In 1993 Medicaid accounted for approximately 52 percent of all long term care payment -- and about 69 percent of all nursing facility residents -- in the United States. If current trends continue unchecked, Medicaid will be burdened with an ever increasing share of the nation's long term care costs as the baby boomers reach retirement. But these current trends cannot continue. Federal and state budgets -- already strained badly by current Medicaid long term care obligations -- cannot bear such costs. Nor would the elderly be well served by an overwhelmed Medicaid program.

February 1993 Gallup Organization survey results indicated that 76 percent of Americans agree that "government should pay the cost of nursing home care only for those who cannot afford it." In order to meet the nation's growing long term care needs without both emptying the public purse and sacrificing quality of care, our society cannot afford to rely solely on government. Instead we must encourage and enforce an expectation of personal responsibility on the part of those with the means to plan for and pay for potential long term care costs. Government can -- and must -- help in this effort by working to see that individuals have the information and resources needed to accept responsibility for meeting their own long term care needs.

LONG TERM CARE COSTS ARE IMPOVERISHING SENIOR CITIZENS

Most elderly Americans are unaware of the magnitude of long term care costs and of the limits of government assistance. Most Americans do not foresee needing long term care. Most probably do not realize how costly months or years of long term care can be. Many Americans wrongly assume that government programs or their general health insurance will cover the costs of any long term care services they might need. For all these reasons, individuals and families face long term care costs for which they have not planned and which they cannot afford.

The cost of long term care can quickly wipe out the assets even of those who have worked and saved for a lifetime. The cost of one year of nursing home care is more than triple the average annual income for an elderly American. Eighty percent of all health care expenditures for the elderly in excess of $2,000 per year are for nursing home care. But the nation's current long term care policy does not promote personal planning, saving, or the purchase of insurance against the financial risk of long term care costs. Nor does our nation provide comprehensive social insurance against the financial catastrophe of long term care costs. Only after a long term care recipient has been impoverished does government assistance become available through Medicaid -- a "welfare" program.

MEDICAID IS IMPOVERISHING THE FEDERAL AND STATE GOVERNMENTS

According to the Health Care Financing Administration (HCFA), total Medicaid payments (state and federal) have tripled over recent years -- from $54.5 billion in fiscal year 1989 to a projection of almost $160 billion in fiscal year 1995. At the current rate, the program would grow at 9.8 percent annually through the year 2000.

The countless court battles over Medicaid reimbursement, and the protracted battle over "provider specific taxes" well illustrate the strain that Medicaid is putting on state and federal resources. This strain jeopardizes the availability and quality of both acute and long term care for those who must depend on Medicaid. Clearly, if current long term care needs have stretched federal and state budgets to their limits, the future needs of a burgeoning population of elderly Americans will overwhelm our current arrangements for long term care financing. Therefore, the nation must look to sources other than government for additional resources to meet future long term care needs.

We believe that long term care financing legislation should have the following goals:

- providing appropriate access to the full continuum of long term care services;
- ensuring that all Americans have the means to meet the cost of long term care;

- moving individuals and families away from dependence on government welfare programs for long term care financing; and
- addressing the nation's long term care needs in a fiscally responsible way.

Fostering a robust long term care insurance market is key to meeting these long term care reform goals.

THE ROLE OF PRIVATE LONG TERM CARE INSURANCE

Results from a March 1993 Gallup Organization survey indicate that 79 percent of Americans agree that "to keep government costs as low as possible, private insurance should play a more active role in paying for nursing home bills for most Americans."

Private insurance, so useful in protecting individuals and families from the financial risk of acute illness, has great potential also for marshaling private sector resources to meet long term care costs. Insurance offers a very good means to preserve an individual's choice from among various long term care arrangements and competing providers. Its expanded use would make an appropriate private/public long term care partnership viable. It has great potential for lessening the long term care cost burden that the graying of America will otherwise put on the American taxpayer.

To date, private insurance accounts for less than two percent of all payments for long term care services. AHCA is confident, however, that with appropriate changes in federal policies private long term care insurance can and will take on a larger role in meeting long term care costs. AHCA is looking 15 to 20 years into the future to a time when private long term care insurance will represent 15% or more of payments for long term care services. In order to reach such a future, however, we must take steps now.

FEDERAL TAX TREATMENT OF LONG TERM CARE INSURANCE

AHCA's members feel strongly that, with the right federal policies, private long term care insurance can become the centerpiece of a private/public long term care partnership that would help families, states, and the federal government meet the costs of long term care. Therefore, we strongly support the provisions of the Private Long Term Care Family Protection Act that would foster the development of the private long term care insurance market and increase private sector resources available to meet the costs of long term care. Specifically, AHCA supports the tax clarification provisions of the legislation that would:

- clarify that qualified long term care services are treated as medical expenses;
- allow long term care insurance premiums to be deducted as medical insurance subject to the 7.5 percent of adjusted gross income floor;
- clarify that employer-provided long term care coverage is deductible as a business expense and excluded from employee income;
- exclude long term care insurance benefit payments from income;
- clarify that an accelerated death benefit received by a terminally ill person is excluded from taxable income; and
- permit tax-free early withdrawals from Individual Retirement Accounts (IRA) for the purchase of a long term care insurance policy.

FEDERAL STANDARDS AND CONSUMER PROTECTIONS

Appropriate federal standards and consumer protections for long term care insurance would inspire consumer confidence; foster the growth of the private long term care insurance market; and ensure that elderly consumers are spared the problems that once plagued the "Medigap" insurance business. As long term care providers, AHCA's members do not benefit from private insurance policies that provide inadequate coverage. Nor do providers benefit from sales practices that lead individuals to purchase inappropriate policies or policies that they cannot afford to pay for. Accordingly, AHCA supports federal standards to ensure appropriate policy design and sales practices.

At the same time, providers and the elderly cannot benefit from private insurance policies priced out of the reach of consumers by federal regulation that is too heavy-handed. Therefore, AHCA recommends that proposed federal standards be balanced by considerations of affordability. Congress needs to consider carefully the trade-off between the value of a policy feature and the cost to consumers of mandating that feature.

AHCA strongly supports the federal standards and consumer protection provisions of the Private Long Term Care Protection Act. The balanced and thorough federal standards and consumer protection provisions of this legislation would help ensure that long term care policies offer value to consumers and that policies would pay appropriately and adequately for quality long term care when needed.

PRIVATE/PUBLIC PARTNERSHIPS FOR LONG TERM CARE

Working with the Robert Wood Johnson Foundation, Connecticut, New York, Indiana, and California have established private/public long term care partnerships that encourage the purchase of approved long term care insurance policies by offering purchasers enhanced asset protection under the Medicaid program. Generally, under such a partnership program, if a long term care insurance purchaser requires long term care and eventually exhausts his or her insurance benefits, the state will raise the Medicaid asset eligibility threshold by the amount of the long term care coverage purchased.

In a number of states, there is considerable interest in establishing private/public partnerships along the lines of those already underway in Connecticut, New York, Indiana, and California. However, the Omnibus Budget Reconciliation Act of 1993 (OBRA '93) included provisions [Section 13612 (a) (C)] that discourage states from implementing such partnerships. Specifically, these provisions require states to make recovery from the estates of those who had enjoyed enhanced Medicaid asset protection. That is, these provisions make a partnership's asset protection only temporary.

AHCA supports the provisions of the Chairman's long term care legislation that would allow additional states to establish "asset protection" programs for individuals who purchase qualified long term care insurance policies, without requiring states to recover such assets upon a beneficiary's death.

IMPACT OF LONG TERM CARE INSURANCE ON MEDICAID SPENDING

Publishing in Health Affairs in the Fall of 1994, Marc Cohen, Nanda Kumar, and Stanley Wallack estimated that having a long term care insurance policy reduces the probability of spending down to Medicaid eligibility levels by some 39 percent. The authors estimate that, in the aggregate, Medicaid expenditures would be reduced by $8,000 to $15,500 for every nursing home entrant who had a long term care insurance policy. According to the analysis of Cohen, Kumar, and Wallack, this translates into cutting what Medicaid pays per nursing home entrant in half for long term care purchasers.

AHCA hopes that when the Congress considers the tax expenditure cost of conferring the same federal tax treatment on long term care insurance that accident and health insurance already enjoys, Congress will also consider the great potential for private insurance to decrease Medicaid spending over the long run. Action today can plant the seeds for significant savings in state and federal long term care spending tomorrow.

LONG TERM CARE CONSUMER EDUCATION

A public opinion survey conducted for the Employee Benefit Research Institute in the summer of 1994 found that 45 percent of respondents believe that Medicare pays for long term care. This means that even after nearly 30 years of Medicare, many beneficiaries are in for a rude awakening should they need long term care coverage.

