LONG-TERM CARE INSURANCE AS AN EMPLOYMENT BENEFIT

HEARING

BEFORE THE

SUBCOMMITTEE ON THE CIVIL SERVICE

OF THE

COMMITTEE ON GOVERNMENT REFORM AND OVERSIGHT

HOUSE OF REPRESENTATIVES

ONE HUNDRED FIFTH CONGRESS

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CONTENTS

LONG-TERM CARE INSURANCE AS AN EMPLOYMENT BENEFIT

THURSDAY, MARCH 26, 1998

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON THE CIVIL SERVICE,
COMMITTEE ON GOVERNMENT REFORM AND OVERSIGHT,
Washington, DC.

The subcommittee met, pursuant to notice, at 9:30 a.m., in room 2154, Rayburn House Office Building, Hon. John L. Mica (chairman of the subcommittee) presiding.

Present: Representatives Mica, Pappas, Morella, Cummings, and Norton.

Also present: Representative Allen.

Staff present: George Nesterczuk, staff director; Caroline Fiel, clerk; Jeff Shea and Charli Coon, professional staff members; and Cedric Hendricks, minority counsel.

Mr. MICA. I would like to call this meeting of the House Civil Service Subcommittee to order.

This morning we are going to consider the question of long-term care insurance as an employee benefit for our Federal employees. I will begin this morning's hearing with an opening statement. Then I will yield to others for their opening statements. I see we have two panels this morning.

Ladies and gentlemen, this morning our subcommittee is examining the issue of long-term care insurance and the role that it can play in protecting individuals and families from facing catastrophic financial risk, and reducing their reliance on Medicaid when they or their loved one needs long-term care.

Employee-based plans represent the fastest growing market for long-term care insurance. Employer-based plans are marketed to individual employers and are generally available to the firm's employees, their spouses, parents of employees, and spouses and retirees on a beneficiary-pay-all basis.

As one of the Nation's largest employers, I strongly believe it is time for us, we here in Congress, to examine the feasibility of offering long-term care insurance as a benefit to our Federal employees. As a group plan, long-term care insurance would be less costly to Federal employees than purchasing an individual plan, due in part to economies of scale in marketing and administration.

Providing this employment benefit, I believe, will help the Government remain competitive with private-sector compensation practices. But perhaps more importantly, making affordable long-term care insurance available to Federal employees would help our Fed-

eral employees plan for financing long-term care services and to avoid severe financial hardships in the future.

Federal employees have already expressed a very significant interest in being offered an option to purchase long-term care insurance. In a customer feedback survey that the Office of Personal Management distributed to Federal employees from January through March 1997, an amazing 86 percent of those that responded expressed interest in long-term care insurance.

In light of the growth in private-sector employers offering employees a long-term care insurance option and the obvious interest of Federal employees in long-term care as a benefit, the time is right, I believe, for Congress to carefully examine this issue. That is the purpose of today's hearing, to collect information on long-term care insurance, to examine how private-sector employees are addressing their employees' long-term care needs, and then to make an informed decision about how to give our Federal employees access to this important and long overdue benefit.

Let me say also, off the script, that as chairman of this subcommittee for the past 36-plus months, it has been my intent, as I said in my statement, to see how we can assist our Federal employees and try to bring them in line with what is happening in the private sector. We have done that through several mechanisms. One, we have passed through this committee and through the House adjustments to life insurance coverage for our Federal employees. Our Federal employees have inadequate life insurance coverage at an expensive rate, fixed in stone by a law that is outdated and a system that has not been competitively bid, in my opinion, in 40 years. And we are going to change that.

We also have the problem of health care insurance. We have looked at what has happened to our Federal employees and our Federal retirees, and on average they have experienced a 15-percent increase in 1 year, which is not acceptable, particularly when they get a very small, around a 3-percent or less, increase for cost of living, and their health care insurance costs have gone up dramatically. With the concerns in mind of our retirees and others, we are looking at and we will pass some other options, including medical savings accounts, to bring down those costs for all of our Federal employees and retirees.

Today, we will look at something that has been ignored by this panel, but, in fact, is needed and should be something that we consider, as a Congress, for those who are employed in our Federal work force, and that is long-term care insurance for our Federal employees as a benefit. We will do those things.

With those comments, I am pleased to recognize our ranking member, the gentleman from Maryland.

Mr. CUMMINGS. Thank you, Mr. Chairman, for holding this hearing and bringing to the forefront an issue of great importance to thousands of Americans and their families.

As we, as a society, age, more and more people are coming to consider the desirability, if not the necessity, of taking steps to ensure that during their senior years they and their family members continue to enjoy a high quality of life. In part, this can be addressed through a secure retirement annuity and the maintenance of comprehensive health insurance. However, what it can also re-

quire is protection from the extraordinary costs of care that can arise should one experience a health-related incapacitating disability.

True peace of mind in our golden years will come only with knowing that we will have access to services that will help us cope with heart disease, strokes, arthritis, vision and hearing impairments, Alzheimer's and other debilitating conditions and illnesses. We are here today to discuss whether and how best to offer Federal employees and retirees this peace of mind through the provision of long-term care insurance as a new benefit option.

Many families are already struggling today with the cost of quality child care for their children. To add to this, the cost of quality nursing home care for a parent, a spouse or child can trigger a financial crisis that is difficult to handle. With nursing home care averaging over $40,000 a year, and no private insurance to cover such a cost in place or available, financial resources can quickly be depleted, and poverty becomes the likely result. Only then can the limited public assistance provided by Medicaid be obtained to help secure the needed replacement.

The purchase of private long-term care insurance is the means by which an ever-increasing number of families are providing for the cost of severe medical disability. This product is still in its infancy, and many questions remain about it. Specifically, what I would like to know is: What steps should be taken to make Federal employees and retirees more aware of the need and availability of long-term care insurance? What type of long-term care insurance coverage could be offered as part of the overall Federal employee benefit package? How should a long-term care insurance benefit for Federal employees and retirees be administered? And whether the group purchasing power of Federal employees and retirees can make long-term care insurance more affordable than it would be if purchased on an individual basis?

I hope these questions will be addressed by today's witnesses. I thank them for appearing and look forward to the testimony.

Again, I thank you, Mr. Chairman.

Mr. MICA. I now recognize the gentlewoman from Maryland Mrs. Morella.

Mrs. MORELLA. Mr. Chairman, I want to thank you for holding today's hearing on long-term care as an employee benefit. We all worry about long-term care, whether it is for our own futures, for our spouse, for our parents, for our dependents. Despite our worries, we are never adequately prepared to face the challenges of long-term care. Long-term care is often necessary in the face of a serious injury, chronic illness or the effects of aging. Drawing from my own family's experiences, I know how emotionally difficult long-term care is.

Long-term care is incredibly expensive, and we are ill-prepared as a Nation to pay for it. Soon baby boomers will retire, increasing the need for long-term care. From 1997 to 2030, individuals 85 and over will more than double from about 3.9 million to about 8.5 million. By 2050, that number will double again to about 18 million individuals. This is a time to act. Medicaid was designed as a program for the poor, but in many States a large proportion of Medicaid is used for middle-income people to fund long-term care ex-

penses. At a cost of between $40,000 and $50,000 a year, long-term care expenses can quickly drain families' resources. Unfortunately, many people make the incorrect assumption that Medicare covers long-term care expenses. Long-term care insurance would go a long way toward helping those facing an already difficult transition.

Today, we will consider the possible outcomes of offering long-term care insurance as a potential benefit for Federal employees. I look forward to working with my colleagues to make this idea a reality. I have heard from many constituents, and I know they are very enthusiastic about this idea.

I am very interested in hearing from today's witnesses. The Department of Health and Human Services has been working with OPM to examine employer group long-term insurance. I believe the Federal Government should lead the way in offering long-term insurance through the workplace, and I look forward to working on this issue.

I thank you, Mr. Chairman.

Mr. MICA. I now yield to the gentlewoman from the District of Columbia, Ms. Norton.

Ms. NORTON. Thank you Mr. Chairman. I particularly appreciate your initiative in calling this hearing. I regard it as a kind of consciousness-raising hearing, a wake-up call. The average employee, I think certainly the average Federal employee, understands the importance of having ordinary health insurance, but I do not think that is the case for most Federal employees or most Americans when it comes to long-term care. Counted among the reasons may be that most people don't want to face the fact that they might need long-term care, and in case one is inclined to face that fact, there is the cost of long-term care, which makes it easy to want to avoid facing that fact. Therefore, I think it is up to this committee and to Congress to raise this issue, particularly given the statistics on long-term care that we already have and that we know confront us with the baby boom generation.

The FEHBP is seen as a state-of-the-art health program based largely on costs and choice. FEHBP is ahead of most health insurance programs and remains a model for many. It may still be the more likely model for national health insurance than any other that has been put forward. National health insurance is simply going to have to come.

Part of the 15 percent increase we see now is because we don't have in place a national system that both contains costs and makes health care available to Americans. It is one of the great shames of America, as it crosses the millennia. FEHBP offers a way to begin to address that problem, particularly for working Americans who do not have health insurance. FEHBP itself, however, will not remain a state-of-the-art health care system unless we find the way to make an affordable option for long-term care available to Federal employees. I, therefore, very much appreciate your initiative in calling this hearing this morning.

Thank you, Mr. Chairman.

Mr. MICA. The Chair recognizes the gentleman from New Jersey, Mr. Pappas.

Mr. PAPPAS. Thank you Mr. Chairman. I commend you for calling this hearing. The issue of long-term care and the option that—addi-

tional options that our folks, Federal employees and retired Federal employees should have, I think, is very important. This is long overdue, and I certainly thank you for calling this.

Mr. MICA. I would like to ask our first panel to come up and take your seat, please. I am so pleased this morning to recognize and welcome to our panel the distinguished gentleman from Maine, Mr. Allen. I understand Mr. Allen is with us, and would like to recognize him either for an opening statement or to introduce, if he would for the panel, one of our panelists, who I believe is from his State.

Mr. Allen, you are recognized.

Mr. ALLEN. Thank you Mr. Chairman. I will try to do both. I want to thank you for your leadership in addressing the long-term care crisis that our Nation is facing. I am not a member of this particular subcommittee, though I am a member of the Committee on Government Reform and Oversight. But I am here really to welcome my good friend, David Brenerman, to the committee. Mr. Brenerman and I both served as mayors of the city of Portland. He was an outstanding mayor and city councilor for our city, and David Brenerman's dedication to the public has continued with his work as the second vice president for Governmental Relations for UNUM Life Insurance Co. UNUM's corporate headquarters are in Portland. David is the immediate past chair of the Long-Term Care Committee of the Health Insurance Association of America, for which he will testify today.

UNUM has been the largest writer of group health, of group long-term disability insurance, since 1976 and a leader in personal accident, sickness, life and cancer insurance policies in this country. I am proud to welcome Mr. Brenerman to the committee.

I would also like to say that one staff member on this committee has shared with my office how in her words UNUM and this type of insurance has "saved her family." About 10 years ago her mother was diagnosed with an illness that required long-term care. UNUM at that time was one of the very few companies in the country that was offering this type of coverage. Her mother had a policy that kicked in when she needed it.

It is clear that this kind of long-term care insurance coverage is essential for a great many Americans. As our society is aging, the need for long-term care coverage is more compelling. It is estimated that 30 percent of the 7.3 million elderly are severely disabled and require assistance. About 22 percent live in nursing homes. Again, the need is clear, and expanded coverage ever more important.

Mr. Chairman, I thank you for your leadership on this issue and for allowing me to welcome Mr. Brenerman. I regret that I have another committee meeting which will not allow me to stay here, but I certainly will review the materials and the testimony that have been presented.

[The prepared statement of Hon. Tom Allen follows:]

Opening Statement by Representative Tom Allen (ME)
before the
Subcommittee on the Civil Service
Committee on Government Reform and Oversight

March 26, 1998

Thank you, Mr. Chairman. I want to thank you for your leadership in addressing the long-term care crisis that our nation is facing. I am here to welcome my good friend, David Brenerman, to the committee. Mr. Brenerman and I both served as Mayors of the City of Portland. He was an outstanding Mayor and City Councilman for our city. Mr. Brenerman's dedication to the public has continued with his work as the Second Vice President for Government Relations for UNUM Life Insurance Company. UNUM's corporate headquarters is in Portland, ME. David Brenerman is the immediate past Chairman of the Long-Term Care Committee of the Health Insurance Association of America for which he will be testifying today.

UNUM has been the largest writer of group long term disability insurance since 1976 and a leader in personal accident, sickness, life and cancer insurance policies in the country. I am proud to welcome Mr. Brenerman to the committee. I would also like to say that one staff member on this committee shared with my office how UNUM has saved her family. Approximately ten years ago, her mother was diagnosed with an illness that required long-term care. UNUM was at that time one of the very few companies to offer this type of coverage. Thankfully, her mother had a policy that kicked in when she needed it. It is clear that long-term care insurance coverage is essential. As our society is aging, the need for long-term care coverage is more compelling. It is estimated that 30% of the 7.3 million elderly are severly disabled and require assistance. About 22% live in nursing homes. Again, the need is clear, and expanded coverage ever more important.

Mr. Chairman, thank you again for your leadership on this issue and for allowing me to welcome Mr. Brenerman.

Mr. MICA. Before I introduce the balance of our panel, I would like to take a moment of personal privilege and ask Mr. Cedric Hendricks to come up and stand next to me.

Ladies and gentlemen, I am chairman of this subcommittee, and we don't often get this many Members of our panel here. Maybe I could get a photographer to take a picture. I wanted to take just a moment to recognize Cedric. Cedric, I was informed today, is going to be reassigned, but over the past years I have known and had the privilege as chairman to work with him. He is the chief assistant for the subcommittee, for the full committee, and also assigned to this subcommittee. He has had to endure several ranking members and me as chairman, so he certainly deserves our praise. I cannot tell you of anyone with whom I have more enjoyed working with as far as staff or Member on either side of the aisle. We are certainly going to miss him. I want to tell him personally and publicly how much we appreciate what he has done, not just for the panel, but also for the Congress and for our Federal employees and retirees, and others. We will miss you. I am sorry to hear about this reassignment, but you are welcome back any time either on that side or this side.

I would like to recognize the ranking member.

Mr. CUMMINGS. I want to say that since I have been the ranking member here, I have worked very closely with Cedric. I just want to thank you for all that you have done, Cedric. There are few individuals that—you know I am a stickler for errors, and I can say that you have never presented anything to me with an error in it. You have been very, very efficient and have always been there for me and for the Members on this side. I just want to thank you for persistently pursuing excellence and being the very best that the Congress has to offer. We are going to miss you tremendously. We know that you are now moving onto higher ground, but always know that we really love you, and we thank you so much for giving your blood, sweat and tears to us. Thank you, and thank you again.

Mr. MICA. I would like to recognize the gentlewoman from Maryland.

Mrs. MORELLA. Cedric, I don't know why you are leaving us. We have enjoyed so much the relationship we have had, remembering the old Post Office and Civil Service Committee, when we could always rely on Cedric to come up with the issue, background and the people orientation. He has always been very fair, and I hope you do know that we would like to have you back here. It is just a pleasure in a bipartisan manner to say here is a guy who serves Congress and the people well.

Mr. MICA. Ms. Norton.

Ms. NORTON. Thank you, Mr. Chairman. I regard Cedric as my gift to the committee, although I was a very unwilling and uncheerful giver. At least we got the benefit, however, of Cedric's enormous intelligence and energy, because he continued to work on areas of great concern to the District of Columbia. Cedric was my legislative director when I came to the Congress in 1991.

Cedric will challenge us, I think, to demonstrate that the truism that no one is irreplaceable is, in fact, the case. He brought and accumulated—was not born with, but accumulated—encyclopedic knowledge of two very difficult areas of our jurisdiction, of the ju-

risdiction of the full committee, that simply do not cross-cut with other jurisdictions.

On my own staff I have people to meet with Cedric when they come on so they will know how to be a staff person, which means he has become what in the teaching profession they call a master teacher. I suppose the rest of it call it a mentor. In any case, his standard of excellence he has achieved I will not say will be hard to achieve, I will say will be what we should demand that others strive for.

Cedric, you are irreplaceable. Now, go out and prove it by finding us somebody as good as you to replace you.

Mr. MICA. Mr. Pappas.

Mr. PAPPAS. Cedric, I certainly wish you well. It wasn't that long ago that you trekked up to central New Jersey to my district in probably one of the worst rain storms that we have had in a long time. You endured that, and I think you probably were concerned that the chairman would be taking this subcommittee on the road a bit more and did not want to encounter any more monsoons. I appreciate your participation that day, your taking your time and the effort that you did to come participate in that, and certainly have appreciated your professionalism as a member of this subcommittee. I wish you well.

Mr. MICA. I thank each of my fellow panelists for recognizing someone who has served us very well. We will miss him, and we wish him well.

I would now like to proceed with our first panel. We have had the privilege of having Mr. Allen introduce Mr. David Brenerman, second vice president of Government Relations for UNUM Life Insurance Co., and on behalf of the Health Insurance Companies Association of America. Second panelist is Mr. David S. Martin, director of contracts and legislation division of the John Hancock Mutual Life Insurance Co., on behalf of the American Council of Life Insurance. The third panelist this morning is Mr. Paul Fronstin. He is a research associate with the Employee Benefit Research Institute. And then last, but not least, someone who is very well known to this panel, a very distinguished national president of the National Association of Retired Federal Employees, Charles R. Jackson, who is a familiar face and a gentleman we have all worked with on this panel.

I welcome our first panel. Mr. Jackson, you know the routine. This is an Investigative and Oversight Subcommittee of Congress. We swear in all of our witnesses, so, gentlemen, would you please stand, raise your right hands.

[Witnesses sworn.]