AHCA supports the provisions of the Chairman's legislation that would promote awareness on the part of senior citizens and their families of the potential costs of long term care, the limits of current public long term care assistance, long term care insurance options, and of information necessary to be a smart long term care insurance consumer. In addition, AHCA suggests that the federal government's Medicare and Social Security beneficiary information mailings could include long term care insurance consumer information. At the least, the use of Social Security and Medicare beneficiary information could provide the public service of correcting the widespread belief that Medicare covers long term care.

PROPOSALS TO "BLOCK-GRANT" MEDICAID

The U.S. House of Representatives and the U.S. Senate are just now beginning in earnest the annual congressional budget process. Although this Congress fell short of passing a balanced budget constitutional amendment, House and Senate Republicans are ready to push ahead with aggressive efforts to bring the federal budget into balance by the year 2002. Because of the size of Medicare and Medicaid expenditures, their rate of growth, and the politics that remove other budget balancing measures from the table, bringing the budget into balance requires unprecedented cuts in Medicare and Medicaid.

The House and Senate Budget Committees are working on budget proposals that call for savings in Medicaid of $150 billion or more over a seven year period. These budgets are based on assumptions that incorporate the idea of block-granting Medicaid to the states and limiting the annual growth in federal funding to a figure well below recent growth -- the Senate Budget Committee would limit growth in federal funding to 4% annually. The idea is that states can do more with less -- if only Washington would get out of the way. States would have less federal funding but more "flexibility" to meet the health and long term care needs of the poor. BUT:

- "Flexibility" really means managed care. However, states cannot expect managed care savings from the long term care component of Medicaid -- 37% of Medicaid spending (1993 number).

- The elderly population will rise dramatically in the coming decades. States would be overwhelmed by the demographic tidal wave of those who will be senior citizens in the decades to come.

- When the combination of health care inflation, population growth, and the increased acuity of long term care recipients outstrip the annual cap -- which they surely would -- states would have to cut people out of the program; ration services; or diminish quality of care.

Block-granting Medicaid long term care would:

- undo the progress of the nursing home reforms of OBRA '87

- reduce government funding for the nation's elderly

- end federal assurances of adequate reimbursement for quality long term care

- guarantee a mismatch between state fiscal capacity and a growing elderly population's need for long term care and

- inevitably lead to denial of adequate and appropriate long term care to the frail elderly.

A BETTER IDEA FOR LONG TERM CARE

Congress can provide elderly Americans with long term care coverage without making them poor -- and without pushing responsibility for long term care onto the states under an arbitrary growth limit. Instead, Congress can meet the crucial needs of the elderly through an enhanced private public partnership based on private long term care insurance.

The nation created **Medicare** because Americans did not think it was right to let the costs of care for sickness or injury bankrupt senior citizens after a lifetime of work, taxpaying, and self-sufficiency. Yet **Medicaid** requires that those who have worked and paid their own way for a lifetime must lose everything before they can get help with long term care. It is a welfare program. It is time to change this -- to move long term care from welfare to health care. By relying on private long term care insurance, Congress can transform Medicaid long term care without increasing federal budget deficits.

Instead of block-granting Medicaid long term care to the states, Congress should:

- maintain a strong federal role in long term care;

- integrate long term care and Medicare's acute care coverage;

- establish the strongest possible incentives to get Americans to plan for, save for, and insure against long term care costs;

- set income-related cost sharing that would target government assistance to those most in need AND prompt those who can afford it to insure against long term care costs; and

- give the Secretary of Health and Human Services the authority to phase in new coverage only as means are found to offset their costs with budget savings or revenues.

Moving long term care from a "welfare entitlement" to a federal "health insurance" benefit would:

- end the requirement that the elderly impoverish themselves to get long term care help;
- remove the stigma attached to long term care recipients;
- facilitate the creation of a "seamless" web of care for the elderly;
- make things easier for beneficiaries to understand;
- simplify administration and eliminate multiple layers of government;
- facilitate coordinating private long term care coverage with government coverage; and
- reduce dependency on government funding.

CONCLUSION

Fiscal necessity and pragmatism clearly show that government cannot continue to bear an increasing financial burden of long term care. Private sector ways and means must be harnessed in partnership with public programs and resources.

AHCA is pleased that this Committee is considering import questions bearing on the future of long term care financing. The Chairman has drafted a thorough and comprehensive bill for marshaling the private sector resources that the nation will need to pay for its future long term care needs.

Thank you for including us in your deliberations.

The CHAIRMAN. Thank you very much, Dr. Willging.
Mr. Halamandaris.

STATEMENT OF VAL J. HALAMANDARIS, PRESIDENT, NATIONAL ASSOCIATION FOR HOME CARE, WASHINGTON, DC

Mr. HALAMANDARIS. Thank you, Senators. That is a long name, and it tends to throw some people. I am delighted to be here with you.

I, too, would like to begin by commending you for your bill. It shows great intelligence, and it shows great leadership on your part. We want to support it very vigorously. Your recognition of using the Tax Code in order to make social policy is crucial. What we are doing in our Tax Code at the present time, i.e., encouraging spend down, is absolutely an outrage. We should not allow that as a matter of public policy.

As you remember, Mr. Chairman, I served this Committee for 15 years as a staff member and counsel. Then the Pepper Committee, where you served also, for 5 years. I sometimes get enthusiastic when I speak, and I don't want that to come off as appearing like I know all the answers; I don't. It is amazing how much you can learn if you listen to people. So, if you will forgive me for my enthusiasm, I do feel passionately about this issue.

Long-term care, as was said by the previous witness from UNUM, is the biggest unfunded liability we have in this country. It is going to hit us like a wave on the beach. I don't think people are prepared for how significant the problem of long-term care is going to be. You have only to look at demographics, and remember that the baby boom generation, which represents one-third of the U.S. population, will start to become 50 as of January 1, 1996, at the rate of one every 8 seconds.

The problem is upon us. GAO gave us some wonderful estimates of what we are going to be facing in the future unless we take action. I do think you are correct that we do need both a public and a private approach to this problem. It is simply too big for one group or another to try to handle it.

The private role, as is evident in the charts that GAO has provided on private long-term care insurance, is woefully underfunded, and inadequate. So, the reasons are why? Why is long-term care insurance not more readily understood, or readily available? I agree with the witnesses who said there is a great deal of misunderstanding about what Medicare and Medicaid cover.

It is also a simple fact that most of the policies that have been sold in the area of long-term care are deficient. It is my experience that if you have something good, you don't have to get out and yell and scream and tell everybody how fabulous it is. People will flock to buy it. Consumers Union, 2 years ago, took a good look at long-term care policies and couldn't find one that they would recommend.

I have not read, and am not familiar myself with products that have been developed over the last year and a half. I don't know the UNUM product specifically, so it may be that the plans have developed and they have more economic value, and the perception on the part of the public is that they are more valuable.

I do know that they have been deficient historically in that they cover primarily nursing home care, and cover limited home care. As that changes, I think the acceptance of the policies will grow greatly. As you pointed out in your statement, Mr. Chairman, most people who are receiving long-term care are receiving their care at home, usually through the help and assistance of relatives. Therefore, a long-term care policy better address that alternative, in addition to the institutional or nursing home option. Both are essential, and I don't mean to downplay one or another.

So, we need products that find acceptance with the American people. They have to have economic value. We have talked a lot about required standards. Your bill, I think, sets us on the right course with respect to provisions related to nonforfeiture and so forth.

But I have not heard much by way of standards related to economic value. Some people would say this is incorporated by reference to the National Association of Insurance Commissioners Standards, but minimum loss ratios, the percentage of the dollars that you get back from a policy, the percentage that get burned off in administrative expenses, are very, very important as an index to the value of the policy. Some emphasis needs to be placed upon that as well.

The provisions that you have in your bill that would allow individuals to deduct money that they spend in the care of relatives from their taxes are very important. Those same provisions have been included in the House in the Republican Contract with America. This is extremely intelligent to recognize that we need to use tax policy to create incentives for brothers and sisters to pool their resources and take care of mother and dad, and grandmother, and be able to deduct those from their taxes.

The alternative is the spend down, and forcing Uncle Sam and all of us collectively, to pay many multiples of millions of dollars that are completely unnecessary. So, our social policy should be in the direction of encouraging mothers and fathers to be cared for, encouraging them to provide for their own care as much as possible, also encouraging family members to jump in and do what they ought to do. We can say they should do so as a matter of right and ethics, but it also helps to have tax policy which reinforces this.

To make a long story short, Mr. Chairman, we are very excited about your bill. It sets us on the right course, and we believe it should be enacted immediately. We can't find any provisions in it that we find objectionable. Quite the contrary, it is very commendable.

I would like to end by reminding us, as you have so often, of the importance of what we are doing here today. John Kennedy quoted the historian, Arnold Toynbee, who said you can tell the durability and the greatness of every society by a common yardstick. That yardstick is the manner in which they care for the disabled and the seniors. What is at stake here today is not merely our fiscal policy,

but it is the matter of the very survival of our Nation, and the way that we will be judged through the prism of history. Therefore, it is extremely important we get on with the business, and get your bill enacted.