Mr. MICA. Welcome again, and for our new panelists, let me just tell you our MO here. If you have a lengthy statement, we will be glad to make that and any other documents or testimony part of the record, and we will do that by unanimous consent. We do have to ask you to limit your oral presentation before the subcommittee to 5 minutes. We will put the timer on this morning.

With that I would like to recognize first Mr. David S. Martin. You are welcome, sir, and recognized.

STATEMENTS OF DAVID S. MARTIN, DIRECTOR, CONTRACTS AND LEGISLATION DIVISION, JOHN HANCOCK MUTUAL LIFE INSURANCE CO., ON BEHALF OF AMERICAN COUNCIL OF LIFE INSURANCE; DAVID BRENERMAN, SECOND VICE PRESIDENT, GOVERNMENT RELATIONS, UNUM LIFE INSURANCE CO., ON BEHALF OF HEALTH INSURANCE ASSOCIATION OF AMERICA; PAUL FRONSTIN, RESEARCH ASSOCIATE, EMPLOYEE BENEFIT RESEARCH INSTITUTE; AND CHARLES R. JACKSON, PRESIDENT, NATIONAL ASSOCIATION OF RETIRED FEDERAL EMPLOYEES

Mr. MARTIN. Good morning, Mr. Chairman and members of the subcommittee. I am David Martin, director of contracts and legislation at John Hancock. I also serve as chair of the Subcommittee on Long-Term Care Issues for the American Council of Life Insurance. Our member companies that provide long-term care insurance to the American public represent more than 80 percent of that marketplace.

On behalf of the ACLI, I want to thank you for the opportunity to present our comments to you today. ACLI supports the efforts of the committee with regard to offering long-term care insurance to Government workers as an employee benefit. We look forward to working with committee members on this issue.

Congress has played a key role in encouraging private-sector solutions to financing long-term care. The recently enacted Health Insurance Portability and Accountability Act of 1996, referred to as HIPAA, sets standards for tax-favored policies and imposes strong consumer protection provisions. While these Federal initiatives are important first steps, there is an urgent need to do more to address the challenge of financing long-term care in the 21st century.

Earlier this month in testimony before the Senate Special Committee on Aging, William Scanlon, director of Health Financing and Systems Issues, stressed that the aging of the baby boom generation will lead to a decrease in the elderly population, especially those over age 58 who are most likely to need long-term care services. A study just completed by the ACLI indicates that Medicaid and individual out-of-pocket long-term care expenditures for elderly baby boomers could rise by over 360 percent within the next 30 years. A copy of our study is included with our written testimony. By the year 2030, when the class of baby boomers reach retirement, it is estimated that the number of elderly persons will double from 35 million to nearly 70 million. Over 20 percent of the population will be over 65 in 2030 compared with 13 percent in 1990. This means that in about 30 years, 32 States will resemble Florida's population today.

As a very significant employer in America, the Federal Government can reach over 2.8 million workers. By offering this product to persons during their working years, the Government can help encourage the purchase of private insurance at younger ages when premiums are very affordable.

We believe that private long-term care insurance can play an important role in financing long-term care and providing for a secure retirement. Relying on savings to pay for long-term care needs is not a financially feasible option for most middle-income Americans. The chart, which you have a copy of as well as up here, Ways to

Pay for Future Long-Term Care, illustrates that the financial protection long-term care insurance can provide is a clear alternative to asset and savings depletion. As the second chart entitled Long-Term Care Insurance: Average Annual Premiums, and you have a copy of that as well, indicates, a more affordable alternative is private insurance. The chart shows average premiums for a 2-year and a 5-year plan, including inflation protection of 5 percent per year.

The ACLI study shows that private insurance can go a long way toward financing the Nation's long-term care needs in the future, helping individuals and reducing Federal and State Medicaid budgets. In the private sector over 1,500 employers have already recognized the importance of long-term care insurance and offered this benefit to their employees. These organizations range in size from very small firms to Fortune 500 companies. Such nationally prominent employers as General Motors, Ford Motor Co., Chrysler Corp., IBM, AT&T to name just a few, have sponsored long-term care programs.

Employer-sponsored private insurance for long-term care is usually available to employees, retirees, spouses and parents, and parents-in-law. Average age purchase of employer-sponsored coverage is 43.

A recent survey by the National Alliance for Care Giving and AARP found that there are 22 million American households with at least one member providing some unpaid assistance to a spouse, relative or other person over age 50. A study by Met Life estimates that family caregiving costs U.S. businesses $11 to $29 billion per year in lost productivity.

For the majority of employers, long-term care insurance is an employee-pay-all benefit. Our study found that close to two-thirds of persons over age 35, and over 80 percent of those ages 45 to 49, could afford a high-quality policy that covers both nursing home and community-based services. I would again refer you to the sample premium chart in the handout.

Long-term care insurance policies for Federal employees should be of high quality and affordable. To ensure high quality and strong consumer protections, any group or individual private long-term care insurance offered to Federal employees should be a qualified long-term care insurance contract as defined in HIPAA.

Offering private long-term care insurance as a core Government benefit needs to be coupled with an educational program to increase awareness among Federal employees and their families about the importance of planning ahead for long-term care. Workers need accurate and credible information about the limitations of Government programs in paying for long-term care services and the potential risk of needing long-term care services.

We believe that private long-term care insurance is an important part of the solution for tomorrow's uncertain future. As Americans approach the 21st century, living longer than ever before, their lives can be made more secure knowing that long-term care insurance can provide choices, help assure quality care and protect their hard-earned savings and assets when they need assistance in the future. The Federal Government can take a leading role in ensur-

ing that people plan for their future by offering this important benefit to their employees and their families.

Thank you Mr. Chairman. We look forward to working with you.

Mr. MICA. I thank you.

[The prepared statement of Mr. Martin follows:]

Good morning, Mr. Chairman and members of the Committee. I am David Martin, Director, Contracts and Legislation, at John Hancock Mutual Life Insurance Company in Boston. I also serve as the chair of the State/NAIC Subcommittee on Long-Term Care Issues for the American Council of Life Insurance (ACLI). The ACLI is a Washington, D.C.-based national trade association that represents 532 member life insurance companies. Our member companies that provide long-term care insurance to the American public represent more than 80 percent of the long term care insurance marketplace.

On behalf of the ACLI, I want to thank you for the opportunity to talk about the key role the federal government can play in helping its employees take greater responsibility for their long-term care needs through private insurance. ACLI supports the efforts of the Committee with regard to offering long-term care insurance to government workers as an employee benefit. We look forward to working closely with Committee members on this issue.

Congress is increasingly emphasizing the need to encourage private-sector solutions to financing long-term care. The recently enacted Health Insurance Portability and Accountability Act of 1996 (HIPAA) allows individuals to deduct as medical expenses the cost of certain premiums for qualified long-term care insurance from their federal taxes. HIPAA also excludes benefit payments from qualified policies from taxable income. Equally important, the provisions of this Act encourage employers to offer long-term care insurance by allowing employers to deduct premium payments for their

employees who have long-term care coverage. Employer contributions to a qualified long-term care plan are also excluded from the gross income of the employee. More recently, members of Congress have begun to sign on as co-sponsors of H. Con. Res. 210, which expresses the sense of Congress with respect to promoting coverage of individuals under private long-term care insurance.

While these federal legislative initiatives are important first steps, there is an urgent need to do more to address the challenge of financing long-term care in the 21st century. Earlier this month, in testimony before the Senate Special Committee on Aging, William Scanlon, Director of Health Financing and Systems Issues (GAO), stressed that the aging of the baby boom generation will lead to a tremendous increase in the elderly population, especially those over age 85, who are most likely to need long-term care services. A study just completed by the ACLI indicates that Medicaid and individual out-of-pocket long-term care expenditures for elderly baby boomers could rise by over 360 percent within the next 30 years (see attached).

There is still time to seek out private sector solutions to the looming long-term care crisis. As a very significant employer in America, the federal government can reach over 2.8 million workers. In addition, by offering this product to individuals during their working years, the government can help encourage the purchase of private insurance at younger ages, when premiums are very affordable.

Private long-term care insurance can play an important role in financing long-term care and providing for a secure retirement.

Most working-age adults are preoccupied with the immediate concerns of paying for child care, housing expenses, and saving for their children's education. Looking to the future, many worry that protecting against life's uncertainties, especially the uncertainty associated with long-term care costs, is going to be very challenging. This is because long-term care costs are extremely expensive and would require a large amount of savings. For example, a 45 year-old would have to save almost half a million dollars ($489,000) to pay for a two year nursing home stay at age 85. To reach this goal, she would have to save $3,500 annually. Considering the multiple demands on workers today, relying on savings to pay for long-term care needs is not a financially feasible option for most middle-income Americans.

A more affordable alternative is private insurance. Long-term care insurance, like other insurance, spreads the risk across many individuals and thus lowers costs to any one individual in the event he or she would need long-term care. A 45 year-old would pay about $417 a year for a policy covering two years of long-term care services. This policy would include inflation protection of 5 percent a year. Compared to the $3,500 needed in savings, long-term care insurance could save her over $3,100 a year. In terms of lifetime savings, these numbers are even more substantial. After paying long term care premiums, the 45 year-old could protect over $430,000 of her savings if she buys a long-term care policy instead of paying for nursing home care on her own in the 21st century.

The ACLI study shows that private insurance can go a long way toward financing

The ACLI study shows that private insurance can go a long way toward financing the nation's long-term care needs in the future. For example, if a large number of baby boomers (workers age 34 to 52) purchased long-term care insurance, the share of nursing home expenditures paid for by private insurance could increase from 3 percent today to 29 percent in 2030. Under this scenario, the Medicaid program could save $28 billion (in 1996 dollars) or 21 percent of total Medicaid nursing home expenditures. Similarly, about 40 percent of individual "out of pocket" nursing home costs could be saved by the increased ownership of long-term care insurance.

Many employers provide a long-term care insurance option to their employees.

In the private sector, over 1,500 employers have already recognized the importance of long-term care insurance and offer this benefit to their employees. These organizations range in size from very small firms (under 100 employees) to Fortune 500 companies. Employer-sponsored private insurance for long-term care is usually available to employees and immediate family members. In addition, about three-quarters of employers offering this benefit extend the option to purchase long-term care insurance to retirees and their spouses. Average age of purchase of employer-sponsored coverage is 43.

In these times of restraint in employee benefits, why are increasing numbers of employers offering long-term care insurance? A recent study by William Mercer found that the most important reason cited by employers is the desire to offer a cutting-edge benefit. Employers are beginning to recognize the importance of incorporating long-term

care insurance as an essential part of retirement planning. They are concerned that rapid increases in long-term care expenditures projected for the 21st century could have serious implications for their workers' retirement security. An unanticipated nursing home stay (projected to cost $97,000 per year in 2030) could deplete hard-earned savings and threaten a family's financial protection.

Employees and retirees are also increasingly requesting this type of insurance. Part of this interest stems from their experiences in providing care to aging parents. A recent survey by the National Alliance for Caregiving and AARP found that there are 22 million American households with at least one member providing some unpaid assistance to a spouse, relative, or other person over age 50. Most firms offer long-term care insurance not only to employees but also to their parents and parents-in-law. Knowing that their parents have this protection can be particularly important for middle-age employees, many of whom must juggle caregiving with the demands of management or other senior-level positions. Employers also benefit, since caregiving often reduces worker productivity through absenteeism, workday interruptions, and the loss of skilled employees who quit due to elder care responsibilities. A study by MetLife estimates that family caregiving costs U.S. business over $11 billion per year in lost productivity.

For the majority of employers, long-term care insurance is an employee-pay-all benefit. This means that the employer pays for administrative costs. Since employees pay the premiums, some policymakers are concerned that private insurance may be unaffordable for most federal workers. In reality, the cost of a long-term care policy is

tied to the age of purchase. Our study found that close to two-thirds (62 percent) of individuals over age 35, and over 80 percent of individuals ages 45 to 49 could afford a high quality policy that covers both nursing home and community-based services. This is because private long-term care insurance is less expensive when purchased during one's working years. For example, compared to a 65 year old, premiums are more than 50 percent lower for a 55 year old purchaser, and 70 percent lower for a 45 year old.

The private long-term care insurance market

While the market for private long-term care insurance is relatively small, it is growing. Over 4.3 million policies had been sold as of 1995. A total of 125 companies sell long-term care policies, though 12 companies account for about 80 percent of all individual and group association policies sold. More than half of the companies have been in the market for at least seven years and have actively participated in the development of this innovative product.

The majority of policies have been sold to individuals or through a group association (such as AARP). Employer-sponsored long-term care insurance is a relatively new product. In 1995, this product was sold by about 18 percent of insurance companies and represented about 12 percent of the total policies purchased. The sale of employer-sponsored policies continues to grow. Within the last ten years, the employer-sponsored long-term care insurance market grew at an average annual rate of 60 percent.

Long-term care has long been associated with care of the elderly in a nursing home. However, it is much more than that. People of all ages may require long-term care as a

result of an accident, chronic illness, or disability. Long-term care insurance will pay for a variety of services when a person is unable to perform a specific number of activities of daily living (also termed "ADLs"), such as bathing, eating, going to the toilet, maintaining continence, moving from one place to another, and dressing. Policyholders can also qualify for benefits if they have Alzheimer's disease and other cognitive impairments.

Today's long-term care policies cover a wide range of services to help people live at home, participate in community life, as well as receive skilled care in a nursing home. Policies may also include respite care, medical equipment coverage, care coordination services, payment for family caregivers, or coverage for home modifications. These options can enable people with disabilities to live in the community and retain their independence.

Designing long-term care policies for federal employees.

The design of long-term care insurance policies for federal employees will require a variety of considerations. Most important, the policies should be of high quality and affordable. In addition, since most employees will not need their long-term care benefits for many years, it will be important to ensure that federal employees obtain coverage from financially sound companies that have the experience and administrative capacity to serve individuals covered by private insurance.

Premiums for private insurance vary considerably based on plan design. To benefit from the wide range of options offered in the marketplace today, government employees

should be able to purchase private insurance from carriers meeting the criteria set forth by the Office of Personnel Management.

To ensure high quality and strong consumer protections, any group or individual private long-term care insurance offered to federal employees should be a qualified long-term care insurance contract, as defined in the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191. Title III, Subtitle C of this Act imposes strong consumer protections in all tax-qualified policies. These include:

- Prohibitions against limitations and exclusions by type of illness, treatment, medical condition or accident, except for preexisting conditions or diseases, mental or nervous disorders (excluding Alzheimer's Disease), alcoholism and drug addition, suicide, acts of war or military service, or participation in a riot or felony.

- Prohibitions against post-claims underwriting unless a policyholder misrepresents his or her medical status at the time of application.

- Disclosure of provisions for renewability, riders and endorsements, payment of benefits, benefit triggers, tax consequences, and limitations or conditions on eligibility for benefits.

- Mandatory offer of a policy where benefits increase with inflation. In addition, insurance companies must offer individual and group policyholders a nonforfeiture provision that provides at least reduced paid up insurance, extended term insurance, or a shortened benefit period.

- The right to designate at least one other person who will receive a notice of lapse or termination of the policy due to nonpayment of the premium. In addition,

policyholders providing proof of cognitive impairment or loss of functional capacity within five months after termination may reinstate coverage for long-term care insurance if they pay past due premiums.

- The contract should be fully insured by the carrier or reinsured in all or part with other carriers.

- Policies should be noncancellable or offered on a guaranteed renewable basis. This ensures that policyholders will be able to retain their long-term care coverage as long as they pay their premiums. In addition, the contract should provide benefits that cannot be unilaterally changed by the carrier, except for nonpayment of premiums or in the case of misrepresentation.

- Policies should have continuation of coverage. This means that individuals covered under an eligible contract would be entitled to pay premiums directly to the carrier to continue the insurance if they no longer worked for the government or if their withholding became insufficient (such as after a divorce).

- The carrier should be licensed by the State or other jurisdiction in which the policyholder is located or resides.

Anecdotal evidence suggests that lapse rates are much lower in the group long-term care insurance market when premiums are paid through payroll deductions. To facilitate payment for private insurance and help minimize lapses, the government should withhold the amount equal to the premium from the pay of each enrolled employee. Such withheld funds would be paid by the government to the carrier for each contract.

Offering private long-term care insurance as a core government benefit needs to be coupled with an educational program to increase awareness among federal employees and their families about the importance of planning ahead for long-term care. Currently, many Americans underestimate the risk of becoming disabled and also have misconceptions about who will pay for long-term care. Wo:kers need accurate and credible information about the limitations of government programs in paying for long-term care services, and the potential risk of needing long-term care services.

In conclusion, protection and coverage for long-term care is critical to the economic security and peace of mind of all American families. However, planning for the future is a formidable task for anyone. It requires early and thoughtful preparation. Long-term care insurance is an important part of the solution for tomorrow's uncertain future. As Americans approach the 21st century—living longer than ever before—their lives can be made more secure knowing that long-term care insurance can provide choices, help assure quality care, and protect their hard-earned savings and assets when they need assistance in the future. The federal government can take a leading role in ensuring that people plan for their future by offering this important benefit to its employees and their families.

Thank you Mr. Chairman, and again, we look forward to working with you. I will happy to answer any questions that the Committee may have at this time.