[The prepared statement of Mr. Halamandaris follows:]

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Testimony of Val J. Halamandaris, President

National Association for Home Care
Washington, D.C.

My name is Val Halamandaris. I am President of the National Association for Home Care (NAHC), which represents our nation's home care providers -- including home health agencies, home care aide organizations and hospices -- and the people they serve. NAHC is committed to assuring the availability of humane, cost-effective, high-quality home health services to all individuals who require them. Toward this end, NAHC believes that America must do better at ensuring access to high quality home care and hospice services in both the acute and long-term care settings. These vital services provide millions of individuals--the aged, infirm, disabled, and children--the ability to receive care in the settings that allow them the highest level of satisfaction, independence, and dignity--in their homes.

I would like to take this opportunity to commend the Chairman and the Committee for examining ways to assist families. I would particularly like to commend the Chairman for his introduction of S.423, The Private Long-Term Care Family Protection Act of 1995. We are delighted to work with the Chairman on ways to help families care for parents and other loved ones at home. We believe in individual responsibility and family responsibility to care for the aged, infirm, and disabled to the extent it is possible to do so. We believe the problem of long-term care is so great that private insurance as well as state and federal governments must share their resources now and in the future in order to deal with it.

As one who served for 20 years as counsel to both the House and Senate Aging Committees, I have a long history with family caregiver issues and understand both the financial and physical toll that providing for a dependent loved one takes on American families.

Long-term care is one of the most devastating problems America faces today. Estimates indicate that between 9 and 11 million Americans of all ages require long-term care because of chronic illnesses or disabilities that render them unable to perform basic tasks of daily living without assistance. This number could double by the year 2030 to more than 19 million.

Spending for long term-care is currently estimated at $57.8 billion. Yet neither Medicare nor private insurance provides adequate protection against the costs of long-term care. Many families exhaust their emotional and financial resources providing and purchasing long-term care services. A million Americans a year are impoverished trying to meet the cost of long-term care. Only the most wealthy Americans are insulated from potential financial devastation. The rest can have their lifetime savings wiped out in a matter of months paying for long-term care.

Long-term home care improves the quality of life because it is more humane. It reinforces and supplements the care provided by family members and friends and maintains the recipient's dignity and independence, qualities that are all too often lost in even the best institutions.

Long-term home care is also often much less costly than institutional care. New York State's experience with its Nursing Home Without Walls program is that the great majority of clients who would otherwise need to be placed in a nursing home can be cared for at home for a much lower cost.

Medicaid waiver programs have increasingly relied on home care services as a way to reduce states' long-term care costs. For example, New Mexico's waiver program for people with AIDS estimates a savings of $1100 a month for patients who use home care rather than skilled nursing facility care. The average patient plan of care costs $1000 a month for home care compared to $2100 a month for skilled nursing facility care. Moreover, New Mexico reports that only about 47 percent of patients receiving waiver services are hospitalized in a given year, compared to 70 percent of those not under waiver.

The National Governors' Association (NGA) recognized the importance of home care in a resolution it adopted in 1992 stressing the importance of making home and community based services a key component of all long-term care policies and programs. NGA recommended elimination of the current institutional bias in public programs for long-term care in favor of home care as a more preferred and cost effective method of care.

The National Association for Home Care applauds the Committee's commitment to making long-term care more accessible for the millions of Americans with chronic disabilities. Very few individuals can afford to pay for long-term care at home or in a nursing home out of their own pockets, and yet neither Medicare nor private insurance cover those services to any great degree. Private long-term care insurance policies first appeared on the market nearly 17 years ago, but have grown dramatically in the past several years. Between 1987 and 1991, companies offering policies increased from 75 to more than 130. Although the proliferation of policies has created competition among insurers to significantly improve their products, problems remain in even the most improved policies.

Regulation of the private long-term care insurance market is left up to the states and the National Association of Insurance Commissioners (NAIC) has recommended model laws and regulations. Nearly all states have adopted the NAIC model act, but only 28 states have issued regulations, only 14 require any form of inflation protection, and only 12 have issued home care coverage standards.

Ongoing problems with high lapse rates, coupled with persistent reports about abusive sales tactics, has fueled concern over the ability of states to regulate the private long-term care insurance market to ensure the sale of high quality products and protect consumers from fraud and abuse.

NAHC supports Congressional efforts, such as S. 423, which would create favorable tax incentives to promote the purchase of long-term care insurance. Tax incentives are especially needed to foster development of long-term care insurance through employer-based plans and vested retirement funds. Employment-based plans could be more attractive and affordable and extend coverage to the largest number of people.

Present restrictions on buying long-term care insurance through cafeteria plans and flexible spending accounts should be removed. In addition, individuals should be allowed, before and after retirement, to use money accumulated in pension plans, individual retirement accounts, and life insurance policies for long-term home care needs without penalties or loss of tax deductions. In the alternative, Congress should allow tax deductions for individuals who establish individual medical accounts devoted to long-term care needs.

The Private Long-Term Care Family Protection Act would address several of these issues. Under Section 103, benefits paid under qualified long-term care insurance policies would be excluded from income and employer-paid long-term care insurance would be a tax free employee fringe benefit. Long-term care would be considered a "qualified benefit" that could be included in a cafeteria plan.

Section 303 of the Act would permit tax free distributions from IRAs or individual retirement annuities for those individuals above 59 1/2 years of age to purchase long-term care insurance. Those below age 59 1/2 could withdraw from their IRAs without penalty to purchase a qualified long-term care plan. NAHC supports these provisions as well.

Probably the provision in the Act that may be most valuable to individuals in need of long-term care and their families is Section 101 which would allow qualified individuals to deduct out-of-pocket long-term care services as medical expenses subject to a floor of 7.5 percent of adjusted gross income. This benefit would not be limited to those who purchase private long-term care insurance and would help all families burdened with out-of-pocket long-term care expenses. This proposal could even help to delay nursing home placement and help individuals avoid having to spend down their life savings in order to qualify for Medicaid nursing home coverage.

However, tax incentives for the purchase of long-term care insurance must be accompanied by aggressive minimum standards and consumer protections for long-term care insurance. Policies should not be sold, and certainly should not be given preferential tax treatment, that do not meet strict federal consumer protection standards. Only in this way will Congress ensure that individual purchasers are guaranteed a high quality product that will provide them with the measure of protection they expect when purchasing long-term care insurance. Federal tax incentives should not be available for the purchase of inferior policies that offer only hollow promises.

Just as Congress, in 1990, established federal minimum standards for the sale of Medicare supplemental insurance (Medigap) policies, so should Congress establish minimum federal standards for the sale of long-term care insurance policies. These standards should, at a minimum, specify coverage standards for home care and hospice services, require inflation protection and nonforfeiture benefits, and regulate sales practices.

The Private Long-Term Care Family Protection Act would require all long-term care policies to meet national consumer protection standards. Those policies which would not meet these consumer protection standards would be denied favorable tax treatment and penalties would be imposed on long-term care issuers failing to meet the minimum federal standards.

Probably the greatest coverage failing with private long-term care insurance today is the inadequate coverage that most of these policies provide for long-term home care -- undoubtedly the benefit most purchasers prefer over nursing home care. Private policies provide very poor coverage for long-term home care needs. Some companies limit home care coverage by requiring prior nursing home care, paying only a small fraction of the nursing home benefit, covering only medically necessary services, and excluding coverage for home care aide services. Mandatory federal minimum standards for home care coverage can help address this failing, and help make private long-term care insurance policies more attractive to consumers.

State attempts to regulate the private long-term care insurance market have had only limited success. In the absence of federal regulation, it is up to consumers to carefully sort through the myriad policies, riders and features to find an affordable reliable plan. The choices are complex and the figures easily manipulated. Only by mandating federal standards for long-term care insurance will all consumers be protected. Regulation of the market will foster confidence among consumers that private long-term care insurance constitutes a viable option for their protection from large out-of-pocket expenses in the event that they may need long-term care services.

Inadequate access to long-term care is one of the most devastating problems facing America. Although private long-term care insurance will not be a total solution for financing long-term care, it can help protect some people against large out-of-pocket expenses. It gives some individuals the opportunity to retain choices and develop a flexible, planned response to a potentially ruinous event that will confront many people over 65 as well as many disabled people under 65.

Thank you for your interest in this important area and for the opportunity to present our views for consideration by the Committee. We look forward to working with the Committee on this important issue.

The CHAIRMAN. Thank you very much, Val. I had ambivalent emotion when you recalled my service in the House, because it goes back to 1975, when the first Aging Committee was created, with Chairman Pepper on that Committee. I was one of the original members back then. That reminds me of exactly how long I have been sitting in this chair, looking down trying to do certain things on the Aging Committee.

This brings me to Steve McConnell, who, of course, served as the chief of staff under Senator Heinz, on this committee. So, Steve, we welcome you back, as well.

STATEMENT OF STEPHEN McCONNELL, CHAIR, LONG-TERM CARE CAMPAIGN, AND SENIOR VICE PRESIDENT FOR PUBLIC POLICY, ALZHEIMER'S ASSOCIATION

Mr. MCCONNELL. Thank you, Mr. Chairman. It is nice to be back here, even though I am on this side of the table.

Mr. Chairman, on behalf of the 141 organizations of the Long-Term Care Campaign, which represents 60 million Americans, I'd like to thank you for this hearing. I'd also like to commend your staff, who have done an excellent job. We have worked with them over the years, and are pleased that they are with you.

The Campaign has always supported a comprehensive long-term care policy that would be provided to people regardless of their age, disability, or their income. We have been working on long-term care issues since 1988, when we were first formed, and we have done a lot to increase awareness of the need for a comprehensive solution. Back in 1988, More than 80 percent of the population thought Medicare covered long-term care. We have made some progress toward correcting that misperception. We have a ways to go, but the educational process is underway and we join you in that effort.

This hearing focuses on the elderly, which of course, leaves out a third of the population that has severe disabilities, the younger disabled. It also focuses on private insurance, which has been acknowledged by you and others that leaves out a fair number of older people for a variety of reasons, and is in fact only a partial solution.

The Long-Term Care Campaign supports private insurance as playing a role in providing long-term care coverage for older people. But, we also need a public solution. We have several concerns with private insurance. One is cost, which has been talked about here at length. There are a variety of studies that estimate that only 10 percent to 40 percent of the elderly can afford it. The HIAA and the insurance industry itself estimates only about 40 percent. That leaves a majority of older people uncovered.

The whole issue of encouraging younger people to purchase private insurance is notable and noble, but given the expenses of child care, mortgages, colleges expenses, rising health costs, and so forth, it is difficult for most of them to do that. Even if we are successful in signing up many more younger people, that is a solution that will begin to show results 30 or more years from now. So, we still need a public solution.

On the issue of underwriting I want to make a point, not as a criticism of private insurance. It is essential to private insurance

to not fund people, or insure people who are already in need of long-term care. But, I think it is worth noting attached to my testimony is a page from a very good private insurance long-term care policy that lists the kinds of things that people are asked before they apply. Have you had Alzheimer's dementia, chronic memory loss, senility, multiple sclerosis, Parkinson's, more than one stroke, muscular dystrophy, AIDS, or AIDS-related complex, open heart surgery, back or spine surgery within the past 6 months, a stroke or TIA within the past 12 months, cancer of the bone, brain, liver, lung, ovaries, pancreas, stomach, testes within the past 48 months, need for a walker, wheel chair—the list goes on. Then the policy says if you have had any of these things, don't apply.

The reason I raise this is not to criticize private insurance, but to point out that the 11 million Americans who now have a disability have no chance of purchasing private insurance. Those are people that only a public solution can help.

What is needed? We have talked about national long-term care insurance standards. We would support national standards as represented in your bill. I want to point out that the insurance industry has been very responsive to some of the things that the Alzheimer's Association has done. For example, we did an analysis a few years ago on several policies and found them lacking. We sat down with a few people from Traveler's and other insurance companies and they have responded. I think that is worth pointing out.

The Congress should not give tax breaks for the sale of private insurance until there are national standards to ensure good quality so the consumers are protected. We also would add that we don't think the first dollar should go to provide incentives for the sale of private insurance. We would prefer that it be put into helping people with home and community based care, or maybe to prevent some of the cuts that have to come in Medicaid. But, if the Government is going to provide tax incentives, we have to have the standards to go along with them. And again, we commend you for your efforts in that regard.

Regarding family support, your chart up here is very important. There is something missing, however. The chart includes only the costs of long-term care that are paid. As you know, 75 percent of the care is provided by families, it is not paid care, but families are giving up a lot to provide it. My mother cared for my father for 7 years. She didn't pay a lot, except she had to quit her job, and give up a lot of other things. That is not represented up there, as you know. Some of the tax changes that are being discussed would be very helpful to families providing care. If we treat long-term care expenses as a medical expense, so that people can deduct those, like they do medical expenses, it would be very helpful to families.

Next is the tax credit for persons with disabilities, who want to keep working. That is something that would help younger people, and allow them to stay productive in the work force.

Finally, and really the most important, is Medicaid. The proposals to cut $185 billion over the next 7 years from Medicaid cannot be absorbed by States without making drastic cuts in long-term care. The Long-Term Care Campaign did an analysis of these cuts. Assuming that the growth in Medicaid is slowed to 5 percent, and the Senate Budget Proposal would slow it even more than that,

would cut $37 billion out of long-term care coverage by the year 2000, and knock 1.7 million people out of getting protection for long-term care. Hardest hit would likely be home and community based care protection. We also oppose turning Medicaid into a block grant.

Final word. We have a long-term care system in place today, Mr. Chairman. We call it the family. Families are the ones who provide and pay for most of the care. This is the private system we need to support and encourage through our public policy on long-term care.

Mr. Chairman, you have always understood that long-term care is a problem that requires a comprehensive response, and your comments earlier were heartwarming to all of us. We need a mix of public and private solutions. I am sure that you are as frustrated as we are, as long-term advocates, that the current debate is focused on the two ends of the scale, encouraging private financing for those with means, and retrenching the program that provides assistance for those most in need. If that happens, we will only widen the gap between those who can make it on their own, and those for whom some public responsibility is needed, leaving an ever-increasing number of people in the infamous no-care zone. I am confident that this Committee with your leadership will not let that happen.

[The prepared statement of Mr. McConnell follows:]

THE LONG TERM CARE CAMPAIGN

TESTIMONY OF

STEPHEN McCONNELL
CHAIR, LONG TERM CARE CAMPAIGN
and
SENIOR, VICE PRESIDENT FOR PUBLIC POLICY
ALZHEIMER'S ASSOCIATION

Mr. Chairman and Members of the Committee. Thank you for inviting the Long Term Care Campaign to testify at this very important hearing. The Campaign is a coalition of 141 national organizations, with a combined membership of 60 million Americans who have a direct interest in long term care. We represent retirees, younger persons with disabilities, families with children, paralyzed veterans, family caregivers, religious and community organizations, nurses and long term care workers. The Long Term Care Campaign was organized in 1988 to respond to a national crisis:

- A crisis that is causing physical, emotional and financial devastation for millions of American families who have a child, a spouse, or a parent with a chronic disease or disability who requires full time care;

- A crisis that is robbing young women and men with serious disabilities of their dreams of independence because they cannot get the help they need to live in the community and return to the work force;

- A crisis that is adding avoidable costs to our national health care bill, because affordable services are not available to prevent excess disabilities and because the absence of coverage of appropriate services forces people into hospitals and nursing homes who do not need to be there.

We congratulate you for holding this hearing. Congress is rushing toward major change in tax policy and huge reductions in Medicare and Medicaid that will have major impact on the direction of long term care policy in this country. It is important to take the time to consider the implications of these proposals, to assure that Congress does not make the long term care crisis worse, but in fact moves us in the right direction. We appreciate the opportunity to participate in this discussion this morning and look forward to working with you as the debate goes forward in the coming months.

As you know, Mr. Chairman, the Campaign is organized to promote a comprehensive long term care policy that guarantees services and supports to all who need them regardless of age, income or disability. We realize that today's hearing is focused on one part of the larger problem: the long term care needs of the elderly. That leaves out of the discussion one-third of the people with serious disabilities who are under age 65, including 1 million children. Their needs are often the most expensive, because they may go on for a lifetime.

This hearing is also focused on a very partial solution to the problem -- the role of private financing. That will not be a solution for most people who are likely to need long term care in the near term, or for a large part of the population that does not have enough extra income to take advantage of private financing options.

We look forward to the time that we can get back to consideration of a comprehensive approach to the long term care crisis. But recognizing the limits of today's hearing, my testimony will focus on four points:

First, while there is a role for private long term care insurance in a comprehensive approach to long term care, it will not solve the problem for most people because of cost, exclusionary medical underwriting, and limitations on coverage. Congress should be cautious about using scarce tax dollars to subsidize this product. If there are any new dollars available this year to support long term care, the Campaign urges Congress to use those funds to shore up critical home and community based long term care for those who need help now and for whom insurance is not a viable option.

Second, uniform national standards for long term care insurance are needed to protect those consumers who can consider purchase of private insurance.

Third, of all of the proposals to use the tax code to address the issue of long term care, there are two that would be of immediate help to people dealing with long term care: clarifying the tax code to treat long term care expenses as medical expenses for personal income tax purposes; and providing a tax credit for the costs of personal assistance services that enable persons with serious disability to work.

Fourth, Members of Congress concerned about long term care cannot look just at private financing but must fight to protect the only source of assistance that now exists for individuals and families without private means of financing long term care -- Medicaid.