American Council of Life Insurance®

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

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

March 9, 1998

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

Study Overview

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

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

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

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

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

The Looming Crisis: Aging Baby Boomers

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

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

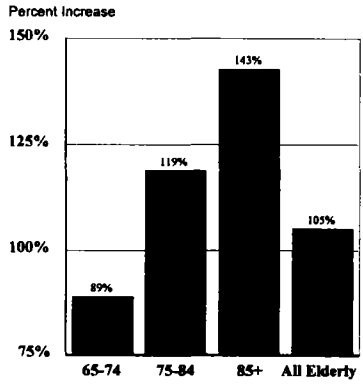
By the year 2030, when the last of the baby boomers reach retirement, it is estimated that the number of elderly individuals will double from 35 million to nearly 70 million. Over 20 percent

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

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

Figure 1

Percent Increase in Elderly Age Groups From 1990 to 2030



Source: Social Security Administration Intermediate Projections

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

Long-Term Care Expenditures Are Likely to Increase Dramatically

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

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

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

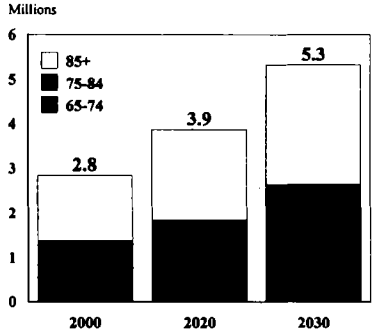
Long-term care can be expensive. For example, a person with a severe disability who lives at home may pay over $36,000 per year for the help of a home care aide.[3] Assisted living facilities charge $26,000 on average. A nursing home can cost $40,000 per year.[4] All of these figures are averages and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

Increasing numbers of baby boomers are becoming aware of long-term care as they provide care to their own aging parents. Many of these caregivers are beginning to think, who is going to take care of me? Baby boomers emphasize that they do not want to end up in a nursing home. However, despite people's preference for services to help them stay in the home and community, government spending predominantly pays for institutional care. Medicaid is the largest government payer of long-term care, but only 21 percent of Medicaid long-term care expenditures cover home and community-based services.[5] Less than half of states (22) have programs that pay for long-term care services in assisted living facilities.[6] As a result, those who impoverish themselves paying for long-term because they lack private insurance or substantial funds could spend their remaining days as a Medicaid recipient in a nursing home.

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

Figure 2

Projected Nursing Home Residents, 2000 - 2030 By Age

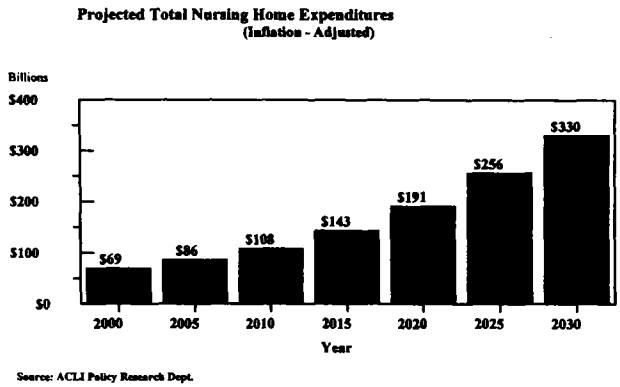


Source: Forecast by American Council of Life Insurance

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

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

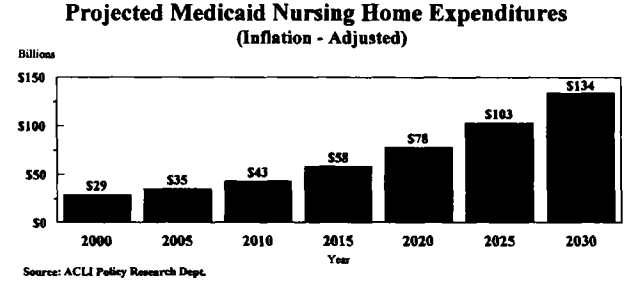
Figure 3



The Impact of Rising LTC Expenditures on Government and Individuals

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

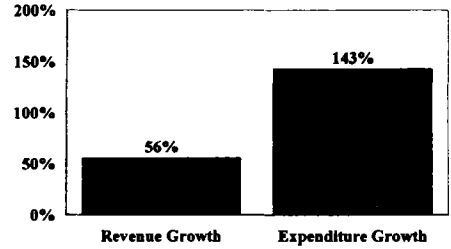
Figure 4



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

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

Medicaid Revenues vs. Expenditures For Nursing Home Care 2000-2030



Source: ACLI Policy Research Dept.

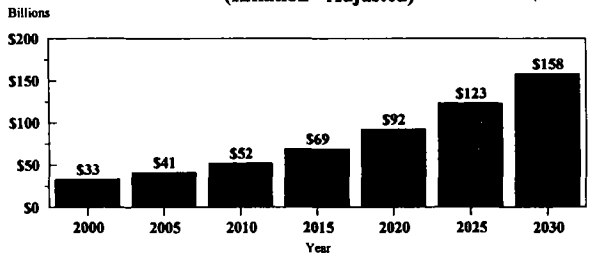
Though government pays for a large portion of long-term care costs, if baby boomers fail to plan ahead and purchase private insurance, much of the burden of rising nursing home costs will continue to fall on individuals and their families. Currently, about 48 percent of nursing home costs are paid for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

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

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

Figure 6

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



Source: ACLI Policy Research Dept.

Rising life expectancy increases the likelihood that baby boomers will rely more on their children to help them with their long-term care needs. As elderly boomers live longer, they are also more likely to face multiple chronic conditions that require complex and physically demanding care. At the same time, the pool of potential family caregivers is shrinking due to smaller family sizes and greater geographic dispersion of families. Caregiving in the 21st century will be further complicated by the fact that the burden of providing assistance will increasingly fall on family members who are employed. In 1960, only one-third of married women worked outside the home. By 1996 over three-fifths of women were in the labor force. About 14 million American households include working caregivers who currently provide some unpaid care to elderly relatives and friends living in the community. As the physical stress of caregiving increases, many of these families may face additional financial burdens if they have to rely more on paid long-term care.

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

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

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

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

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

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

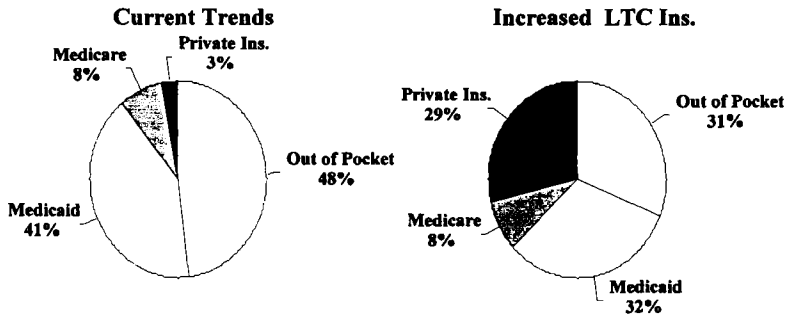
Scenario I: Current Financing Trends Continue

Scenario II: Increased Purchase of Long-term Care Insurance

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

Figure 7

Nursing Home Financing in 2030



Source: ACLI Policy Research Dept.

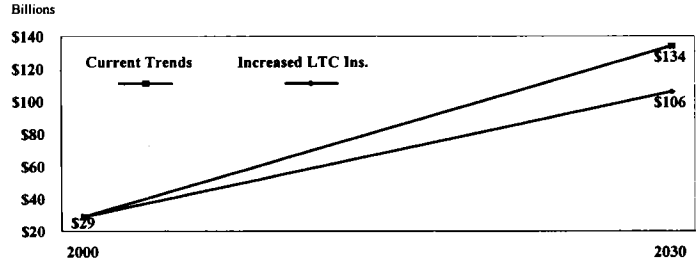
The results of this study indicate that private insurance can be an important source of funding for long-term care in the future and can substantially reduce nursing home expenditures for both Medicaid and individuals. Assuming three-fourths of purchasers retain their policy to the year 2030, the share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

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

Figure 8

Impact on Medicaid NH Expenditures (2030)

(Inflation - Adjusted)



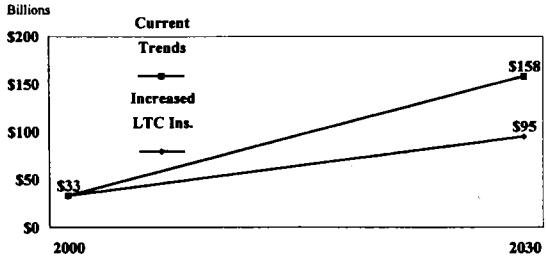
Source: ACLI Policy Research Dept.

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

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

Figure 9

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



Source: ACLI Policy Research Dept.

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

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

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

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

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

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

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

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

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

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

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

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

Many baby boomers are not planning for the future because they are preoccupied with more immediate concerns. Boomers currently represent almost half of all workers, and are parents of about 60 percent of the nation's children under age 18. The baby boomers are now in their high-expense years, between the ages of 32 and 50, when child care and housing expenses tend to dominate their budgets. In addition to their immediate needs, baby boomers are also trying to save enough for their children's college education.

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

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

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

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

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

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

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

Figure 10

Alternative Ways to Pay for Future Long-Term Care Needs

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

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

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

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

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

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

Figure 11

Long-Term Care Insurance

Average Annual Premiums

By Age

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

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

Source: American Council of Life Insurance

Purchasing at an earlier age has other benefits. Since this product involves medical underwriting, those who purchase insurance at an early age are more likely to qualify for coverage. In addition, lower premiums also increase the likelihood that baby boomers will be able to purchase policies with very comprehensive benefits. A 1994 survey by the Health Insurance Association of America found that purchasers age 55-64 had policies with more coverage (almost 7 years) than older purchasers (about 5 years for those age 65 to 74 and 4 years for those age 75+). Younger purchasers were also far more likely to choose inflation protection (61 percent) as a policy feature in contrast to older purchasers (38 percent of those 65-69, 27 percent of those 70-74).

Figure 12

Percent Who Can Afford LTC Insurance by Age

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

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

Conclusions

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

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

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

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

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

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

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

About the Authors

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

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

Endnotes

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9. Affordability is defined as spending no more than 2 percent of income for ages 35 to 44, 3 percent for ages 45-54, 4 percent of income for ages 55-59, and 5 percent of income for ages 60 to 64, and 5 percent of income for ages 65+.

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11. U.S. Dept. of Health and Human Services, (1997) "Characteristics of Elderly Nursing Home Residents: Data from the 1995 National Nursing Home Survey". NCHS, Washington, D.C.

12. Lewin VHI, Inc. (1994). "Aging Baby Boomers: How Secure Is Their Economic Future?", Report Prepared for the American Association of Retired Persons.

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Ways to Pay for Future Long-Term Care

	AGE TODAY	
	45 years	**60 years**
1. ASSET ACCUMULATION		
Annual savings needed	$3, 557	$4,481
Lifetime assets needed at age 85 to pay for 2 years of nursing home care	$489,446	$235,432
2. PURCHASE PRIVATE LONG-TERM CARE INSURANCE		
Annual premium contributions	$417	$824
Lifetime value of premiums	$57,907	$52,097
POTENTIAL SAVINGS FROM LONG-TERM CARE INSURANCE		
Annual savings from long-term care insurance	$3,140	$3,657
Lifetime savings from long-term care insurance	$431,539	$183,335

Note: Calculations are based on a 2-year long-term care policy with inflation protection of 5 percent. All numbers are represented in dollars in year 2030.
Source: American Council of Life Insurance

Long-Term Care Insurance: Average Annual Premiums*

	2-YEAR POLICY		5-YEAR POLICY	
Ages	**Annual**	**Per pay period**	**Annual**	**Per pay period**
35–39	$358	$14	$507	$20
40–44	$403	$16	$605	$23
45–49	$500	$19	$734	$28
50–54	$645	$25	$905	$35
55–59	$892	$34	$1,204	$46
60–64	$1,265	$49	$1,709	$66

* Prices represent a composite of five large long-term care insurance companies. Actual prices may vary by company.
Source: American Council of Life Insurance

Mr. MICA. We will suspend questioning until we finish the entire panel.

I will next recognize, representing the Health Insurance Association of America, Mr. David Brenerman.

Mr. BRENERMAN. Thank you, Mr. Chairman, members of the subcommittee. I am David Brenerman, second vice president of government relations for UNUM Life Insurance Co. of America, which is based in Portland, ME.

First, although the Congressman has left, I would like to thank Congressman Allen for his kind introduction.

Today, I am speaking as the immediate past chairman of the Long-Term Care Committee of the Health Insurance Association of America. On behalf of HIAA, I appreciate the opportunity to talk to you today about the role of private long-term care insurance in financing our Nation's long-term care bill and the importance of offering a long-term care insurance benefit to Federal employees.

Our Nation faces a looming crisis. Long-term care is the largest unfunded liability facing Americans today. For today's elderly and tomorrow's retirees, long-term care is the single major catastrophic expense. About 40 percent of all elderly will spend some time in a nursing home. With annual nursing home costs averaging over $41,000 today and increasing to about $100,000 in 1996 dollars by the year 2030, such expenses can indeed cause financial ruin. Instead of pooling risks, the current system places each household on its own, and when household resources have been depleted, Medicaid becomes the payer of last resort.

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

By the end of 1996, close to 5 million long-term care insurance policies had been sold. The market has grown an average of 22 percent annually. Approximately 80 percent of long-term care insurance policies have been sold in the individual market. The employer-sponsored market enhanced this growth by contributing about 14 percent of all policies sold. Today more than 650,000 policies have been sold through 1,500 employers.

The growth in employer-sponsored plans is particularly promising. Employer plans offer the opportunity to reach a large number of people efficiently during their working years when premiums are more affordable. The average age of the employee electing coverage is 43. This is strong evidence that with education and availability, younger people can and will purchase long-term care protection.

Long-term-care-related issues cost employers $29 billion a year in lost time, lost employees and lost productivity. Many believe, therefore, that private long-term care insurance coverage can have its greatest impact in the employer-sponsored market. With the Federal Government, the Nation's largest employer, offering this

benefit to its employees, this impact would be magnified tremendously.

A Federal employee long-term care insurance plan is particularly encouraging because of three factors. First, such an action would be the clearest signal of Government support for encouraging personal responsibility and planning for long-term care through avenues such as long-term care insurance. Second, the sheer size of the Federal Government as an employer would assure an immediate and heightened awareness of long-term care financing issues among working adults. And finally, because the Federal active employee population is large and considered to be a relatively young and healthy group, the administrative and marketing costs would be less. Premiums will be lower, and underwriting may be minimized.

We have submitted as part of our written testimony our initial thoughts on the parameters we believe should be considered when drafting legislation that would enable this to happen.

I would like to commend the Congress for passage of major incentives for the purchase of long-term care insurance that were included in the Health Insurance Portability and Accountability Act of 1996. HIPAA's provisions have improved the climate for private long-term care insurance. Nevertheless, HIPAA is not a panacea, and will not, by itself, achieve the optimum public-private partnership for long-term care financing. HIAA believes other equally important tax-related changes could make long-term care insurance more affordable to a greater number of people. We have included examples of such actions in our written testimony.

Finally, the importance of consumer education about financing long-term care insurance cannot be overstated and is the shared responsibility of both the public and private sectors. The public must understand the need to plan for long-term care and be aware that there is no government program, including Medicare, unless they become destitute. A Federal employee and retiree long-term care plan will only be successful with a carefully planned education program.

Over time, HIAA fully believes that private long-term care insurance will give millions of people an opportunity to be financially independent throughout their retirement years. Recognition of the private long-term care insurance market in this hearing is a solid step in this direction. Thank you, Mr. Chairman and members of the subcommittee. We look forward to working with you as you develop legislation.

Mr. MICA. Thank you, sir.

[The prepared statement of Mr. Brenerman follows:]

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

On behalf of HIAA, I appreciate the opportunity to talk to you today about the critical role of long-term care insurance in financing our nation's long-term care crisis. I would also like to commend the Subcommittee for realizing the potential of the long-term care insurance market by considering legislation that would enable federal employees to purchase long-term care insurance as an employee benefit. Today, more than 100 companies provide long-term care insurance to over 5 million people. In addition, over 1500 employers have now sponsored a long-term care insurance plan for their employees. High quality private insurance coverage is offered through a variety of mechanisms, including individual, group association and employer-sponsored arrangements and riders to life insurance plans.

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

- Our nation faces a long-term care crisis. Long-term care is the largest unfunded liability facing Americans today. Despite the tremendous need for long-term care protection, there is a clear lack of adequate planning for it. While the current system is flawed, the financing of long-term care is complicated and requires a thoughtful solution, not a rush to judgment.

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

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

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

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

- The government plays a critical role in enhancing the growth of the private long-term care insurance market. Government initiatives which show support of the private long-term care insurance market emphasizes to the public the importance of assuming personal responsibility and less reliance on public support for their own long-term care.

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

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

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

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

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

4. Stimulate the private insurance market through enhancement of the tax status of long-term care insurance and offering of long-term care insurance to all federal government employees.

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

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

Nature of the Problem

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

Long-term care is the major catastrophic health care expense faced by the elderly today and will definitely remain so for our retiring baby boomers. For the elderly who have out-of-pocket health care expenses of over $2,000 a year, an average of 80 percent is spent on nursing home care. With annual nursing home costs averaging $41,000 (increasing to about $100,000 in 1996 dollars by 2030), and easily double that amount in high cost areas, such expenses can indeed cause financial ruin. Instead of pooling risks, the current system places each household on its own and when household resources have been depleted, Medicaid becomes the payer of last resort. This approach combining out-of-pocket outlays and welfare features remediation and relief when prevention and planning should be the preferable approaches.