PRIVATE LONG TERM CARE INSURANCE -- WHERE IT FITS

As your first witnesses this morning made abundantly clear, long term care insurance can provide real protection for some people. But even if insurance is made as affordable and accessible as possible, it is far from a complete answer to this major national problem.

Most of the debate about private insurance focuses on cost and affordability. Experts differ in their estimates of how many persons over age 65 could afford a private policy that would cover the majority of their expected lifetime expenditures for long term care. The estimates vary from as low as 10%, according to an analysis by Coopers and Lybrand and William M. Mercer, to a high of 30% to 40% according to the insurance industry itself. Even if you take the most optimistic assumptions, that leaves the majority of older Americans unprotected, on the basis of cost alone.

Some are pinning their hopes on increasing the numbers of people who buy protection in their 40s, when premiums are lower. But that will not be easy to do. That means persuading working families to purchase protection for something that may happen to them 30 to 40 years in the future, at a time when they are dealing with mortgage payments, child care, braces, savings for college tuition, and higher costs of basic health insurance. It also means guaranteeing some premium stability and inflation protection in the long term care insurance market, so that policy holders can afford to maintain their insurance until they need it and can be assured that their protection keeps up with inflation. To the extent this age group can be brought into the market and can afford to buy and hold a good policy until they need it, we will not begin to see the impact until well into the next century. Meanwhile, we have a more immediate problem to address -- those who need long term care now and have no insurance.

But cost is only part of the picture. Medical underwriting presents an even bigger problem, because it excludes the very people who are most likely to need long term care -- whether they can afford to pay the premiums or not. Attached to this testimony is the first page of the application form for one of the best long term care policies now on the market. It asks if the potential buyer has (or had) any of the following:

- Alzheimer's, dementia, chronic memory loss, senility, multiple sclerosis, Parkinson's, more than one stroke, muscular dystrophy, AIDS or AIDS related complex, a positive HIV test, metastatic cancer,
- Open heart surgery, back or spine surgery within the past 6 months,
- A stroke or TIA within the past 12 months,
- Cancer of the bone, brain, esophagus, liver, lung, ovary, pancreas, stomach, testes within the past 48 months,
- Need for a walker, wheelchair, oxygen, respirator, kidney dialysis, assistance or supervision bathing, dressing, eating, toileting, bowel or bladder control, walking, getting in or out of a chair or bed.

If the answer to any part of these questions is yes, the company will not consider the person's application.

This is not a criticism of private insurance. It is exactly what any company has to do to have a viable product -- it has to avoid adverse risk selection to stay in business. That is a fact of life of private insurance. But it means that at least 11 million Americans with chronic disease and disability cannot buy long term care insurance today. And this will become a bigger problem as scientists find genetic markers for diseases like Alzheimer's and ways to diagnose these diseases earlier. These are exciting discoveries that offer hope for finding effective treatments and cures, but they will mean even more people will be written out of the long term care insurance market.

Putting limits on preexisting condition exclusions will not take care of this problem. That would limit an insurer's ability to deny payments once a person has a policy. But it will not prevent insurers from denying coverage based on medical underwriting. The bottom line is, even if you make long term care insurance as attractive and affordable as possible, it will not solve the problem. It will help. But we will still need a public response.

THE NEED FOR NATIONAL STANDARDS FOR LONG TERM CARE INSURANCE

While industry leaders have made steady improvements in their products, there are still more than 118 companies selling long term care insurance, with no consistency in coverage, defined benefits, or consumer protections. For years, the National Association of Insurance Commissioners has worked to develop good model standards for these policies. But these standards have not been adopted uniformly by all of the states. According to a new report from the Health Insurance Association of America, all states have adopted some of NAIC's 28 standards but only 39 have adopted even half.

Virtually everyone -- the insurance industry, long term care providers, consumers -- agree that such standards should be in place. Congress cannot allow the current patchwork to continue. Uniform national standards should be adopted to address issues like inflation protection, premium stability, guaranteed renewability, nonforfeiture, post claims underwriting, standardized benefits, and sales and marketing practices.

Congress should not provide tax incentives for long term care insurance, at least until such standards are in place. Even then, organizations in the Long Term Care Campaign would question priorities that use tax dollars for subsidies to those in a better position to finance their long term care, especially at a time when drastic cuts are being proposed in Medicaid -- the only source of assistance for those who cannot finance their own care. We believe there is a much higher priority for any tax dollars available now for long term care -- to add resources to the home and community care programs that states are struggling to develop and maintain.

OTHER PRIVATE FINANCING OPTIONS

Today, private financing of long term care means that individuals and families pay for care out of their own income and savings, as long as the money lasts. There are two ways that Congress can provide real help through the tax code to people who are paying those bills. Both of these proposals enjoy wide bipartisan support.

> The first would clarify the tax code to specify that expenses for long term care, including home and community based care and all forms of residential care, for persons of any age, should be treated as medical expenses for personal income tax purposes.
>
> The other would provide a tax credit for the cost of personal assistance a person with a serious physical disability needs in order to work.

This will not help those who do not have the money to spend for long term care in the first place, or for those who do not have enough tax liability to use the deduction, but it would provide real assistance for those who do have large long term care expenses and tax liability, and it would be fair.

Other proposals, to allow payment of accelerated death benefits from life insurance policies or tax-free withdrawals from retirement savings accounts to meet long term care expenses, offer people more flexibility to use their savings when a long term care need arises. But like most of the other private financing proposals, they help a narrow segment of the population and those with the most means. That does not mean they are bad ideas; only that they are not complete answers.

THE IMPACT OF MEDICAID CUTS ON LONG TERM CARE

Nothing Congress may do now to encourage private financing of long term care will significantly impact the critical role of Medicaid in financing long term care for those who cannot pay the bills on their own, particularly in the near term. Yet this week, the House and Senate Budget Committees are considering proposals to cut as much as $190 billion from Medicaid over the next 7 years. (Medicaid will take an even larger "hit" if the Budget Committees force higher cost-sharing under Medicare, since Medicaid pays those costs for low-income beneficiaries. There will be even less money to go around.)

There is no way states can achieve these budget reductions without cutting back drastically on long term care. More than 40% of Medicaid dollars now help pay for long term care, for 4 million frail elderly and people with disabilities -- 2.1 million people in the community and 1.9 million in nursing home or facilities for the mentally retarded.

Medicaid today pays half of the nation's nursing home bill. Six out of ten nursing home residents receive some help from Medicaid because even after they have given the nursing home the money they do have, it is not enough to pay the entire bill.

The projected rate of growth of Medicaid long term care over the next 5 years is 9.2%. Most of that growth will occur in home and community based care, as states look to less costly and more appropriate ways to meet expanding need. Tragically, this is almost certainly where states would make their first cuts if Congress forces them to make reductions. The Long Term Care Campaign has looked at what it would mean for long term care if Congress holds Medicaid growth to 5%. Assuming that states would apply that 5% evenly between acute and long term care, Medicaid spending for long term care would be cut by $37.4 billion over the next 5 years. This could mean the loss of long term care benefits for as many as 1.74 million people in the year 2000. And it could mean less quality care for those who do receive assistance.

There are no private financing mechanisms to absorb cuts of this magnitude in this time period.

The Long Term Care Campaign is concerned not just with the size of the proposed cuts but with the potential shift of Medicaid to a block grant to the states. This would eliminate any assurance of assistance for those who have reached Medicaid financial eligibility levels. It would also put at risk basic protections which Congress has carefully written into the law -- including nursing home quality standards and protections against spousal impoverishment. It is difficult to see how states could sustain these essential elements of the current Medicaid program with far fewer resources and enormous political competition for remaining funds.

A final word. We have a private long term care system in place today -- we call it the family. Families are the ones who provide and pay for most of the care. This is the private system we need to support and encourage through our public policy on long term care.

Mr. Chairman, you have always understood that long term care is a problem that requires a comprehensive response, a mix of public and private solutions. I am sure that you are as frustrated as we are, as long term care advocates, that the current debate is focused on the two ends of the scale -- encouraging private financing for those with means, and retrenching the programs that provide assistance for those most in need. If that happens, we will only widen the gap between those who can make it on their own and those for whom we will assume some public responsibility -- leaving an ever increasing number of people in the infamous "no care zone". I am confident that this Committee will do all that it can to keep this from happening.

Again, thank you on behalf of the entire Long Term Care Campaign for inviting us to participate in this hearing. I will be happy to respond to your questions.

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PLEASE COMPLETE ALL SECTIONS BEFORE SUBMITTING APPLICATION

BENEFIT AMOUNT SELECTIONS			BENEFIT OPTIONS
Daily Maximum	Benefit Multiplier	Elimination Period	Inflation Protection
$ ______	☐ 730 ☐ 1460 ☐ 1095 ☐ 2190 ☐ Unlimited	☐ 0 days ☐ 50 days ☐ 100 days	☐ Compound 5% ☐ Equal 5% ☐ None

Premium Payment Method: ☐ Check ☐ EFT* ☐ American Express® Card* Premium Payment Mode: ☐ Monthly (Check Method not available) ☐ Quarterly ☐ Semi-Annual ☐ Annual	* Be sure to complete the Authorization Form (note: some states restricted).	Submitted Premium: $ ______	Agent Producer Code (Required): 006 _ _ _ _ _ _ _

AMEX *Life Assurance Company*
1650 Los Gamos Drive, San Rafael, California 94903

Please Print Clearly

APPLICATION
For Group Insurance

☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms.

Name ______________________ (As It Should Appear On Your Certificate)

Street Address ______________________

City ______________ State ____ Zip ______

Social Sec. No. [illegible]

Married? ☐YES ☐NO • If YES, is spouse applying? ☐YES ☐NO

Birthdate ________ Age ____ Sex ☐M ☐F

( ) ________ DAY TELEPHONE ( ) ________ EVENING TELEPHONE

Weight: ______ lbs. Height: ____ ft. ____ in.

For more space, attach a signed and dated sheet with question number and details

YES NO ***INSURABILITY PROFILE***

☐ ☐ 1. Are you covered by Medicaid (not Medicare)?

2. Have you had, do you currently have, or have you ever been medically diagnosed as having:

☐ ☐ A. Alzheimer's Disease; Organic Brain Syndrome; Dementia; Chronic Memory Loss; or Senility?

☐ ☐ B. Multiple Sclerosis (MS); Parkinson's Disease; More than One Stroke; Muscular Dystrophy; or ALS (Lou Gehrig's Disease)?

☐ ☐ C. Acquired Immune Deficiency Syndrome (AIDS); AIDS Related Complex (ARC); or positive HIV test?

☐ ☐ D. Metastatic Cancer (spread from original site/location)?

☐ ☐ 3. Within the past 6 months, have you had: Open Heart Surgery; Back or Spine Surgery?

☐ ☐ 4. Within the past 12 months, have you had a: Stroke; or Transient Ischemic Attack (TIA)?

☐ ☐ 5. Within the past 48 months, have you had Cancer of the: Bone, Brain, Esophagus, Liver, Lung, Ovary, Pancreas, Stomach, or Testes?

☐ ☐ 6. A. Do you use a Walker or Wheelchair; Oxygen; Respirator; or Kidney Dialysis?

☐ ☐ B. Do you need the assistance of or supervision by another person in performing any of the following activities: Moving in/out of bed or chair; Bathing; Dressing; Eating; Toileting; Bowel/bladder control; Walking?

If you answered YES to any part of questions #1 through #6, DO NOT SUBMIT THIS APPLICATION. Otherwise, please continue.

☐ ☐ 7. A. Do you have any other accident and sickness or long term care insurance policy or certificate (including health care service contract, health maintenance organization contract) in force or applied for? If YES, give coverage details below.

Company ______________ Coverage Type ________ Amount $ ______ per ____

Company ______________ Coverage Type ________ Amount $ ______ per ____

B. If you have AMEX Life Nursing Home coverage, please list policy/certificate number(s): ______________

☐ ☐ 8. Did you have another long term care insurance policy or certificate in force during the last twelve (12) months?
If so, with which company? ______________ If that insurance lapsed, when did it lapse? ________

☐ ☐ 9. Do you intend to replace any of your long term care, medical, or health insurance coverage with this certificate?
If so, name of insurer being replaced: ______________
(AGENT: If YES, be sure to fill out Replacement Notice. Leave one copy with applicant; send one copy with application.)

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The CHAIRMAN. Thank you very much, Mr. McConnell. Gentlemen, let me say that among my greatest frustrations is the fact that the debate has become so polarized, in virtually everything we do, not to mention the health care reform debate, and now in Medicare and Medicaid. It seems to me we need to find a way to take the politics out of this. Otherwise, we are simply going to see a continuation of what has taken place in today's debate.

I appeared before the White House Conference on Aging, and I made an appeal to the President at that time. He was not there at the moment, but nonetheless, I wanted to make at least a public announcement calling for a bipartisan approach to welfare reform, another hot political issue. As Republicans, we can exploit this issue and talk about welfare cheating and abuses, and take measures which others might find to be punitive, but this is not productive. I believe the President correctly called for a bipartisan approach. He said we have a very serious social problem. Let's deal with it in a responsible fashion.

We have a serious problem with Medicare and Medicaid funding. On the one hand we have those who are seeking to exploit that problem by casting a net of fear over all of our seniors that somehow the Republicans are out to just devastate those programs in order to pay for tax cuts for the rich.

Somehow, we have to get away from doing this on both sides. Otherwise, we are going to be posturing for the next election, of 1996, then it will be the next election in the year 2000. The problems will continue unabated. They are mounting almost in an exponential growth pattern right now. We are watching deficits increase by $1 trillion every 4 years.

One of the great ironies involved in assuming President Clinton's budget program works as planned, and everything occurs precisely as OMB and others have calculated, is that we will add $1 trillion to the deficit, which of course, puts even a greater burden on the young people coming up. We have talked about it in terms of what their choices are going to be.

There was one study done. I think it was by CBO. It indicated that people being born today, unless there are serious structural changes, will pay roughly 82 percent of all of their income in taxes. Talk about having an absence of choice in terms of what your life style is going to be, if 82 percent of all your income is going to pay income taxes, that is a country that we don't recognize right now, and I don't think we want to leave for our children.

We somehow have to take the politics out of it. I am not sure we can. But, it is my hope we can somehow put an end to the charges of class warfare, and really deal with this in a substantive and meaningful fashion. I know there are people in the Senate who want to approach it in this fashion. I hope there are people in the House who feel the same way.

That brings back the private/public sector debate. We have to have both. I think to the extent that the private sector gets engaged in a very major way, that it is going to lessen the burden of long-term care costs. In order for the private sector to become involved, obviously, we have to have more people in the pool. Otherwise, the cost is going to be prohibitive. We have to figure a way

to encourage more and more people to get in the pool. I think the tax incentive is the best way.

I might indicate that I have tried to use the tax code in the past to effect social policy. I haven't been very successful. Val, we may go to the days in 1978. I had a bill in called the Annual Physical Exam Act of 1978. What I wanted to do was give a tax deduction to people who went and got a physical exam every year, an annual check up. Hopefully, the doctor would go through a series of tests, and try to catch diseases or any kind of abnormality in their initial stages. I think I got more hate mail on that particular proposal than any other piece of legislation. Doctors hated it. Consumers hated it. They said it was just a give away to doctors. Doctors said they didn't have a check list we can run through like your automobile, and hope to find diseases.

Then, I introduced a measure in 1981 called the Wellness Act of 1981. Suggesting that we give a tax incentive to employers who provide nonsmoking campaigns at their place of business, who provide either work-out equipment on premises, or by health membership in health clubs. You get an employee base that is healthier. You have fewer drop-outs. You have less alcoholism. You have more productivity. You have all these benefits. The answer was that if it is so good, the private sector will do it. So, it just sort of went by the wayside.

I haven't been very successful in using the taxes to do that. I think this is going to be essential, though. I don't think we can really educate the American people about, number one, what it is going to take. Dr. Willging, your suggestion is an excellent idea. Put a notice in every Social Security check that goes out that Medicare does not cover long-term care. We must start educating the public that this is not covered. Even my dad is a classic case. I have to work on him all the time, because he thinks that Medicare is going to take of all his problems. It won't.

We have to start educating people. We have to give the tax incentives to get the private sector involved, and get the people to change their habits, because they personally believe the Federal Government is going to take care of their problems. It is not going to be there to take of the problems at the levels that we are now looking at.

It has to be a combination. I hope that we can strike the right balance, bringing in the private sector, getting more people involved, use the tax system to do that, set national standards. I agree we have to set the national standards. We have to give the States flexibility, in terms of how they may implement that, whether making it mandatory for inflation protection and nonforfeiture protection.

Thanks to all of you in coming forward today. I think it is going to be helpful in presenting this case to the American people. We have to do so, and I hope in a de-politicized environment to the extent that we can.

I carried on this mini-filibuster because I have a colleague who has just joined me here from Illinois, and I am sure that she has a statement she would like to make. I now turn the mike over to you.

STATEMENT OF SENATOR CAROL MOSELEY-BRAUN

Senator MOSELEY-BRAUN. Thank you very much, Mr. Chairman. I appreciate your thoughtfulness. As it turns out, I was caught, as we often are, with conflicting committees. But the committee that I just left, the Finance Committee, was addressing the issue of the solvency of Medicare and health care finance generally. So this committee hearing today fits right in with that.

I want to congratulate you, Mr. Chairman, for your efforts in this area. There is no question that the issue of long-term care is one that is lurking in the background of this entire debate. There is no way that we can address fixing Medicare and Medicaid on the one hand, health care reform on the other, without addressing long-term care, even though it is not as much a part of the current equation as it should be. All things fit as a piece, and this is a very, very important one.