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

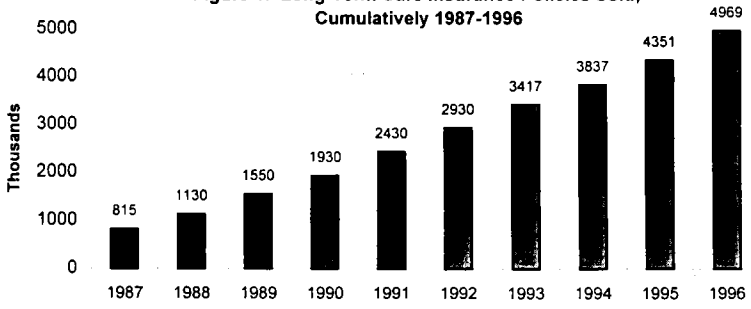
The Private Long-Term Care Insurance Market Today

The insurance industry is justifiably proud of the role it has played in the evolution of the largest private insurance system in the world. Now, we are entering the next logical phase of this evolution. Advances in medical

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

The market is developing rapidly, as evidenced by the number of companies developing long-term care insurance products, the number of individuals covered and the variety of products available to the public today. By December 31, 1996, over 100 companies have sold close to 5 million long-term care insurance policies. The number of policies purchased increased by more than 600,000 in 1996 alone, and the market has grown an average of 22 percent between 1987 and 1996. These insurance policies include individual, group association, employer-sponsored and riders to life insurance policies that accelerate the death benefit for long-term care. (See Figure 1 below).

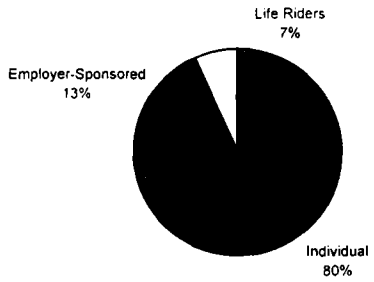
Figure 1: Long-Term Care Insurance Policies Sold, Cumulatively 1987-1996



Source: HIAA LTC Market Survey, 1997

The majority of long-term care insurers continue to sell policies in the individual market. As of the end of 1996, approximately 80 percent of the 4.96 million long-term care insurance policies had been sold through the individual and group association markets. However, about one-third of the 1996 long-term care insurance carriers sold policies in either the employer-sponsored or life insurance markets, up from 14 percent in 1988. These two markets also represented 20 percent of all long-term care policies sold as of 1996, up from less than 3 percent in 1988. (See Figure 2 below.)

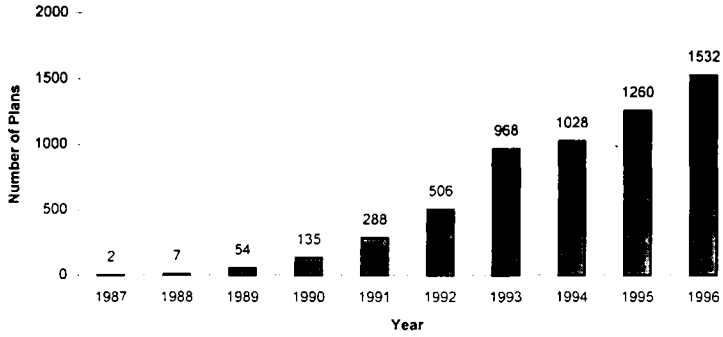
Figure 2: Distribution of Long-Term Care Insurance Policies Sold, as of December 1996



Although all three markets experienced growth in 1996, the majority of growth, about 79 percent, can be attributed to the individual and group association markets. The total premium volume for the individual and group association policies sold in 1996 alone was about $750 million. The employer-sponsored market enhanced this growth by contributing close to 20 percent of the sales in 1996. At the close of 1996, over 650,000 policies had been sold through 1,532 employers. (See Figure 3 on the following page.) Although the growth in the long-term care life insurance rider market was minimal in 1996, it continues to

account for about 7 percent of the entire long-term care insurance market, with over 340,000 policies sold cumulatively as of the end of 1996.

Figure 3: Number of Employer-Sponsored Long-Term Care Insurance Plans Offered, by Year, Cumulatively, 1987-1996



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

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

- All plans are guaranteed renewable, have a 30-day free look period, cover Alzheimer's disease, have a waiver of premium provision, offer unlimited or lifetime nursing home maximum periods.
- Whereas in previous years, most companies used a 6-month preexisting condition limitation, 9 of the 12 sellers now waive their preexisting condition limitation as long as pertinent medical conditions are disclosed at the time of application.
- Age limits for purchasing are also expanding. Companies now offer individual policies to people as young as 18 and as old as 99 years.
- All plans offer the NAIC Model Act and Regulation inflation protection requirement of benefits increasing at an annual 5 percent compounded rate, funded with a level premium.
- All companies offer plans that have a nonforfeiture benefit, with a shortened benefit period or a return of premium, as the most common types.

In addition to examining each top seller's policy provisions and marketing materials, we also reviewed the premiums they offered for their most recent policy. Premiums for long-term care insurance policies varied widely depending on multiple factors, including entry-age of the policyholder and benefit designs chosen. HIAA analysis reveals that the average annual premiums reported by the 1996 leading sellers (see Table 1 below) have been decreasing over time.

Table 1: Average Annual Premiums for Leading Individual and Group Association Long-Term Care Sellers in 1996

AGE	Base	With 5% Compounded Inflation Protection (IP)	With a Nonforfeiture Benefit (NFB)	W/ IP & NFB
40	$250	$590	$340	$800
50	$365	$800	$520	$1200
65	$1000	$1830	$1320	$2450
79	$4000	$5600	$5200	$7500

(NOTE: These are preliminary estimates for premiums of 1996 leading sellers. Premiums are generally for a $100/$50nursing home/home health coverage, 4 years coverage, and 20-day elimination period.)
SOURCE: HIAA LTC Market Survey, 1997.

The average premiums in 1996 decreased an average of 5 percent when compared to the average premiums for the leading sellers in 1995. This is a strong indication that market competition and insurers' increasing confidence with their pricing and anticipated claims experience have kept premiums stable, if not more affordable. In addition, given the tremendous changes in long-term care insurance policy design (i.e., elimination of prior hospitalization requirements, expansion of available benefits, coverage of additional sites and levels of long-term care), buyers are now clearly receiving more benefits for their premium dollar.

The Employer-Sponsored Long-Term Care Insurance Market

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

By the end of 1996, 1,532 employers were offering a long-term care insurance plan to their employees and retirees. There were over 500 employer-sponsored plans introduced in 1995 and 1996. Most of these plans were employee pay-all plans. However, at least 432 of these employers paid part or the entire

employee premium for long-term care insurance. The majority of these employers were very small firms (under 100 employees), and were insured by one insurance company. Among the employee pay-all plans, employee participation rates varied widely by insurer and employer. The average percent of active employees participating in this coverage per employer group is about 6 percent.

Since June 1990, many small employers (1-500 employees) have started offering long-term care insurance to their employees. This number has increased from 58 in 1990 to over 600 in 1996. This group represents over 60 percent of all employers offering long-term care coverage to their employees and/or retirees. There have also been substantial increases in the number of medium-sized and large-sized employers who offer long-term care coverage.

Offering of Long-Term Care Insurance to Federal Government Employees

Long-term care related issues cost employers $29 billion a year in lost time, lost employees, and lost productivity. Many believe, therefore, that private long-term care insurance coverage can have its greatest impact in the employer-sponsored market. With the Federal Government, the nation's largest employer, offering this benefit to its employees, this impact would be magnified tremendously.

A Federal Employee Long-Term Care Insurance Plan is particularly encouraging because of three factors. First, such an action would be the clearest signal of government support for encouraging personal responsibility and planning for

long-term care through avenues such as long-term care insurance. Second, the sheer size of the Federal Government as an employer would assure an immediate and heightened awareness of long-term care financing issues among working adults. Finally, because the federal employee population is large and considered to be a relatively young and healthy group (compared to the more senior population that individual long-term care insurance policies are currently being marketed to), administrative and marketing costs will be less; premiums will be lower; and underwriting may be minimized.

HIAA supports the offering of long-term care insurance to all federal employees. It is imperative that the structure of a Federal Employee Long-Term Care Insurance Plan allow for market competition and design flexibility. This would assure that long-term care insurance policies that would be offered to federal employees through this program would be affordable and not hinder product development and future innovation in the coverage of long-term care services. In this regard, below are some initial thoughts on the parameters HIAA feels should be considered when drafting legislation that would enable this to happen.

- Authorization: The Office of Personnel Management (the "Office") shall establish the program under which eligible group and individual long-term care insurance contracts are made available to federal employees, annuitants; and eligible family members of such employees and annuitants with long-term care insurance coverage. Eligible family members are an employee's or annuitant's spouse, children, parents, grandparents, and such other individuals as the office may specify.

- Withholding: Premiums for eligible long-term care insurance contracts shall be withheld from the pay of each enrolled employee and the annuity of each enrolled annuitant, and be contributed to the government. Such withheld

amounts shall be timely paid by the government to the carrier for each such contract.

- Eligible Contract: Any group or individual long-term care insurance contract (including reimbursement and per diem type policies) that:

  (a) is a qualified long-term care insurance contract (as defined in Title III, Subtitle C of the Health Insurance Portability and Accountability Act of 1996, Pub. L, 104-191, or as this definition may be amended),

  (b) is issued by a carrier that is licensed by the State or other jurisdiction in which the insured resides to issue insurance contracts,

  (c) provided benefits and coverage that cannot be unilaterally changed by the carrier (except for nonpayment of premiums and in the case of misrepresentation that would permit a carrier to contest a qualified long-term care insurance contract), and provides premiums that are determined on a noncancellable or guaranteed renewable basis.

  (d) is fully insured by the carrier or reinsured in all or part with other carriers, and

  (e) the Office determines to be appropriate for the provision of long-term care insurance, taking into account the financial soundness of the carrier and its administrative capability to serve covered insureds.

  For this purpose, a carrier means a voluntary association, corporation, partnership, or other non-governmental organization which is lawfully engaged in providing, paying for, or reimbursing directly or indirectly the cost of long-term care services under group or individual contracts of insurance in consideration of premiums or other charges payable to the carrier.

- Enrollment Season and Communications: The Office shall, at least annually, provide a period of not less that 3 weeks during which any employee or annuitant shall be permitted to apply for coverage with a carrier. In addition, employees may apply for coverage any time during a calendar year. The Office shall, after consultation with the carrier, make available to each such employee and annuitant information as may be necessary to enable the individual to exercise an informed choice among eligible contracts.

- Continuation of Coverage: If an individual (whether or not an employee or annuitant) is covered under an eligible contract and withholding ceases to be available or sufficient (such as after a divorce), such individual shall be entitled to pay premiums directly to the carrier to continue the insurance in force.

- Reports and Audits: As a condition of participation in the program, carriers must agree to furnish such reasonable reports as the Office determines to be necessary to enable it to carry out its functions under this program, and permit the Office and representatives of the General Accounting Office to examine records of the carriers as may be necessary to carry out the purposes of this program. In addition, each Government agency shall keep such records and furnish the Office with such information and reports as may be necessary to enable the Office to carry out its functions under this program.

- Jurisdiction of Courts: The district courts of the United States have original jurisdiction, concurrent with the United States Court of Federal Claims, of a civil action or claim against the United States founded under this program.

- Coordination with State Laws: Any requirements or standards relating to the Federal Government Long Term Care Insurance Program shall supersede and preempt any state or local law, or regulation which relate to long term care services or insurance contracts. This rule shall not be construed to alter the requirement that an eligible contract must otherwise constitute a qualified long term insurance contract.

- Regulations: The Office may prescribe regulations necessary to carry out this program

- Authorization of Monies: There should be sufficient funds appropriated to carry out this program, including amounts to cover administrative costs that may be incurred. In addition, there should be an authorization of future Government contribution for a portion of the cost of any eligible contract covering an employee or annuitant or the spouse of any such persons as may be necessary to encourage the purchase of long-term care insurance coverage.

Challenges to the Long-Term Care Insurance Market

Incentives for the purchase of long-term care insurance were included in the recent passage of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). A new federal focus on streamlining public expenditures and encouraging individual responsibility has emerged. HIPAA's long-term care provisions have improved the political climate for private long-term care

insurance. Nevertheless, HIPAA is not a panacea and will not, by itself, achieve the optimum public-private partnership for long-term care financing. HIAA believes that several factors could hasten the development of private long-term care insurance and strengthen its ability to respond to the baby boomer's demand and need for long-term care protection.

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

Over the last several years, the insurance industry has made an extensive effort to inform the public about long-term care and its potential costs. Since 1987, when the HIAA long-term care consumer guide was first published, over two million copies have been distributed. (A copy of the most recent *HIAA Guide to Long-Term Care Insurance* is attached.) It is clear the public wants information on this subject. HIAA remains willing to work with all levels of government to further similar consumer communication and education efforts.

Public Expenditures Should be Targeted – HIAA also recognizes that the private sector alone cannot realistically meet society's entire need. There will always be a significant need for public sector involvement. For those unable to finance their own long-term care services, a "safety net" program of public assistance must continue to be provided. This is true especially for the current

generation of elderly and disabled individuals, who have not had the time, product availability or financial resources to provide effectively for themselves. In this regard, HIAA supports initiatives to improve the current long-term care public assistance programs and research and demonstrations on innovative needs-based public long-term care programs.

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

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

Federal and state governments have an important role in encouraging the growth of private long-term care insurance market. This could be achieved by enhancing tax provisions for long-term care insurance. Encouraging additional tax provisions for these products would reduce the cost of long-term care

insurance for many Americans, would increase their appeal to employees and employers, and would increase public confidence in this relatively new private insurance coverage. Further, enhancement of tax incentives for the purchase of long-term care insurance would demonstrate the government's support for and its commitment to the private long-term care insurance industry as a major means of helping Americans fund for future long-term care needs. It also reinforces the message to the public about individual responsibility.

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

- Enhance the deduction for long-term care insurance premiums, such that premium dollars are not subject to a percentage of income;
- Permit the tax-free use of IRA and 401(k) funds for purchases of long-term care insurance;
- Permit the premiums to be paid through cafeteria plans and flexible spending accounts;
- Provide a tax subsidy for the purchase of long-term care insurance; and
- Encourage state tax incentives for the purchase of long-term care insurance.

These tax incentives would largely benefit two groups: those who did not have the opportunity to purchase such coverage when they were younger and the premiums were lower and as a result, now face the greatest affordability problems because of their age; and those younger adults, our current baby boomers, who need incentives or mechanisms to fit providing for their own long-term care protection into their current multiple priorities (e.g., mortgage and

children's college tuition) and financial and retirement planning. Further, the educational effects of such tax incentives could far outweigh its monetary value by educating consumers about an important issue and as a result, would help to change attitudes as well.

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

Public expenditures should also focus on research affecting long-term care use and costs, and support of budget-neutral demonstrations involving public-private financing partnerships. In addition, more resources are needed in basic and applied biomedical aging research to facilitate the management of chronic disease and disability. Treatments which ameliorate or control conditions such as Alzheimer's disease, incontinence, and osteoporosis will greatly enhance the quality of an older person's life and significantly reduce or delay the need for costly long-term care services.

Another priority for additional public spending on long-term care would be the monitoring of genetic studies. These studies could help in learning more about the aging process and how to reduce or delay the impact of aging on service delivery. Applying lessons learned from these efforts could improve the ability of

future long-term care insurance products to meet the needs of consumers. However, it is essential that such studies not impede development and growth of the market and that insurers continue to have access to and consider any relevant medical information for insurance purposes. Like all insurance, long-term care insurance will only remain affordable if adverse selection can be minimized.

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

Summary and Conclusions

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

The public and private sectors must combine their efforts and knowledge to create a solution that will benefit most Americans today and in the future. This Subcommittee's consideration of offering long-term care insurance to all federal employees is an investment that will pay off many times over as our population ages and will help our nation avoid placing an insupportable tax burden on our children.

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

Guide to Long-Term Care Insurance

HIAA

Health Insurance Association of America

Guide to Long-term Care Insurance

Most Americans know about the kind of health insurance that pays doctor and hospital bills. But the kind that pays for long-term care in a nursing home or at home is not as familiar. This booklet explains what long-term care is, how long-term care insurance works, and what it costs. It also has a checklist you can use to compare policies. With this information, you'll be able to make an informed decision.

What is long-term care?

Long-term care goes beyond medical care and nursing care to include all the assistance you could need if you ever have a chronic illness or disability that leaves you unable to care for yourself for an extended period of time. You can receive long-term care in a nursing home or in your own home, in the form of help with such activities as bathing or dressing. Long-term care can be of help to a young or middle-aged person who has been in an accident or suffered a debilitating illness. But most long-term care services are used by older people.

Beyond nursing homes, there is a range of services available in the community to help meet long-term care needs. Care given by family members can be supplemented by visiting nurses, home health aides, friendly visitor programs, home-delivered meals, chore services, adult daycare centers, and respite services for caregivers who need a break from daily responsibilities.

These services are becoming more widely available. Some or all of them may be found in your community. Your local Area Agency on Aging or Office on Aging can help you locate the services you need. Call the Eldercare Locator at 800-[illegible]-1116 to identify your local office.

Are you likely to need long-term care?

This year about 7 million men and women over the age of 65 will need long-term care. By the year 2005, the number will increase to 9 million. By the year 2020, 12 million older Americans will need long-term care. Most will be cared for at home; family members and friends are the sole caregivers for 70 percent of elderly people. But a study by the U.S. Department of Health and Human Services indicates that people of age 65 face at least a 40 percent lifetime risk of entering a nursing home. About 10 percent will stay there five years or longer.

The American population is growing older, and the group over age 85 is now the fastest-growing segment of the population. The odds of entering a nursing home, and staying for longer periods, increase with age. In fact, statistics show that at any given time, 22 percent of those age 85 and older are in a nursing home. Because women generally outlive men by several years, they face a 50 percent greater likelihood than men of entering a nursing home after age 65.

You may never need a nursing home. But the longer you live, the greater the chance that you will need some form of long-term care.

What does long-term care cost?

Long-term care can be very expensive. As a national average, a year in a nursing home is estimated to cost $40,000. In some regions, it can easily cost twice that amount.

Home care is less expensive but it still adds up. Bringing an aide into your home just three times a week—to help with dressing, bathing, preparing meals, and similar household chores—easily can cost $1,000 each month, or $12,000 a year. Add in the cost of skilled help, such as physical therapists, and these costs can be much greater.

Who pays the bills?

For the most part, the people who need the care pay the bills. Generally, neither Medicare nor private Medicare supplement insurance nor the health insurance you may have either on your own or through your employer will pay for long-term care.

Medicare supplement insurance (often called Medigap or MedSup) is private insurance that helps cover some of the gaps in Medicare coverage. Those gaps are hospital deductibles, doctors' deductibles, and coinsurance payments or what Medicare considers excess physician charges—but they are not long-term care.

About one-third of all nursing home costs are paid out-of-pocket by individuals and their families. Only about 8 percent is paid by Medicare, for short-term skilled nursing home care following hospitalization. Medicare also pays for some skilled at-home care but only for short-term unstable conditions and not for the ongoing assistance that many elderly people need. Most of the balance of the nation's long-term care bill—more than half of all nursing home costs—is picked up by Medicaid, either immediately, for people meeting federal poverty guidelines, or after nursing home residents "spend down" their own savings and become eligible. Many people who begin paying for nursing home care find that their savings are not enough to cover lengthy confinements. If they become impoverished after entering a nursing home, they turn to Medicaid to pay the bills. Turning to Medicaid once meant impoverishing the spouse who remained at home as well as the spouse confined to a nursing home. Recent changes in the law, however, permit the at-home spouse to retain specified levels of assets and income.

You can't predict what kind of care you might need in the future, or know exactly what the costs will be. But since you may have long-term care expenses, you need to know if long-term care insurance is appropriate for you.

What kind of insurance is available?

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Long-term care insurance is similar to other insurance in that it allows people to pay a known and affordable premium that offsets the risk of much larger out-of-pocket expenses. Although long-term care insurance is relatively new, more than 100 companies now offer coverage.

Several types of policies are available, but most are **indemnity** policies. This means that they pay a fixed dollar amount for each day you receive specified care either in a nursing home or at home. No policy is guaranteed to cover all expenses fully.

Policyholders usually have a choice of indemnity amounts ranging from $40 to more than $200 per day for nursing home coverage. These amounts are pegged to the average daily cost of a nursing home. The daily benefit for at-home care is usually much less than the benefit for nursing home care. Note, though, that you are responsible for your actual nursing home or home care costs.

Because the per-day benefit you buy today may be inadequate to cover higher costs after a number of years, most policies now offer an **inflation adjustment** feature. In many policies, for example, the initial benefit amount will increase automatically each year at a specified rate (such as 5 percent) compounded over the life of the policy.

Some life insurance policies offer long-term care benefits. Under these **accelerated** or **living benefits** provisions, a portion of the life insurance benefit is paid to the policyholder if long-term care is needed instead of to the beneficiary at the policyholder's death. Some companies make these benefits available to all policyholders; others offer them only to people buying new policies.

What do policies cost?

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In 1994, individual policies without an inflation adjustment feature ranged in cost from about $325 per year to more than $3,641. Inflation adjustments can add 30 percent to 90 percent to your premium, depending on the option you select, but can keep benefits in line with rising costs.

But the actual premium you'll pay depends on many factors, including your age, the level of benefits, and the length of time you are willing to wait until benefits begin. Here are details.

Age

In 1994, a policy offering an $80 per day nursing home benefit for four years, with a 20-day deductible, cost a 50-year-old about $325 per year. For someone who was 65 years old in 1994, the same policy cost about $855, and for a 79-year-old, the cost was $3,641. The same policy with an inflation feature may cost $659 at age 50, $1,538 at age 65, and $5,095 at age 79.

Premiums generally don't increase with age but remain the same each year (unless they are increased for all policyholders at once). The younger you are when you first buy a policy, therefore, the lower your annual premium will be.

Benefits

The premium is also directly affected by the size of the daily benefit and the length of time for which benefits will be paid. For example, a policy that pays $100 a day for up to five years of nursing home care costs more than a policy that pays $50 a day for three years.

Elimination or deductible periods

So-called elimination or deductible periods refer to the number of days you must be in residence at a nursing home or the number of home care visits you must receive before policy benefits begin. Most policies offer a choice of deductible ranging from 0 to 100 days. A 20-day elimination period, as an example, means that

your policy will begin paying benefits on the 21st day. The longer the elimination or deductible period, the lower the premium.

You can lower your own costs for long-term care coverage, therefore, by buying a policy at an early age and by selecting carefully both the level of benefits and the deductible period. In making your selection, bear in mind that while 45 percent of nursing home stays last three months or less, more than one-third last one year or longer. It's the costly longer stay that may be the devastating financial blow that you may want to insure against.

What do long-term care insurance policies cover?

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Most long-term care policies will pay benefits either when need is demonstrated by the inability to perform a specific number of personal functions or activities of daily living such as bathing, dressing or eating or when care is needed due to cognitive impairment, or when care is medically necessary and prescribed by the patient's physician. New policies no longer require a hospital stay before paying nursing home benefits.

Today's policies cover skilled, intermediate, and custodial care in state-licensed nursing homes. Long-term care policies usually also cover home care services such as skilled or nonskilled nursing care, physical therapy, homemakers and home health aides provided by state-licensed and or Medicare-certified home health agencies. Newer policies no longer require a certain period of nursing home care before covering home health care services.

Many policies also cover adult daycare and other care in the community, alternate care, and respite care for the caregiver.

Alternate care refers to non-conventional care and services developed by a physician that can serve as an alternative to more costly nursing home care.

Benefits may be available for special medical care and treatments, different sites of care, or medically necessary modifications to the insured's home, like building ramps for wheelchairs or modifications to a kitchen or bathroom. A health care professional develops the alternate plan of care, the insured or insurer may initiate the plan, and the insurer approves it. It is important to note that the benefit amount will reduce the maximum or lifetime benefit available for later confinement in a long-term care facility and that most policies limit the expenses covered under this benefit (i.e., 60 percent of the lifetime maximum limit).

Alzheimer's disease and other organic cognitive disabilities, leading causes for nursing home admissions (and a leading cause of worry for many older Americans), are generally covered under long-term care policies.

What is not covered?

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All policies contain limitations and exclusions. Otherwise premiums would become unaffordable. But the specific limitations and exclusions are likely to differ from policy to policy.

Consider:

Preexisting conditions

Insurance companies may require that a period of time pass before the policy pays for care related to a health problem you had when you became insured. Such health problems are called preexisting conditions. Some companies exclude coverage of preexisting conditions for six months. If you need long-term care within six months of the policy's issue date for a condition for which treatment was either underway or had been recommended before you took the policy, you may be denied benefits.

Specific exclusions

Before you buy, be sure you understand exactly what is and is not covered under a particular policy. Some mental and nervous disorders are often not covered.

Alcoholism and drug abuse are usually not covered, along with care necessitated by an act of war or an intentionally self-inflicted injury.

Prior levels of care

Most policies will pay for whatever level of care you need. A few require a certain period of nursing home care before you are eligible for home care. Generally, fewer restrictions make policies more useful.

What else should I know before I buy?

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Despite some move to uniformity—virtually all policies now cover Alzheimer's disease and no longer require a hospital stay before paying nursing home benefits—there are different options available under different policies. These are some of the things to consider.

Eligibility

If you are in reasonably good health and can take care of yourself, and if you are between the ages of 50 and 84, you can probably buy long-term care insurance. Most companies do not sell individual policies to people under age 50 or over age 84.

Note that these age limitations apply only to your age at the time of purchase, not at the time you use the benefits.

Duration of benefits

Long-term care policies generally limit benefits to a maximum dollar amount or a maximum number of days and often have separate benefit limits for nursing home and home health care within the same policy. For example, a policy may offer five years of nursing home coverage (many policies now offer lifetime nursing home coverage) and two years of home health care coverage.

Generally, there are two ways in which companies define a policy's maximum benefit period. Under one definition, a policy may offer a one-time maximum benefit period. A policy with five years of nursing home coverage, issued by a company using this definition, would pay just once in a policyholder's lifetime. Other policies offer a maximum benefit period for each "period of confinement." Under this second definition, a policy with a five-year maximum benefit period would cover more than one nursing home stay lasting up to five years each if the stays were separated by six months or more.

Renewability

Virtually all long-term care policies sold to individuals are guaranteed renewable; they cannot be canceled as long as you pay your premiums on time and as long as you have told the truth about your health on the application. Premiums can be increased, however, if they are increased for an entire group of policyholders.

The renewability provision, normally found on the first page of the policy, specifies under what conditions the policy can be canceled and when premiums may increase.

Nonforfeiture benefits

This benefit returns to policyholders some of their payments if they drop their coverage. Most companies now offer this benefit as an option. The most common types of nonforfeiture benefits offered today are "return of premium" or reduced paid-up." With a "return of premium" benefit, the policyholder receives cash, usually a percent of the sum of premiums paid to date after lapse or death. With a "reduced paid-up" benefit, the long-term care coverage continues but the daily payment amount is reduced as specified in the policy. A nonforfeiture benefit can add from 20 to 100 percent to a policy's cost.

Waiver of premium

This provision allows you to stop paying premiums during the time you are receiving benefits. Read the policy carefully to see if there are any restrictions on this provision, such as a requirement to be in a nursing home for any length of time (90 days is a typical requirement) before premiums are waived.

Disclosure

Your medical history is very important because the information you provide on your application is used by the insurance company in assessing your eligibility for coverage. The application must be accurate and complete. If it is not, the insurance company may be within its rights to deny coverage when you file a claim.

What about switching policies?

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New long-term care insurance policies may have more favorable provisions than older policies. Newer policies, as noted above, generally do not have requirements for prior hospital stays or for prior levels of care. But, if you do switch, provisions excluding preexisting conditions for specified periods of time will have to begin again. So you should never switch policies before making sure that the new policy is really better than the one you already have. And you should never drop an old policy before making sure that the new one is in force.

A summary of features

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The National Association of Insurance Commissioners has developed standards that protect consumers. Look for a policy including:

- At least one year of nursing home or home health care coverage, including intermediate and custodial care. Nursing home or home health care benefits should not be limited primarily to skilled care.
- Coverage for Alzheimer's disease should the policyholder develop the disease after purchasing the policy.
- An inflation protection option. The policy should offer a choice among:
  - automatically increasing the initial benefit level on an annual basis;
  - a guaranteed right to increase benefit levels periodically without providing evidence of insurability; or
  - covering a specific percentage of actual or reasonable charges.

- An "outline of coverage" that systematically describes the policy's benefits, limitations, and exclusions, and also allows you to compare it with others.
- A long-term care insurance shopper's guide that helps you decide whether long-term care insurance is appropriate for you.
- A guarantee that the policy cannot be cancelled, nonrenewed, or otherwise terminated because you get older or suffer deterioration in physical or mental health.
- The right to return the policy within 30 days after you have purchased the policy (if for any reason you do not want it) and to receive a premium refund.
- No requirement that policyholders:
  - first be hospitalized in order to receive nursing home benefits or home health care benefits.
  - first receive skilled nursing home care before receiving intermediate or custodial nursing home care.
  - first receive nursing home care before receiving benefits for home health care.

A final word

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Insurance policies are legal contracts. Read and compare the policies you are considering before you buy one, and make sure you understand all of the provisions. Marketing or sales literature is no substitute for the actual policy. Read the policy itself before you buy. Discuss the policies you are considering with people whose opinions you respect—perhaps your doctor, your children, or an informed friend or relative.

Ask for the insurance company's financial rating and for a summary of each policy's benefits or an outline of coverage. (Ratings result from analyses of a company's financial records.) Good agents and good insurance companies want you to know what you are buying.

And bear in mind: even after you buy a policy, if you find that it doesn't meet your needs you generally have

30 days to return the policy and get your money back. This is called the "free look."

Don't give in to high-pressure sales tactics. Don't be afraid to ask your insurance agent to explain anything that is unclear. If you are not satisfied with an agent's answers, ask for someone to contact in the company itself. Call your state insurance department if you are not satisfied with the answers you get from the agent or from company representatives.

Long-term care policy checklist

The following checklist will help you compare policies you may be considering:

1. Which services are covered?
   - Nursing home care
   - Home health care
   - Adult daycare
   - Alternate care
   - Respite care
   - Other
2. How much does the policy pay per day:
   - For nursing home care?
   - For home health care?
   - For adult daycare?
   - For alternate care?
   - For respite care?
   - Other?
3. How long will benefits last?
   - In a nursing home?
   - At home?
4. Does the policy have a maximum lifetime benefit? If so, what is it?
   - For nursing home care?
   - For home health care?
5. Does the policy have a maximum length of coverage for each period of confinement? If so, what is it?
   - For nursing home care?
   - For home health care?
6. How long must I wait before preexisting conditions are covered?
7. How many days must I wait before benefits begin?
   - For nursing home care?
   - For home health care?
8. Are Alzheimer's disease and other organic mental and nervous disorders covered?
9. Does this policy require:
   - An assessment of activities of daily living?
   - An assessment of cognitive impairment?
   - Physician certification of need?

A prior hospital stay for:
- Nursing home care?
- Home health care?
- A prior nursing home stay for home health care coverage?
- Other?

10. Is the policy guaranteed renewable?
11. What is the age range for enrollment?
12. Is there a waiver-of-premium provision?
    - For nursing home care?
    - For home health care?
13. How long must I be confined before premiums are waived?
14. Does the policy have a nonforfeiture benefit?
15. Does the policy offer an inflation adjustment feature? If so:
    - What is the rate of increase?
    - How often is it applied?
    - For how long?
    - Is there an additional cost?
16. What does the policy cost:
    - Per year:
      - With inflation feature
      - Without inflation feature
    - Per month:
      - With inflation feature
      - Without inflation feature
17. Is there a 30-day free look?

A new law's impact on long-term care insurance.

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A new law, the Health Insurance Portability and Accountability Act of 1996, affects long-term care insurance. The following are answers to commonly asked questions about the law's tax clarification provisions and consumer protection standards.

Tax clarification

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Q. What is tax clarification for private long-term care insurance, and why is it necessary?

A. The tax clarification provisions for long-term care insurance are contained in the Health Insurance Portability and Accountability Act of 1996, signed by President Clinton on August 21, 1996. The clarifications assure that the tax treatment for private long-term care insurance is the same as that for major medical coverage.

Q. Will benefits received by consumers under a long-term care policy be taxed?

A. With the clarifications, benefits from private long-term care coverage, generally, are not taxable. Without the clarifications, benefits from long-term care insurance might be considered taxable income.

Q. Will consumers be able to take a tax deduction for the cost of long-term care insurance? Can consumers deduct from their taxes costs associated with receiving long-term care?

A. The answer to both questions is "yes." Since private long-term care insurance will now receive the same tax treatment as accident and health insurance, effective January 1, 1997, premiums for long-term care insurance, as well as consumers' out-of-pocket expenses for long-term care, can be applied toward meeting the 7.5 percent *floor* for medical expense deductions contained in the federal tax code. However, there are limits, based upon one's age, for the total amount of premiums paid for long-term care insurance that can be applied toward the 7.5 percent floor. Check with your accountant to see if you are eligible to take this deduction.

Q. *Will employers be able to deduct anything for the cost of providing or paying for private long-term care insurance for their employees?*

A. Generally, employers will be able to deduct, as a business expense, both the cost of setting up a long-term care insurance plan for their employees as well as the contributions that they may make toward paying for the cost of premiums.

Q. *Will employer contributions be excluded from the taxable income of employees?*

A. Yes.

Q. *Can Individual Retirement Accounts (IRAs) and 401K funds be used to purchase private long-term care insurance?*

A. No. However, under a demonstration project, tax-free funds deposited in Medical Savings Accounts can be used to pay long-term care insurance premiums.

Consumer protection standards

Q: *Is there a connection between the long-term care consumer protection standards in the new health insurance reform law and the tax clarification of long-term care?*

A: Yes. To qualify for favorable tax treatment, a long-term care policy sold after 1996 must contain the consumer protection standards in the new law. Also, insurance companies must follow certain administrative and marketing practices or face significant fines. Generally speaking, policies sold prior to January 1, 1997, automatically will be eligible for favorable tax treatment. Lastly, nothing in the new law prevents states from imposing more stringent consumer protection standards.

Q: *What kinds of procedures must insurance companies comply with to protect consumers?*

A: There are several. Here are some of the more important ones. Consumers must receive a "Shopper's Guide" and a description of the policy's benefits and limitations (i.e., Outline of Coverage) early in the sales process. The Outline of Coverage allows consumers to compare policies from different companies. Companies must report annually the number of claims denied and information on policy replacement sales and policy terminations. Sales practices such as "twisting"—knowingly making misleading or incomplete comparisons of policies—are prohibited as are high-pressure sales tactics.

Q: *How do the new standards address limitations on benefits and exclusions from coverage?*

A: No policy can be sold as a long-term care insurance policy if it limits or excludes coverage by type of treatment, medical condition, or accident. Several exceptions to this rule exist, however. For example, policies may limit or exclude coverage for preexisting conditions or diseases, mental or nervous disorders (but not Alzheimer's), or alcoholism or drug addiction. A policy cannot, however, exclude coverage for preexisting conditions for more than 6 months after the effective date of coverage.

Q: *What will prevent a company from canceling my policy when I need it?*

A: The law prohibits a company from canceling a policy except for nonpayment of premiums. Policies cannot be canceled because of age or deterioration of mental or physical health. In fact, in the event a policyholder is late in paying a premium, the policy can be reinstated up to 5 months later if the reason for nonpayment is shown to be cognitive impairment.