I also had an opportunity to meet and speak outside the hearing room with a constituent from Illinois, Mr. John Spear, who was the first witness.

The CHAIRMAN. You missed a fine presentation.

Senator MOSELEY-BRAUN. Did I? I am so sorry. Senator Simon and I have a town meeting every Thursday morning, and Mr. Spear was kind enough to come to the town meeting, so we were able to touch base with him then, and just now outside the hearing room.

I did have a couple of questions. I don't know if these questions have been answered or not, because I wasn't here. I won't take long.

Have you recommendations with regard to activities that we might undertake to deal with the proposed budget cuts in Medicare and Medicaid?

Mr. WILLGING. How many hours would you like to discuss that, Senator?

Senator MOSELEY-BRAUN. I'll throw you a nice soft ball on that one. That is obviously the immediate issue. Obviously, we have long-term and structural issues to address, but in the short term we are going to have to deal with where we are with regard to this budget that is now being taken up.

Mr. WILLGING. Certainly, with respect to Medicaid, which is the primary public funding source for long-term care services, unlike Medicare, which a post-acute, post-hospital funding mechanism, I think at least Mr. McConnell and I have agreed that one solution is not to simply ship the entire Medicaid program off to the States, and then leave them with the financial burden of trying to make up the difference.

Long-term care is growing not because of the practices of providers or the whims of recipients, but long-term care is growing at 10 percent per year for a variety of factors that can't be controlled. They can't be controlled at the Federal level. They cannot be controlled at the State level.

The demographics of American society is one of those factors. The utilization of more intense services by those who are elderly is another factor. Price inflation is the third.

What we have suggested is that while one might wish to block grant the acute care portion of Medicaid, it makes no sense to block

grant the long-term care portion, and simply devolve upon the States that very difficult, probably insoluble problem of trying to match what will always be a 10 percent growth rate with a 5 percent funding cut. Rather, we suggest that we do a better job of coordinating the long-term care part of Medicaid with other Federal programs that are necessary to the support of the elderly—Social Security and Medicare.

We have also suggested, however, not simply to make long-term care yet one more entitlement without any cap, without any limitations in terms of payment. Certainly, we can do a lot. Utilizing long-term care insurance is the linch pin, if you will, of that kind of an approach, to provide the same level of support, to make sure we are not simply throwing people off the rolls, eliminating the services that they need, but rather to marshal both private sector and public sector resources.

We think there are solutions, which both protect the elderly and at the same time give deference, as we must, and as you suggested, Mr. Chairman, to the realities of the fiscal environment in which we live. We have to balance those two factors as well.

Mr. McCONNELL. I think one of the really unfortunate things about the Medicaid cuts is that first of all there doesn't appear to be a philosophy about how those savings are going to be generated. I think there is hope, that by managed care we can achieve some savings, but that would affect only a small part of Medicaid. The biggest part is the long-term care piece, and unfortunately, the part that is likely to get hit first, cut at the State level, is the home and community based care programs. Ironically this is the one place where we can find some savings by, producing services less expensively.

Putting on my Alzheimer's Association hat now, I must point out that half of the people in nursing homes have some form of dementia. We have to have nursing home care as an option. But, there are home and community options that are developing in States, a lot of innovation. Senator Cohen knows this very well. These innovations are hopeful for producing savings, and yet if we do this kind of indiscriminate cut, those innovations are the first thing that are going to go.

Mr. HALAMANDARIS. Thank you, Senator. It is good to see you again.

My slant on this is to mention three things that are important, and Senator Cohen has taken an initiative on. This issue of long-term care; the issue of fraud and abuse; the issue of paperwork reduction. The Senator is on target with all three of them.

As providers we do not like to talk about the fact that there is a fair amount of fraud and abuse in Government programs. I am the guy who did most of the investigations in this area when I sat on that side of the dias, so I am well familiar with it. The one area that had the least problems in this area was community based care, but we are starting to see some problems develop in that area. Again, I want to commend the Chairman for jumping on that issue, and doing whatever we can to stem the tide. There is still a significant problem.

Paperwork. If you look at the Medicare program, for all of the wonderful things it does for people; look at the paperwork and

what that does. Now, I am an attorney and former counsel for this Committee, and for Pepper's committee. I was absolutely confounded trying to do the Medicare paperwork for my mother and my father, who had strokes. There is no excuse for that. I don't see any reason why we should set up a paperwork jungle.

Senator MOSELEY-BRAUN. I recollect that was a conversation we had one time, wasn't it, about our respective experiences with trying to get through the system?

Mr. HALAMANDARIS. It was indeed. There is just no excuse for that.

The major item that is pushing all the problems that we see is long-term care, the fact that it isn't recognized. It is throwing a tremendous burden on the Medicaid program. If you talk to any of the Governors, they will tell you the biggest problem they have is the growing Medicaid program. Most of that relates to the burden of long-term care.

The Medicare program, the Chairman pointed out today, is changing from what was an acute benefit, and covering more and more long-term care, except we don't really cover it. Until we address the issue of long-term care, you are going to continue to have problems in the health care system that are completely unmanageable, and costs are going to be out of control.

I would remind everybody that Claude Pepper, our good friend and chairman, who had his finger on the pulse of the American people better than anybody I ever knew, chose to start with long-term care in terms of health care reform. He didn't start with any of the other areas, all of which are vital. But, he said if we don't address this problem, it is going to kill us as a society. It is going to throw an overload in all of the programs.

In providing a system, and comprehensive coverage for long-term care, we will realize some significant cost savings. Let's not be in a position of forcing people to play games with spending down. To go through this system, what we force people to do to get coverage in this country is criminal. It should not be required. That is one of the fundamental places we have to work.

Mr. Chairman, when you talked about using tax policy, I just remind you what Pepper used to say. He said, one man who is right is a majority. It took him about 15 years or so to get lend lease through the Senate. I hope you will persevere.

There are some dumb ideas out there that people are talking about. This idea of bundling. Have you heard of this one? They are going to give the hospitals a big chunk of money, and tell them, you decide what portion of this to parcel out to nursing homes and community based care. Not even the hospital industry supports that idea. Still, it is somebody's idea of how you save multiple billions of dollars. So we have to be very, very careful that we do this surgery that we need to do, and to do it carefully rather than to use the meat ax approach that is going to harm everyone.

I do think as you said so well, our eye has to be on the future generations, not just this generation.

Senator MOSELEY-BRAUN. Thank you very much.

The CHAIRMAN. Gentlemen. Thank all of you for your testimony. It was very helpful today. Hopefully this will be the first of many

discussions that will take place on the part of our education of the American people. The Committee stands adjourned.

[Whereupon, at 12:14 p.m., the Committee adjourned, to reconvene at the call of the Chair.]

APPENDIX

The Seniors Coalition

ISSUE PAPER

The Seniors Coalition

STATEMENT

LONG TERM CARE: CURRENT ISSUES AND FUTURE DIRECTIONS

PRESENTED TO THE

SENATE SPECIAL COMMITTEE ON AGING

UNITED STATES SENATE

MAY 11, 1995

Protecting the Future You Have Earned

Washington D.C. Metro Office: 11166 Main Street, Suite 302 • Fairfax, Virginia 22030 • Phone (703) 591-0663

Long Term Care:
Current Trends and Future Directions

The Seniors Coalition serves as the common-sense advocacy alternative for over one million senior citizens nationwide. Our members believe that free individuals, working together in free markets, can find solutions to most of the problems facing older Americans. They believe there is already too much bureaucratic regulation and red tape in our society. And they believe we should turn to the federal government for help only if solutions cannot be found at the level of the state, the city or county, the neighborhood, the family, or the individual.

The Seniors Coalition is pleased that this committee, under the strong leadership of Chairman William Cohen, is addressing the problem of Long Term Care. Too many senior citizens are forced to "spend down" the accumulated resources of a lifetime because of a serious illness that requires nursing home care. Among millions of older Americans, there is a constant fear that, at any time, they might lose everything they own.

Because of changes in our country's population, the Long Term Care problem will probably get worse. Life expectancy has steadily increased in the United States, with almost all of the increase since 1970 being attributable to decreasing death rates for those over 65 years of age. According to U.S. Census Bureau figures, the oldest segment of the population, those over age 85, will grow the fastest. It is estimated that by the year 2050, nearly a quarter of all people over 65 will be 85 years of age or older.

By 1990, people age 65 or older faced a 43% lifetime risk of entering a nursing home. About one of every five seniors faced a nursing home stay over one year, and about one in ten would be in a facility for five years or longer. The cost of such care can be astronomical. The cost of care in a nursing home in 1992 was about $28,500 a year for unskilled care and about $32,000 a year for skilled care.

Private insurance policies account for only one percent of Long Term Care. Medicaid pays the vast majority. According to the Health Care Financing Administration, under current law Medicaid, by the year 2025, will pay for two-thirds of all Long Term Care.

Congress is now facing the tough choices that will be necessary to balance the budget. But if we do not make reforms in Long Term Care, those choices will be even tougher.