Q: *Will these new standards help people who, for whatever reason, lose their group coverage?*

A: They will. People covered by a group policy will be allowed to continue their coverage when they leave their employer, so long as they pay their premiums in a timely fashion. Further, an individual who has been covered under a group plan for at least 6 months may convert to an individual policy if and when the group plan is discontinued. The individual may do so without providing evidence of insurability.

If you need help

Every state has a department of insurance that regulates insurers and assists consumers. If you need more information or if you want to register a complaint, check the government listings in your local phone book for your state's department of insurance.

Additional information about health care coverage and long-term care is available from the Area Agency on Aging. For your local office, call 1-800-677-1116. Other sources include:

American Health Care Association
1201 L Street, N.W.
Washington, D.C. 20005
(202) 842–4444

National Association of Insurance Commissioners
Suite 1100
120 W. 12th Street
Kansas City, MO 64105
(816) 842–3600

United Seniors Health Cooperative
Suite 500
1331 H Street, N.W.
Washington, D.C. 20005
(202) 393–6222

The Health Insurance Association of America

The Health Insurance Association of America (HIAA) is a national trade association based in Washington, D.C. Its members are insurers and managed care companies that serve tens of millions of Americans. HIAA's membership includes companies that finance and deliver basic health care, and that offer supplemental insurance, long-term care insurance, and disability income protection.

HIAA's activities range broadly, from lobbying to education to collecting and disseminating data and information. Combining a product orientation with member services, HIAA advances both the interests of the industry and of individual members, and works to maintain the strengths of our current health care system and to improve the system to benefit all Americans.

For More Information

- You can find HIAA on the World Wide Web at http://www.hiaa.org.
- HIAA's Insurance Education Program can be reached at (202) 824-1673, 1675, or 1852.
- To order the *Source Book of Health Insurance Data* and other materials, call toll-free 1-800-828-0111.

Mr. MICA. I will now recognize Mr. Paul Fronstin who is with the Employee Benefit Research Institute.

Mr. FRONSTIN. Mr. Chairman and members of the subcommittee, I am pleased to appear before you this morning to discuss the issue of long-term care insurance for Federal employees. My name is Paul Fronstin. I am a research associate at the Employee Benefit Research Institute [EBRI], a private, nonprofit, nonpartisan public policy research organization based in Washington, DC. EBRI has been committed since its founding in 1978 to the accurate statistical analysis of economic security issues. Through our research we strive to contribute to the formulation of effective and responsible health and retirement policies. Consistent with our mission, we do not lobby or advocate specific policy solutions.

Increased life expectancy and the aging of the baby boom generation will bring rapid growth in the number of people at risk of needing long-term care. Relative to the number of individuals who can provide physical and financial assistance, the proportion of those in need will increase dramatically over the next several decades. In response the private-sector long-term care insurance market has grown, growing from approximately 800,000 policies sold by 1987, to over 4 million policies by 1995. Employment-based plans account for a significant proportion of this growth.

Private insurance now finances only a small portion of long-term care needs. Theoretically individuals with assets to protect should be willing to pay for long-term care insurance. While the chances of having extended long-term care needs are small, the cost of such needs are extremely high. Only a small portion of those who can afford long-term care insurance have actually purchased it. For individuals who have no assets to protect or who believe they will never require formal care, long-term care insurance may never be worth the price. However, others may lack information on the probability of needing such care, may mistakenly believe that they are already covered by Medicare, health insurance or disability insurance, or may be dissatisfied or mistrustful of policies that are currently available. Still others may not purchase insurance because of the knowledge that Medicaid covers long-term care.

While private insurance now finances only a small portion of long-term care needs, its use is expected to grow as plan design improves, and as an increasing number of individuals recognize the possibility of needing long-term care and the associated costs. Both individually purchased policies and employment-based plans will expand further as a result of the changes in tax laws. However, barriers remain that may inhibit this growth.

For example, some studies indicate that growth potential is limited because only a small portion of those most likely to need services can afford a long-term care insurance policy.

Premiums for long-term care insurance vary substantially based on age and plan design. For example, average annual premiums in 1995 ranged from $310 for individuals purchasing a base plan at age 50 to over $8,100 for individuals purchasing a plan that included inflation protection and a nonforfeiture provision at age 79.

Other plan features can also significantly affect premium amounts. Premiums may rise over time because rates generally can be increased on a class basis if claims are higher than expected.

And because the long-term care insurance market is such a new market, it is difficult to set premiums accurately. Little long-term claims insurance experience yet exists, and it may not be available for many years to come because many of those who currently hold long-term care insurance will likely not use it for many years.

The largest barrier to the expansion of the private long-term care insurance market is the lack of public readiness to use assets to insure against the relatively low probability of need. Public education is very much needed. Until it occurs and the public is ready to pay either through premiums or taxes, it is unlikely that the goals of adequate coverage, universal access and affordability through risk pooling will be achieved.

Mr. Chairman, this concludes my statement. I would be happy to answer any questions you or members of the subcommittee might have.

Mr. MICA. Thank you.

[The prepared statement of Mr. Fronstin follows:]

Principal Points

- Increased life expectancy and the aging of the baby boom generation will bring rapid growth in the number of people at risk of needing long-term care (LTC). Relative to the number of individuals who can provide physical and financial assistance, the proportion of those in need will increase dramatically over the next several decades. In response, the private-sector long-term care insurance (LTCI) market has also evolved significantly in recent years, growing from approximately 815,000 policies sold by 1987 to a total of 4.4 million by 1995. Employment-based plans accounted for a significant proportion of this growth, increasing from 7 employers offering LTCI in 1988 to 1,260 employers offering it in 1996. Improvements in plan design have helped to fuel this growth.

- Private insurance now finances only a small portion of LTC needs. Theoretically, individuals with assets to protect should be willing to pay for LTCI. While the chances of having extended LTC needs are small, the costs of such needs are extremely high. Only a small portion of those who can afford LTCI have actually purchased it. For individuals who have no assets to protect or who believe they will never require formal care, LTCI may never be worth the price. However, others may lack information on the probability of needing such care; may mistakenly believe that they are already covered by Medicare, health insurance, or disability insurance; or may be dissatisfied or mistrustful of policies that are currently available. Still others may not purchase insurance because of the knowledge that Medicaid covers LTC.

- While private insurance now finances only a small portion of LTC needs, its use is expected to grow as plan design improves and as an increasing number of individuals recognize the possibility of needing LTC and the associated costs. Both individually purchased policies and employment-based plans will expand further as a result of the changes in tax laws. However, barriers remain that may inhibit this growth. For example, some studies indicate that growth potential is limited because only a small portion of those most likely to need services—the elderly—can afford a LTCI policy.

- Premiums for LTCI vary substantially, based on age and plan design. For example, average annual premiums in 1995 ranged from $310 for individuals purchasing a base plan at age 50 to $8,146 for individuals purchasing a plan that included inflation protection and a nonforfeiture provision at age 79. Other plan features can also significantly affect premium amounts.

- Premiums may rise over time because rates generally can be increased on a class basis if claims are higher than expected. And, because the LTCI market is such a new market, it is difficult to set premiums accurately. Little long-term claims insurance experience yet exists, and it may not be available for many years to come because many of those who currently hold LTCI will likely not use it for many years.

- The largest barrier to the expansion of the private LTCI market is the lack of public readiness to use assets to insure against the relatively low probability of need. Public education is very much needed. Until it occurs and the public is ready to pay either through premiums or taxes, it is unlikely that the goals of adequate coverage, universal access, and affordability through risk pooling will be achieved.

Committee on Government Reform and Oversight
Subcommittee on Civil Service

Long-Term Care Insurance

Introduction

Mr. Chair and members of the committee, I am pleased to appear before you this afternoon to discuss the issue of long-term care and the baby boom generation. My name is Paul Fronstin. I am a research associate at the Employee Benefit Research Institute (EBRI), a private, nonprofit, nonpartisan, public policy research organization based in Washington, DC. EBRI has been committed, since its founding in 1978, to the accurate statistical analysis of economic security issues. Through our research we strive to contribute to the formulation of effective and responsible health and retirement policies. Consistent with our mission, we do not lobby or advocate specific policy solutions. I would ask that my full statement be placed in the record.

Increased life expectancy and the aging of the baby boom generation will bring rapid growth in the number of people at risk of needing long-term care (LTC). Relative to the number of individuals who can provide physical and financial assistance, the proportion of those in need will increase dramatically over the next several decades. Continuing trends of more two-worker families, more single workers, and the increased geographic spread of family members means that there will be fewer family members available to provide care on an informal basis. In this testimony I provide an overview of the current LTC financing and delivery system in the United States, focusing on private-sector initiatives to meet the nation's LTC needs.

Long-Term Care

The terms *long-term care* and *long-term care services* refer to a broad range of health, social, and environmental support services and assistance provided by paid and unpaid caregivers in institutional, home, and community settings to persons who are limited in their ability to function independently on a daily basis. Functional dependency can result from physical or mental limitations and is generally defined in terms of the inability to independently perform essential activities of daily living (ADLs) such as dressing, bathing, eating, toileting, transferring (for example, from a bed to a chair), walking, and maintaining continence or to perform instrumental activities of daily living (IADLs) such as shopping, cooking, and housekeeping.

The majority of LTC services are provided by the private sector but are financed through the public sector. LTC can include care in many different settings and for many different kinds of support services (see chart 1). For example, care may be provided at home, in an adult day care center, or in a nursing facility. It may include both skilled medical care (care that can only be provided by a registered nurse on a doctor's orders) and custodial care (for example, assistance with bathing and dressing) or it may include only custodial care. However, skilled care for an acute temporary medical condition is different from LTC. This can be an important distinction because, while treatment for a temporary medical condition by a licensed provider is generally covered by private medical insurance plans and Medicare, custodial care generally is not.

The Market

The population in need of LTC has become increasingly diverse. While the likelihood of requiring long-term care does increase with age, a growing proportion of those in need of services are under age 65. A study by the U.S. General Accounting Office indicates that, of the 12.8 million people needing assistance with everyday activities, 5.1 million (39.6 percent) are working-age adults, and approximately 420,000 (3.3 percent) are children under age 18 (table 1) (U.S. General Accounting Office, 1994). Chronic conditions such as mental retardation and AIDS affect individuals of all ages. In addition, due to advances in medical technology and treatments, individuals are increasingly likely to survive—although not necessarily free from disability—what may in the past have been a fatal accident or childhood ailment.

The needs of this growing and diverse population vary considerably. For example, some individuals may need around-the-clock assistance. Others may simply need assistance with shopping or traveling to and from school or work.

Individuals, employers, and public policymakers have all begun to focus on the impact of these trends. Among the general population, recognition that neither Medicare nor most private health insurance plans cover LTC has come slowly. Nevertheless, many retirees and workers have now begun to understand their exposure to the risk of needing costly community or institutional LTC as an increasing number have faced the necessity of caring for a parent, spouse, or child needing long-term personal care assistance. Employers have also begun to realize that not only must many of their employees now care for young children, but many are being called on to care for elderly parents. Recognizing and meeting the needs of these individuals by assisting them in providing for their children, parents, and grandparents may have the potential to reduce absenteeism and improve morale, company loyalty, and ultimately productivity.

The debate can be expected to continue about whether government or private-sector initiatives hold greater promise for meeting the needs of a growing and increasingly diverse LTC population. Currently, initiatives are being taken in both sectors. The Medicaid program has increased coverage for home- and community-based care, while several public/private sector partnerships have developed that allow people to become eligible for

Medicaid while retaining some of their assets.

The private-sector LTCI market has also evolved significantly in recent years, growing from approximately 815,000 policies sold by 1987 to a total of 4.4 million by 1995 (Coronel and Fulton, 1997).[1] Improvements in plan design have helped to fuel this growth. For example, many plans now include protection against inflation and loss of benefits due to policy lapses. However, perhaps the most significant change has been in the increased flexibility that is now built into many policies, in some cases even allowing individuals to customize the use of their benefits package to meet their needs at the time care becomes necessary. This flexibility enables plans to keep pace with the continually evolving LTC market.

While private insurance now finances only a small portion of LTC needs (chart 2), it is expected to grow as plan design improves and as an increasing number of individuals recognize the possibility of needing LTC and the associated costs. Both individually purchased policies and employment-based plans will expand further as a result of changes in the tax laws. However, barriers remain that may inhibit this growth. For example, some studies indicate that growth potential is limited because only a small portion (10 percent to 20 percent) of those most likely to need services–the elderly–can afford a good quality LTCI policy (Weiner, et al., 1994; Friedland, 1990). In particular, though, there is currently no clear public policy with regard to LTC in the United States.

Private Programs

Private Insurance

Private insurance now finances only a small portion of LTC needs (chart 2). Theoretically, individuals with assets to protect should be willing to pay for LTCI. Furthermore, since people of any age may potentially need LTC services, their assets could be at risk at any time. While the chances of having extended LTC needs are small, the costs of addressing such needs are extremely high. However, for a variety of reasons, only a small portion of those who can afford LTCI have actually purchased it. For individuals who have no assets they wish to protect or who believe they will never require formal care (perhaps because they have a large family), LTCI may never be worth the price. However, others may lack information on the probability of needing such care; may mistakenly believe that they are already covered by Medicare, health insurance, or disability insurance;[2] or may be dissatisfied or mistrustful of policies that are currently available. Still others may not purchase insurance because of the knowledge that Medicaid covers LTC, albeit while restricting choice and requiring that the individual be at or near the poverty level to qualify for coverage.

However, as an increasing number of individuals recognize the possibility of needing LTC and the costs associated with such care, private initiatives to provide for this need have grown, both through individually purchased and employment-based plans. As mentioned above, by the end of 1995, a total of 4.4 million private-sector insurance policies had been sold, up from about 815,000 in 1987 (chart 3). Private policies include individual, group association, continuing care retirement community (CCRC), employment-based, and accelerated death benefits specifically for LTC. While the majority of these plans were sold to individuals or through group associations, employment-based plans accounted for a significant proportion of this growth (increasing from 20,000 policies sold and 7 employers offering LTCI in 1988 to over 530,000 policies sold and 1,260 employers offering LTCI in 1996) (chart 3 and table 2). A separate study indicated that 12 percent of all employers with 10 or more employees offered LTCI in 1993, 10 percent to active employees only and 2 percent to both active employees and retirees (table 3). Most likely to offer coverage were employers in the Northeast (23 percent), in the manufacturing industry (17 percent), and those with 500–999 employees (22 percent). Least likely to offer coverage were employers in the West (5 percent), employers in the transportation, communications, and utilities industries (0 percent), and employers with 200–499 employees (8 percent). Among those who did not offer coverage, 9 percent indicated they would consider offering it in the future.

Plan Types

Individual and group association policies are the most common LTCI products (chart 3) and have been available the longest. Individual policies are marketed on an individual basis rather than through an employer or other group. Group association LTCI policies are made available to members of nonemployment-based groups or associations that typically have elderly or near-elderly memberships such as the American Association of Retired Persons. These types of policies are targeted at elderly or near-elderly individuals for whom the prospect of LTC may seem imminent.

Employment-based plans are marketed to individual employers and are typically available to a firm's employees, their spouses, parents of employees and spouses, and retirees on a beneficiary-pay-all basis. These insurance plans have grown significantly over the past few years but are still uncommon relative to other types of employment-based insurance. For example, analysis of the April 1993 Current Population Survey indicates that 73 percent of workers ages 18–64 worked for an employer that sponsored a health insurance plan in 1993 (Yakoboski, et al., 1994). Data from the Bureau of Labor Statistics indicates that 6 percent of full-time employees in medium and large private establishments in 1993 and 1995 were eligible for LTCI (U.S. Department of Labor, 1995 and 1998). However, these policies have the potential to reach a large number of people because they are marketed not only to older retirees and parents of active workers but also to younger active workers and their spouses. Thus, the average age of employment-based LTCI enrollees is younger (age 43) than enrollees in individual and group association plans (age 68) (Coronel and Fulton, 1997).

LTC coverage sold as a rider to life insurance policies is also fairly new and tends to attract younger enrollees. Life insurance policies with a LTC accelerated death benefit rider generally advance the death benefit

(or a portion of it) to the insured in the event of terminal illness or a specified disease and have experienced rapid growth since their introduction. One study indicated that in 1987 there were no life insurance policies with a LTC rider, but that about 335,000 such policies had been sold by 1995 (chart 3).

Although the market is currently dominated by policies that are sold individually and through associations, employment-based plans offer several benefits over individual policies and could potentially dominate the market in the future. Group insurance can be less costly because of potential economies of scale in marketing and administration. Employment-based groups generally have a particular advantage in this respect because there is a central mechanism for collecting premiums (i.e., payroll deduction). These factors, together with the reduced likelihood of adverse selection when younger groups are enrolled, can make group plans less expensive than comparable coverage offered on an individual basis (Friedland, 1990).

In addition to the potential of group insurance to be less expensive, employment-based LTCI policies may make employees, retirees, and their families aware of the possible liabilities associated with LTC at an earlier age, when they can better afford to plan for LTC needs. Moreover, employment-based LTCI policies are generally negotiated by a benefits professional, who may be better informed than a lay person about the nuances of policy provisions and coverage limitations. Past reports citing the prevalence of sales abuses suggest that having a knowledgeable person conduct the search for the best policy can be particularly valuable (Consumer's Union, 1991; Shikles, 1991).

Plan Design

Private LTCI plans have changed significantly since their inception in the early and mid 1980s. LTCI policies have become less restrictive as they have evolved, and many of today's policies have additional provisions that make them more valuable to employees and other individuals than earlier policies. For example, many plans no longer require only a medical trigger to become eligible for benefits, and several insurers now offer policies that adjust the benefit for inflation. Many policies also now offer an optional rider that ensures that policyholders who have stopped paying premiums will nevertheless retain some of the benefit. These and other innovations give an indication of how much the private LTCI market has evolved. However, the most significant development relates to the flexibility included in current plan design.

LTCI is evolving in an environment of continuously changing regulations and uncertainty regarding the future direction of LTC policy, the cost of LTC, which services are most cost effective, and which design features are best suited to meet individuals' needs–especially given the increasingly diverse population in need of LTC services. The market has responded by creating plans that have several options and that, in some cases, can be custom tailored at the time care is needed. The "alternate plan of care" option provides the possibility of payment for nonstandard customized services not specified in the policy. Services may include alternative sites of care, facilities, and/or providers. Examples are care in a facility that is not a nursing home but that specializes in care for patients with Alzheimer's disease or modifying a residence to accommodate wheelchair access (Teachers Insurance and Annuity Association, 1993). Generally, a plan of care is developed that the insured, insurer, and provider agree on at the time care is needed. In addition, some plans now enable the individual to select from numerous options when purchasing a policy, such as the daily benefit amount, a maximum benefit amount, the type of care to be provided (e.g., nursing home only versus nursing home or other type of care setting to be determined at the time care is needed), or whether to include provisions such as inflation protection. This flexibility is a likely imperative to the survival of the LTCI market given the continually evolving LTC system.

These and other design features now commonly available—particularly in employment-based plans—include those listed in table 4. Much of the following discussion is based on review of individual employers' and insurers' current actual LTC policies for the individual and/or group markets. (Individual and group plan design features are not discussed separately.)

Eligibility and Benefit Eligibility Triggers—Many employment-based plans guarantee issue of insurance to active workers, with limited or no medical underwriting, during an enrollment period. Others (e.g., retirees, spouses, parents, and parents-in-law) are generally medically underwritten.

Benefit eligibility is generally triggered when the insured is unable to perform or needs assistance with two out of five or three out of six or seven ADLs, depending on the insurer and insurer's definition of ADL. Eligibility may also be triggered based on cognitive impairment such as the need for supervision due to Alzheimer's disease.

Benefit waiting periods generally require the individual to wait between 20 days and 100 days from the time of meeting the criteria to the time of receiving payment for services received. The waiting period (often called the elimination period) may be based on a set number of days regardless of the receipt of services or may be based on services received. In the first case, the waiting period generally begins based on the date ADL dependence is ascertained. In the latter case, the waiting period usually begins based on the first day of services received. In general, the waiting period must be satisfied again if care is not received for a specified amount of time (for example, six months) (The Prudential, 1994).

Although policies are now generally less restrictive than in previous years, several limitations may still apply, particularly for individuals who purchased a policy in years past and have not updated that policy. For example, some plans may still base benefit eligibility on physician certification of need and medical necessity rather than on the failure to perform ADLs or on the need for supervision based on a cognitive disability. Because much LTC is by definition not medical in nature, the medical necessity trigger can prevent people from qualifying for claims payment. Some plans may also require prior hospitalization as a prerequisite for nursing home coverage

and/or skilled nursing care as a prerequisite for home- or community-based care. However, medical necessity triggers and prior hospitalization requirements are prohibited by current model regulations and are regarded as anti-consumer by regulators and consumer advocates. For the most part, these features are no longer included in current plan design. However, in past—as well as in current plans—definitions of ADL are not standardized; some insurers may clearly define each ADL, others may not, making eligibility less clear. Some insurers may also specify that the individual be unable to perform the ADL, as opposed to simply needing supervision with the activity, thereby making eligibility more restrictive.

Some plans may also include limitations on preexisting conditions, although such provisions are no longer common. Policies are much more likely to include a specified waiting period for benefits based on a preexisting condition (generally six months).

Sites of Care—Most plans now offer coverage for nursing home care and home- and community-based care. In addition, coverage is often now available in many nontraditional types of settings such as in adult day care centers (see chart 1).

Some plans give potential insureds the option of selecting a nursing-home-only provision or a more comprehensive plan that lets the individual decide on where care will be provided at the time the care is needed. However, even though a policy may indicate that care at home is covered, there may be restrictions such as a maximum daily benefit amount.

Many plans also now include a case management or care advisory provision. Case management is a form of utilization review. In some plans, it is mandatory that the plan of care be followed in order for benefits to be paid. Sometimes mandated case management is combined with premium reduction incentives. More often, plans include a care advisory provision. In this case, the plan of care does not need to be followed in order that benefits be paid but is there to assist the individual in identifying and sorting through care options. Care may also be monitored to ensure that the individual has access to services that meet his or her needs. However, terms are not standard and are not used consistently; therefore, it is important to carefully interpret what type of care provision is included in a given contract.

Benefit Amounts—Private LTCI plans now generally base benefit amounts on a daily benefit maximum, with a corresponding lifetime benefit maximum. Generally, an individual is given several options regarding level of coverage. For example, an individual may select a daily benefit maximum of $50, $100, or $150 per day with corresponding lifetime benefit maximums of $91,250, $182,500, or $273,750. Once the individual becomes eligible for benefits, the insurer would pay based on charges incurred up to the daily benefit maximum and based on the site of care. Nursing home care is generally paid at 100 percent of the daily benefit amount, while charges incurred for home health care and adult day care are generally paid at 50 percent of the daily benefit amount.

The level of benefits selected can significantly affect premiums. Thus, factors to consider in selecting a daily and maximum benefit amount should include, for example, the cost of services in the service area (table 5), what the individual can afford, and the type of care that will likely be needed. For example, if the individual has a good support system (i.e., family members in the area), adult day care and/or respite care benefits may suffice. Others may prefer–or need–nursing home care.[3]

Most plans now also include a coordination of benefits feature to prevent duplication of benefits. For example, if the daily benefit amount selected is $100 and an individual is receiving care at the cost of $90 per day in a nursing home and Medicare pays $19 for that care, then the LTCI plan would pay $71. The remaining $29 would still be available as part of the maximum lifetime benefit.

Inflation Protection—Several insurers now offer policies that adjust the daily benefit maximum and lifetime benefit maximum for inflation. One type of inflation protection feature results in an automatic adjustment in the benefit, commonly 5 percent per year. Premiums for a policy with this feature will be considerably higher than for a policy without such a feature. A second type of inflation protection feature allows policyholders the option of increasing their benefit every so many years (for example, every three to five years) (Teachers Insurance and Annuity Association, 1993; The Prudential, 1994). In this case, premiums are lower from the outset, but the cost of any additional coverage purchased is based on age at the time the increase is selected. Some proposals have advocated that inflation protection be made mandatory, while others would require only that insurers offer the option of an inflation protection feature when a policy is initially sold.

Premiums—Premiums for LTCI vary substantially based on age and plan design. For example, Health Insurance Association of America survey data indicate that average annual premiums for leading individual and group association LTC sellers in 1995 ranged from $310 for individuals purchasing a base plan at age 50 to $8,146 for individuals purchasing a plan that included inflation protection and a nonforfeiture provision at age 79 (table 6). Other plan features, such as categories of care covered (nursing home care, home care, community care), daily benefit amount, maximum benefit duration, and deductible periods can also significantly affect premium amounts (National Association of Insurance Commissioners, 1993). Because premiums are based on age at enrollment, the younger the individual, the lower the premium. Insurers generally attempt to set premiums such that they will remain level over the individual's lifetime. Thus, premiums do not increase based on aging or use of benefits. In addition, policies are guaranteed renewable; thus, as long as premiums are paid, coverage cannot be canceled.

However, premiums may rise over time because rates generally can be increased on a class basis if claims are higher than expected. And, because the LTCI market is such a new market, it is difficult to set premiums

accurately. Little long-term claims insurance experience yet exists, and it may not be available for many years to come because many of those who currently hold LTCI will likely not use it for many years. Insurers are encouraged by current legislative proposals to enter the field of LTC financing in order to provide an alternative to public-sector financing. They are also encouraged to keep premiums level. Yet, the actuarial basis for developing premiums and statutory reserves is limited.

Nonforfeiture—As is increasingly common in private disability insurance, many LTCI policies now include optional nonforfeiture features. Nonforfeiture provisions prevent the policyholder from forfeiting his or her full benefit in the event of a voluntary policy lapse.

Nonforfeiture benefits can take many different forms and may vary with an insured's age, claims history, and the duration the policy has been in force. These benefits may be included in the policy on a voluntary basis, with a higher premium assessed for those purchasing the option.

One type of nonforfeiture provision continues coverage at a reduced benefit level if a minimum number of payments has been made. For example, one employer plan provides that if the insured has paid premiums in the LTCI program for 10 consecutive years and then voluntarily discontinues premium payments, he or she will retain coverage of 30 percent of the original daily maximum benefit. For each year beyond the 10th year that the insured continues to pay premiums, the amount of the reduced coverage is increased by 3 percent, up to a maximum reduced coverage of 75 percent of the daily maximum benefit (IBM, 1994). Some plans, rather than reducing the daily benefit amount, provide for a shortened benefit period. For example, in one plan, if a shortened benefit period nonforfeiture rider has been in effect for at least five years at the time the policy lapses, coverage is continued based on the same benefits in effect at the time of the lapse; however, the policy maximum is reduced (Transamerica Life Companies, 1995).

Another type of nonforfeiture benefit allows partial recovery of premiums paid in the event of voluntary lapse of the policy. For example, one employer plan provides that for every year the policy is in force, 5 percent of the premium will be refunded in the event of a voluntary lapse (less any benefits that have already been paid). Thus, for example, if the policy has been in force for one full year, 5 percent of the premium would be refunded; if the policy has been in force for two full years, 10 percent would be refunded. The individual is entitled to a 100 percent refund if the policy is in force for 20 or more years (The Prudential, 1994).

While a nonforfeiture provision may be effective for the person who does not want another LTC policy, for the buyer who wants to exchange one policy for another, a nonforfeiture provision is of only limited value (McNamara, 1995). On the group side, policies may be upgraded through the same insurer, or reserves may be transferred to a new insurer who will then upgrade the policies. By transferring reserves, credit is given such that the upgraded policies may be based on the age at which coverage was originally purchased rather than at the more expensive rate based on the insured's current age. Some larger employers may be able to negotiate when establishing their plan to provide for upgrades and to ensure that funds will be transferred to another insurer on request. If this is not done, the insurer may refuse to transfer reserves. Then, if the employer does decide to move to a new insurer, individuals in the plan are required to decide whether they want to pay the higher premium or leave the group plan in order to remain with the original insurer.

Although not specifically a type of nonforfeiture benefit, another design feature sometimes included in a policy provides that a portion of the premium may be returned to the insured's estate in the event of death. For example, one employer plan provides that if the insured dies on or before his or her 65th birthday, an amount equal to all contributions paid up to the time of death, less any benefits paid, will be paid to the insured's estate. If the individual covered under the plan dies between his or her 65th and 75th birthday, the estate receives an amount equal to all contributions paid up to the 65th birthday, reduced by 10 percent for each year after the 65th birthday and less any benefits already received (J.P. Morgan & Co., 1994; Prudential, 1994). Many policies also now include protection against unintended lapse through the designation of an alternative party who would be notified in the case of a missed premium payment before the policy lapses.

Some companies may also offer "paid-up" policies. These policies entitle the insured to the full amount of benefits if premiums have been paid for a certain amount of time (for example, for 20 years or 30 years). Once the policy is "paid-up," no additional payments are required (American Association of Retired Persons, 1995).

Waiver of Premium–Many policies now include a provision that allows policyholders to stop paying premiums after a specified number of days of care in a nursing home. Some policies include a waiting period such as 60 days from the day payments are first made to the day premiums are waived.

Financing Sources

The majority of functionally dependent individuals receive LTC on an informal "unpaid" basis from friends and family, making it difficult to measure the total value of this care (U.S. Bipartisan Commission on Comprehensive Health Care, 1990). In a 1993 EBRI/Gallup poll, 59 percent of respondents who indicated they had a family member receiving LTC said they were providing that care (Employee Benefit Research Institute, 1993). However, data from the U.S. Health Care Financing Administration's national health accounts indicate that of the $1,035.1 billion in total health expenditures in 1996, $108.7 billion (11 percent) was spent on nursing home care and on care received from home health agencies (chart 2). Medicaid financed the largest proportion of this care ($41.7 billion or 38 percent), followed by out-of-pocket payments from patients and families ($30.6 billion or 28 percent), Medicare ($22.5 billion or 21 percent), and private health insurance ($7.2 billion or 7 percent). Of the $108.7 billion, nursing home expenditures totaled $78.5 billion in 1996, of which 32 percent was financed through

consumer out-of-pocket payments (chart 4). Most of the remainder was financed through the Medicaid program (47.8 percent), with Medicare accounting for 11.3 percent, other public and private programs accounting for 4.3 percent, and private insurance paying for 5.1 percent. Home health agencies accounted for $32.2 billion, of which 42.2 percent was financed through Medicare, 13 percent through Medicaid, and 18.3 percent through out-of-pocket payments.

Trends

While expenditures for nursing home care have risen from $20.5 billion in 1980 to $78.5 billion in 1996, they have remained fairly constant as a proportion of total national health expenditures over this same time period (table 7). As a proportion of all expenditures for nursing home care, Medicaid has remained fairly constant, with Medicare accounting for an increasingly larger proportion and out-of-pocket costs accounting for an increasingly smaller proportion.

Home health care expenditures have also risen over time (from $2.4 billion in 1980 to 30.2 billion in 1996). However, unlike nursing home expenditures, home health care expenditures have risen as a proportion of total national health expenditures, increasing from 1.0 percent in 1980 to 2.9 percent in 1996. As a proportion of all home health care expenditures, both Medicaid and out-of-pocket expenditures have declined since 1990, whereas Medicare has accounted for an increasingly larger proportion.

Out-of-Pocket

A large proportion of LTC is financed out-of-pocket by recipients or their friends and families. National health account data indicate that $30.6 billion, or 28 percent, was spent by patients and their families on nursing home and home health care in 1996 (chart 2). Additional amounts spent in nontraditional LTC settings, such as for adult day care and respite care as well as, for example, costs for help with personal care and homemaking, meal programs, and special transportation would increase this amount but are difficult to determine.

Nursing home care—the most expensive type of LTC—consumes the greatest amount of out-of-pocket spending. As shown in chart 4, individuals spent $24.7 billion on nursing home care and an additional $5.9 billion on home health care in 1996.

Conclusion

Although a large proportion of LTC is provided on an informal basis by family and friends, many individuals require formal care either in the community or in an institutional setting, which can be quite expensive. The need for LTC services is most prevalent among the elderly. However, individuals of all ages may need LTC services. Moreover, demographic trends such as an aging population, an increased female labor participation rate, and delayed childbearing may mean a reduction in traditional sources of informal LTC. These factors have caused leaders in business, academia, and government to be concerned about financing LTC.

Aside from informal care provided in the community, the current system of financing LTC depends on the Medicaid program and individual financing. Issues confronting this system include spiraling costs associated with LTC services that may threaten beneficiaries' access to care. Other issues include the potential depletion of personal assets, a bias toward institutionalization (which may not always provide the most cost-effective or desired type of care available), and the ability of some individuals who transfer assets to become eligible for Medicaid. Many leaders regard private LTCI as a way to increase access to financing and as a potential alternative to Medicaid and out-of-pocket financing. As a recent innovation, this method of financing care currently accounts for only a small proportion of expenditures. However, tax incentive measures, plan design improvements, and population aging may encourage more Americans to purchase coverage. Some analysts believe that taxpayer financed public social programs should simply be expanded.

The largest barrier to the expansion of the private LTCI market is the lack of public readiness to use assets to insure against the relatively low probability of need. Public education is very much needed. Until it occurs and the public is ready to pay either through premiums or taxes, it is unlikely that the goals of adequate coverage, universal access, and affordability through risk pooling will be achieved.

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Endnotes

[1]These data represent the total number of policies sold as of the date indicated. Due to policy lapses, the number of policies actually in force is lower.

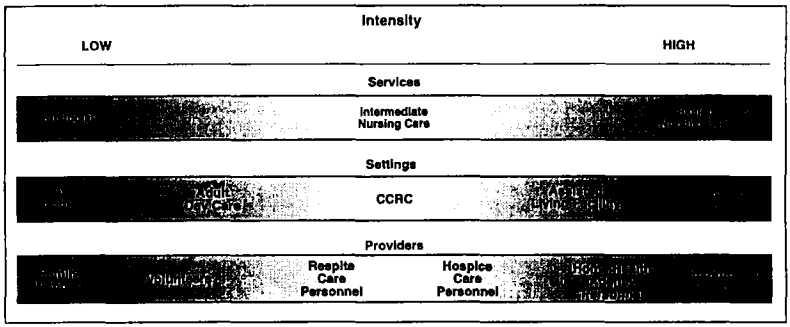
[2] Disability insurance replaces lost wages; it does not cover any health or long-term care costs.

[3]One study indicates that, for persons who reached age 65 in 1990, 43 percent will enter a nursing home at some time before they die. Of those entering a nursing home, 55 percent will have a total lifetime use of five years or more. The authors of the study also projected that women are more likely to enter a nursing home than men (52 percent versus 33 percent). See Kemper and Murtaugh (1991).

Chart 1

LONG-TERM CARE SERVICES, SETTINGS, AND PROVIDERS

Long-term care can generally be classified as skilled nursing care, intermediate nursing care, and custodial (or personal) care. These services have traditionally been provided either by family members at home or in formal settings such as in a nursing home. While care is still often provided at home by family members, a number of nontraditional settings and types of providers have developed that focus on providing care in the most home-like setting possible. While it is difficult to classify these settings and providers, the following continuum attempts to present a range of the services, settings, and providers—from the least intensive to the most intensive—now available.