In recent years, there has been significant progress in the development of private insurance for Long Term Care. The public is beginning to understand the magnitude of the problem of paying for Long Term Care. People are beginning to realize the importance of taking steps now to alleviate hardship later on in life.

Consider the results of a 1993 poll by the Employee Benefit Research Institute. Asked how they expect to pay for Long Term Care, 18% of respondents said they expected to use personal savings; 42% said they expected to use private Long Term Care insurance; and only 28% expected

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the government to pay for it. In other words, by two to one, people expected to use private means to pay for Long Term Care rather than depending on the government. After participants in the survey were given some information about Long Term Care, about two-thirds said they would be interested in purchasing a Long Term Care policy directly from an insurance company or through an employer.

Thus, we see that, while many of today's seniors are forced to bankrupt themselves to qualify for Medicaid coverage, most of tomorrow's seniors look for ways to avoid that indignity.

The question is, how do we build a system that makes private long term health care insurance attractive and affordable to consumers of all ages?

The Seniors Coalition believes that this committee's focus on examinig the role of the private sector in the Long Term Care arena is a big step toward that goal.

No longer should America's seniors be forced into bankruptcy to pay for health care services. Likewise, the federal government should not be expected to continue picking up the tab through Medicaid; most Americans are ready and willing to pay for private Long Term Care insurance. As the figures mentioned earlier aptly illustrate, with the aging trend we're facing, Long Term Care will bankrupt the government. Pursuing legislation that encourages the development of the private long term care market will widen the avenue for shared responsibility between the government, the consumer, and the insurance industry.

Promoting the private market will undoubtedly lead to reduced public financing of Long Term Care. Long Term Care insurance policies have expanded greatly over the past few years and now offer a wide variety of benefit options and more flexible eligibility criteria. As these reforms are passed, I believe we will see a dramatic growth in the employer-sponsored market. If we can make it possible and realistic for working-age people to provide for their long term health care needs now, we can eventually reduce public financing to a bare minimum.

To successfully shepherd this transition, Congress should be careful to set standards and guidelines to ensure consistency between Long Term Care policies. Now this does not mean that we should establish a government-run health care system. But it does mean that there are some inequities between competing plans and carriers that must be addressed to guarantee that consumers are given the best options from which to select a policy.

We would also suggest that Congress take this opportunity to evaluate the role of private Long Term Care insurance in overall Medicaid reforms. It is vital that regulations governing this system be uniform, that they provide adequate reimbursement to care providers. We also must end the bias toward institutionalized care. Not only have Medicaid and Medicare regulations pushed people toward institutionalized care, but the absence of market-driven private policies have made non-institutionalized care too expensive for the vast majority of people. These reforms will end the cycle that encourages the elderly to intentionally divest themselves to qualify for Medicaid coverage.

The work of the House of Representatives in passing H.R. 1215 which includes tax incentives for Long Term Care is a sound basis for beginning this process. Some say that changing the tax code is no way to provide Long Term Care to America's seniors, but we believe they are wrong for three reasons.

First, last year's health care debate, as well as changes in the insurance industry, have heightened people's awareness of Long Term Care, its costs and its methods. Just as they rejected the notion of a government run health care system, seniors are rejecting the notion that the only way to provide for their Long Term Care needs is through a government-run, taxpayer-financed bureaucracy.

Second, there is a growing realization among America's seniors that one federal program after another has, in the name of helping seniors, hurt them. Many of these programs have weakened the economy, raided the Treasury, sent taxes skyrocketing, created rivers of red tape and has taken away peoples' freedom and self-sufficiency. Today's seniors are dismayed that time and time again they are expected to quietly become wards of the welfare state in exchange for their contributions throughout their working years. Today's seniors want options that will let them provide for themselves and determine their own fates.

Third, the fact is that taxpayers change their habits in response to changes in the tax system. For example, if Congress imposes a hefty gas tax, people tend to vacation closer to home, thereby reducing the expected revenues from increasing the tax. If Long Term Care insurance is affordable and accessible, people will take advantage of this opportunity.

The Long Term Care problem is too big and too serious for the solution to come directly from a federal government that can't even balance its own books. Any proposed solution that relies mostly on the federal government is a dead end. The responsibility to finance Long Term Care must be a shared one. The vast majority of people can provide for themselves, and should be expected to. The federal government can help those who, through no fault of their own, cannot provide for themselves.

The opportunity is before us to dramatically change the way American's view their long term health care. Medical technology is extending the length and improving the quality of life in ways that no one imagined. Our nation's policy on Long Term Care will fail if it is based on outmoded and failed notions of centralized government control. Instead, we must build a system that places primary responsibility on individuals and families, with the government stepping in only when absolutely necessary.

The Seniors Coalition is ready to assist you in any way possible to ensure the development of private Long Term Care options for America's senior citizens.

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Long-Term Care Management Institute Supports Private Long-Term Care Financing

The Long-Term Care Management Institute, is an affiliate of Saint Joseph's College in Standish, Maine, dedicated to improving long-term care management and delivery. The Institute, whose activities include education, research, consultation, publication, discussion of issues, policy development, and advocacy, has a national network of participants numbering some 1700 individuals and organizations throughout the U. S. involved in long-term care.

The Institute strongly supports Senator Cohen's efforts to improve access to long-term care through encouragement of private financing. There is great need for innovative financing mechanisms such as some of the public/private financing demonstration projects that are in process. No longer can we rely solely on public financing alone, for several reasons. First, public funds are running out. Second, they have not been adequate to meet the needs of long-term care in the past, and are not adequate now. Third, public funding should be for those with no other options. Those of us who can afford private insurance should contribute to the best of our ability.

As an individual, and as a long-term care educator and consultant, I feel strongly enough about the last point that I purchased a private long-term care policy last year. One of the incentives to do so was the Maine state income tax credit for policy premiums. Similar federal incentives would go far to encourage private involvement in long-term care insurance purchases.

The Long-Term Care Management Institute, along with its affiliated group, the Continuing Care Council, has developed a document titled *Criteria For Designing Or Evaluating A Long-Term Care System©*.

Those Criteria call for a long-term care system that would, among other things, be adequately and fairly financed. To do so, it would:

A. Utilize public and consumer resources to assure universal access to services. All available resources, public and private, should be considered in providing services for current and future consumers.

B. Provide incentives for consumers to use services in an appropriate and cost effective manner. The overall cost of the system can be controlled by avoiding excessive and unnecessary use.

C. Provide incentives for consumers to self-finance their care. Consumers and their families should be encouraged to pay for their own care when possible.

D. Avoid causing impoverishment of consumers and families.

I heartily endorse Senator Cohen's efforts and would be happy to provide any assistance I can.

— John R. Pratt, Director, Long-Term Care Management Institute

NEW ENGLAND SENIORS PLANNING COUNCIL

Helping Seniors Develop Financial Security in Retirement

Private-Sector Insurance Must Be Considered

Spending for long-term care continues to be funded by two major sources: Medicaid and funds from the individuals themselves. This trend must be broken in order to assure the solvency of Medicaid and preserve the wealth of today's middle class of Senior Citizens. The insurance industry is the logical "third payer". Imagine paying for the costs of major medical care without insurance. Imagine trying to rebuild your home after a fire without insurance. It is part of the fabric of our society. It is a risk-management tool which cannot be ignored.

The amount of funding from insurance sources is indicative of the low insurance use. The purpose of insurance has always relied on the "law of large numbers". The more people involved in the risk pool, the lower the individual's share of the expense. The use of private insurance must be encouraged in order to promote financial well-being for individuals as well as the insurance carriers who become involved. With the confusion over taxation, universal healthcare, Medicare coverage and suspicion of insurance companies it is no wonder that the public and many insurance carriers are reluctant to get involved with this insurance.

Our government needs to let the public know that most long-term care costs will not be paid by Medicare, Medicare Supplements or Medical Insurance. My clients seem to be under the impression that Medicare and a supplement policy will cover all of their post-retirement medical needs. This is, of course, not true. With approximately 40% of people over age 65 needing assistance during their lifetime with long-term care, this ignorance bankrupts many Americans annually and costs the Medicaid program billions of dollars. To the extent that ignorance exists, the public will continue the present cycle of spending personal wealth then landing on Medicaid.

In my capacity as a financial planner and licensed insurance consultant, I frequently see instances where private-sector funding of long-term care services would be advantageous to clients and society. I have seen clients spend $60,000 a year from their own pockets until they were bankrupt. My grandfather, a prominent Boston businessman, spent his fortune paying for my Grandmother's nursing care (Parkinson's Disease) over 14 years. The "inheritance" to his children amounted to virtually nothing from what was once one of the largest trucking companies in Boston. This type of story is all-too common in America today. I urge you to consider traditional risk-management options through insurance.

Respectfully,

Clifford P. Ryan, CLU, ChFC
President, New England Seniors Planning Council

ISBN 0-16-047504-X