This continuum is by no means all inclusive or standardized. It is meant to give a general idea of the range of LTC services, settings, and providers. For example, while assisted living facilities are presented as more intensive with regard to the type of setting in which care is provided, based on the given individual's needs, the type of care provided at an adult day care center may actually be more intensive. In addition to variation based on each individual's needs, definitions vary and may overlap. Following are general descriptions of the terms used in this illustration.

Adult Day Care
Adult day care offers a structured daytime program that typically includes assistance with personal care, lunches, and a variety of social, recreational, and rehabilitative activities in a protective environment (The Prudential, 1994). Long-term care insurance (LTCI) contracts may only pay for care in an adult day care center if the center is appropriately state licensed or is recognized as a home health agency by Medicare.

Assisted Living Facilities
These facilities offer shared and supervised housing for those who cannot function independently, including individuals needing only minimal support as well as those who are more severely impaired (Teachers Insurance and Annuity Association, 1993).

Continuing Care Retirement Community (CCRC)
A CCRC is a residential community for older people that offers lifetime housing and a range of social and health care services (Teachers Insurance and Annuity Association, 1993). These services are generally provided in exchange for an upfront fee and monthly payments.

Custodial (or Personal) Care
Custodial care may be given by people without medical skills to help a person perform activities of daily living, which include assistance with bathing, eating, dressing, and other routine activities. It is less intensive or complicated than skilled or intermediate care and can be provided in many settings, including nursing homes, adult day care centers, or at home (National Association of Insurance Commissioners, 1993).

Family Members
Although a large proportion of LTC services are provided informally by family members,[1] most policies, with rare exceptions, specifically exclude coverage for such care.

Home Health Care
This care includes a wide variety of services delivered at home or in a residential setting that can range from skilled nursing care and physical therapy to personal care and help with household chores (Teachers Insurance and Annuity Association, 1993).

Hospice Care
Hospice care includes services provided to assist a person with a terminal illness that may be provided in various settings, including, for example, at home or in a nursing home care setting (Travelers Group, 1995).

Intermediate Nursing Care[2]
This type of care is ordered by a physician and supervised by a registered nurse for stable conditions that require daily, but not 24-hour, nursing supervision. Intermediate care is generally needed for a long period of time (National Association of Insurance Commissioners, 1993), is less specialized than skilled nursing care, and often involves more personal care.

Respite Care
Respite care offers temporary relief, or time off, for family members or other unpaid caregivers who are responsible for the care of a dependent person (The Prudential, 1994). This service is provided by volunteers, an institution, or an adult day care center (Teachers Insurance and Annuity Association, 1993). LTCI plans generally limit the number of days for which respite care is reimbursable (The Prudential, 1994).

Skilled Nursing Care[3]
This care is available 24 hours a day, is ordered by a physician, and involves a treatment plan for medical conditions that require care by skilled medical personnel such as registered nurses or professional therapists. Some people need skilled care for a short time after an acute illness. Others require skilled care for longer periods of time. Sometimes skilled care is provided in a person's home with help from visiting nurses (National Association of Insurance Commissioners, 1993).

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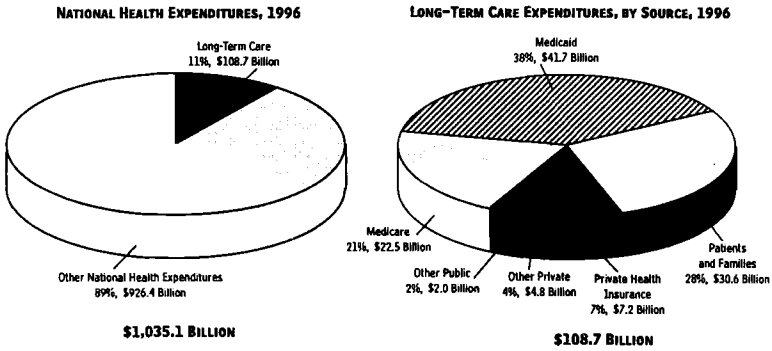
[1] *In 1989, one study estimates that 70 percent of the severely disabled elderly relied solely on family members or other unpaid help to provide long-term care services. See U.S. Bipartisan Commission on Comprehensive Health Care, 1990. (Data are based on Lewin/ICF and Brookings Institution estimates of the 1982 National Long-Term Care Survey.)*
[2] *Medicare and Medicaid have their own definitions of nursing care that do not necessarily match definitions found in LTC policies.*
[3] *Ibid.*

Chart 2

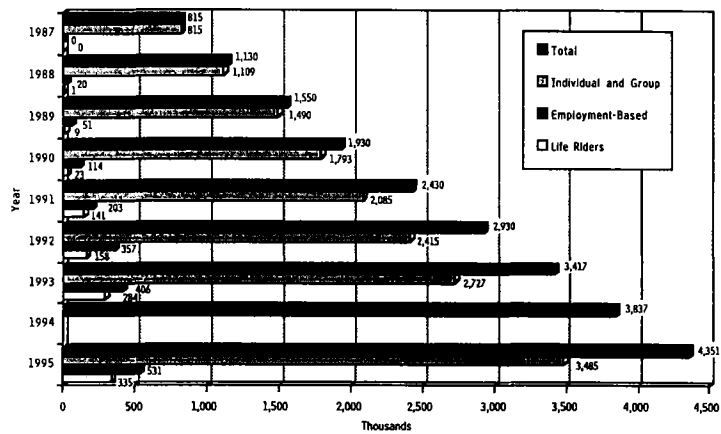
LONG-TERM CARE EXPENDITURES AS A PROPORTION OF TOTAL NATIONAL HEALTH EXPENDITURES AND BY SOURCE OF FUNDS, 1996



Source: Health Care Financing Administration.

Chart 3

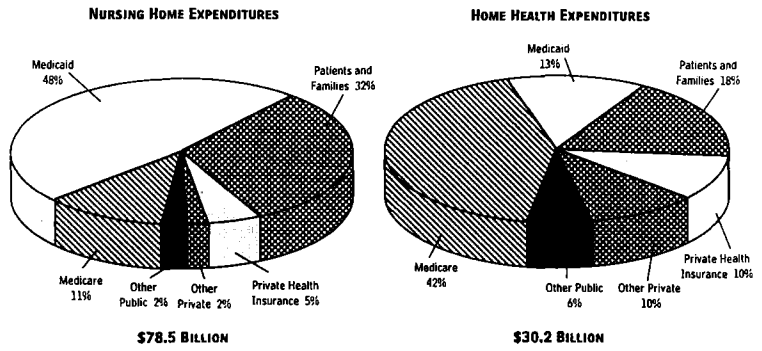
LONG-TERM CARE POLICIES SOLD IN INDIVIDUAL AND GROUP, EMPLOYER, AND LIFE INSURANCE MARKETS, 1987-1995



Source: Health Insurance Association of America.

Chart 4

NATIONAL NURSING HOME AND HOME HEALTH CARE EXPENDITURES, BY SOURCE OF FUNDS, 1996



Source: Health Care Financing Administration.

Table 1

THE U.S. LONG-TERM CARE POPULATION BY AGE AND CARE SETTING

Age Group	In Institutions	At Home or in Community Settings	Total Population
		(thousands)	
Total	2,440	10,400	12,840
Under age 18	90	330	420
Ages 18–64	710	4,380	5,090
Ages 65 and older	1,640	5,690	7,330
		(percentage)	
Total	100.0%	100.0%	100.0%
Under age 18	3.7	3.2	3.3
Ages 18–64	29.1	42.1	39.6
Ages 65 and older	67.2	54.7	57.1

Source: U.S. General Accounting Office, 1994.

Table 2

EMPLOYER-SPONSORED LONG-TERM CARE PLANS INTRODUCED EACH YEAR, 1987-1995

Year	Total Number of Plans Introduced	Cumulative Total of Plans Introduced
1987	2	2
1988	5	7
1989	47	54
1990	81	135
1991	153	288
1992	218	506
1993	462	968
1994	60	1,028
1995	232	1,260

Source: Health Insurance Association of America, 1995.

Table 3
PERCENTAGE OF EMPLOYERS OFFERING LONG-TERM CARE INSURANCE, BY REGION, INDUSTRY, AND FIRM SIZE, 1993

	Percentage of Employers Offering Long-Term Care Insurance to:					Of Those Not Offering Long-Term Care Percentage Who:		
	Active employees only	Retirees only	Both active employees and retirees	Total Offering Coverage	Do Not Offer Coverage	Decided not to offer	May offer in future	Never considered it
Total	10%	0%	2%	12%	89%	3%	9%	87%
Region								
West	5	0	0	2	95	3	11	86
Midwest	7	0	5	12	88	0	10	89
Northeast	20	0	3	23	7	6	6	88
South	8	0	0	8	92	5	10	86
Industry								
Manufacturing	17	0	0	17	83	2	9	88
Wholesale and retail trade	8	0	5	13	87	0	11	89
Services	2	0	5	7	93	0	19	81
Transportation, communications, and utilities	0	0	0	0	100	12	0	88
Health care	14	0	0	14	86	1	1	98
Finance	2	0	2	4	96	1	2	96
Government	3	0	8	10	90	0	6	94
Other	13	0	0	13	87	11	11	77
Firm Size								
10–49	10	0	2	11	89	4	12	84
50–199	13	0	3	15	85	0	0	100
200–499	7	0	1	8	92	1	4	95
500–999	14	0	8	22	78	7	7	86
1,000–4,999	10	2	10	21	79	12	24	64
5,000–9,999	5	0	10	15	85	19	34	47
10,000–19,999	7	1	8	15	85	15	42	41
20,000 or more	4	0	15	19	81	22	37	41
Under 500	10	0	2	12	88	3	9	88
500 or more	11	1	9	21	79	10	18	74

Source: Foster Higgins.

Table 4
TYPICAL COVERAGE OFFERED BY 1995 LEADING SELLERS

Services Covered	Nursing home care (11 out of 11) Home health care (11 out of 11) Alternate care (11 out of 11) Assisted-living facility (9 out of 11) Hospice care (10 out of 11) Respite care (11 out of 11)
Daily Benefit	$40–$250/day nursing home $40–$250/day home health care
Benefit Eligibility	Medical necessity or ADLs or cognitive impairment (11 out of 11)
Maximum Benefit Period	Unlimited/lifetime (11 out of 11)
Deductible Period	0–100 days
Preexisting Condition	6 months (2 out of 11) None if disclosed during application (9 out of 11)
Renewability	Guaranteed (11 out of 11)
Alzheimer's Disease Coverage	For ages 18–99
Age Limits for Purchasing	Yes (11 out of 11)
Waiver of Premiums	Yes (11 out of 11)
Free Look Period	30 days (11 out of 11)
Inflation Protection of 5 Percent Compounded	Yes (11 out of 11)
Nonforfeiture Benefit	Return of premium or reduced paid-up (11 out of 11)
Marketing	Company or independent agents

Source: Health Insurance Association of America.
Note: Eleven sellers were identified as having sold 80 percent of all individual and group association long-term care insurance policies in 1995.

T-109

Addendum to EBRI Testimony

Hearing on

Long-Term Care Insurance

by

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26 March 1998

Table 5

MEDIAN DAILY NURSING HOME CHARGES, 1991 AND 1993

State	Intermediate Care	Skilled Care	Intermediate Care	Skilled Care
	1991		1993	
Alabama	$ 65	$ 68	$ 72	$ 75
Alaska	a	a	a	a
Arizona	69	80	75	85
Arkansas	54	59	55	63
California	85	90	75	94
Colorado	70	74	75	81
Connecticut	130	148	126	157
Delaware	80	91	87	86
District of Columbia	178	178	91	94
Florida	78	85	85	90
Georgia	60	64	65	75
Hawaii	105	115	109	114
Idaho	72	76	79	75
Illinois	65	78	70	80
Indiana	71	86	73	90
Iowa	58	90	60	89
Kansas	52	74	55	70
Kentucky	64	80	66	87
Louisiana	51	59	64	74
Maine	99	124	114	141
Maryland	95	105	101	105
Massachusetts	125	135	134	145
Michigan	79	84	80	86
Minnesota	67	89	66	95
Mississippi	58	60	61	62
Missouri	55	62	60	66
Montana	58	82	74	84
Nebraska	58	68	60	78
Nevada	82	100	93	97
New Hampshire	108	150	120	133
New Jersey	116	122	118	122
New Mexico	75	111	74	138
New York	103	144	105	148
North Carolina	75	86	75	90
North Dakota	65	80	a	82
Ohio	80	93	85	100
Oklahoma	48	75	50	75
Oregon	76	118	76	116
Pennsylvania	90	97	95	101
Rhode Island	107	112	109	115
South Carolina	74	75	75	79
South Dakota	65	69	66	71
Tennessee	58	91	70	105
Texas	57	78	58	78
Utah	65	75	69	80
Vermont	90	100	102	116
Virginia	96	79	80	104
Washington	89	84	89	99
West Virginia	74	76	75	85
Wisconsin	73	80	80	86
Wyoming	75	76	76	76

Source: CNA Nursing Home Cost Surveys.
[a]Data not available.

Table 6

AVERAGE ANNUAL PREMIUMS FOR LEADING INDIVIDUAL AND GROUP ASSOCIATION LONG-TERM CARE SELLERS, 1995

Age	Base Plan	Base Plan with 5 Percent Compounded Inflation Protection	Base Plan with Nonforfeiture Provision	Base Plan with Both Inflation Protection and Nonforfeiture Protection
		Coverage Amount: $80/$40 a Day Nursing Home/Home Health Care		
50	$ 310	$ 651	$ 451	$ 929
65	817	1,481	1,158	2,419
79	3,353	4,579	4,738	6,800
		Coverage Amount: $100/$50 a Day Nursing Home/Home Health Care		
50	$ 378	$ 798	$ 540	$1,124
65	1,010	1,881	1,395	2,560
79	4,148	5,889	5,676	8,146

Source: Health Insurance Association of America.
Notes: These policies generally includes a 20-day elimination period and provides 4 years coverage.

Table 7

NATIONAL HEALTH EXPENDITURES (NHE) IN NURSING HOME AND HOME HEALTH AGENCIES, SELECTED YEARS, 1960-1996

		Nursing Home Expenditures					Home Health Expenditures				
Year	Total NHE	Total	Medicaid	Medicare	Out of pocket	Other	Total	Medicaid	Medicare	Out of pocket	Other
					($ billions)						
1960	$ 27.1	$ 1.0	$ 0.0	$0.0	$ 0.8	$0.2	$ 0.0	$0.0	$ 0.0	$0.0	$0.0
1980	247.3	17.6	8.8	0.3	7.4	1.1	2.4	0.3	0.7	0.5	0.9
1990	699.5	50.9	23.1	1.8	22.0	4.0	13.1	2.1	3.0	3.6	4.4
1996	1,035.1	78.5	37.5	8.9	24.7	7.4	30.2	4.2	13.6	5.9	6.5
	(as a percentage of total NHE)	(as a percentage of total nursing home expenditures)					(as a percentage of total NHE)	(as a percentage of total home health expenditures)			
1960	100.0%	3.7%	0.0%	0.0%	80.0%	20.0%	0.0%	n/a	n/a	n/a	n/a
1980	100.0	7.1	50.0	1.7	42.0	6.3	1.0	12.5%	29.2%	20.8%	37.5%
1990	100.0	7.3	45.4	3.5	43.2	7.9	1.9	16.0	22.9	27.5	33.6
1996	100.0	7.6	47.8	11.3	31.5	9.4	2.9	13.9	45.0	19.5	21.5

Source: Health Care Financing Administration.

EDUCATION AND
RESEARCH FUND

Paul Fronstin, Ph.D.
Employee Benefit Research Institute

Paul Fronstin is an economist with the Employee Benefit Research Institute, a nonprofit, nonpartisan organization committed to original public policy research and education on economic security and employee benefits. Dr. Fronstin's research interests include trends in health insurance coverage and the uninsured, the effectiveness of managed care, retiree health benefits, retirement transitions, employee benefits and taxation, the role of nonprofit organizations in providing employee benefits, and children's health insurance coverage. His most recent publications include a chapter in *Driving Down Health Care Costs: Strategies and Solutions, 1996* on health care cost management strategies, and articles in *Inquiry* and *Social Science Quarterly*, both explaining trends in health insurance coverage.

In 1995, Dr. Fronstin testified twice before the U.S. House of Representatives' Ways and Means Committee, Subcommittee on Health, to discuss health insurance portability and how employers have responded to rising health care costs.

Dr. Fronstin has appeared before many groups to share his expertise on employee benefits. He has spoken before the National Education Association, the Healthcare Leadership Council, the Harvard School of Public Health, the Southern Economic Association, the American Economic Association, the Population Association of America, the Association for Behavior Analysis, the Gerontological Society of America, and the Dade County Economic Forum. He has also made numerous presentations for congressional staff and the media.

Dr. Fronstin has been quoted in numerous newspapers, including the New York Times, the Wall Street Journal, the Washington Post, the Miami Herald, and the Philadelphia Inquirer. In addition, he has appeared on CNBC, C-Span, Money Watch, and America's Talking and has been repeatedly interviewed on National Public Radio.

Dr. Fronstin earned his bachelor of science degree from SUNY Binghamton and his Ph.D. from the University of Miami.

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March 19, 1998

Rep. John L. Mica, Chairman
Committee on Government Reform and Oversight
Civil Service Subcommittee
B-371 Rayburn House Office Building
Washington, DC 20515

Dear Chairman Mica:

This disclosure statement is being provided to you to comply with House and Committee rules regarding receipt of federal monies by witnesses providing testimony. The Employee Benefit Research Institute has been asked to provide testimony at the Civil Service Subcommittee's March 26, 1998 hearing on long-term care insurance issues.

During the current and past two fiscal years, neither the Employee Benefit Research Institute (EBRI) nor its Education and Research Fund (ERF) have received any grants, contracts or subcontracts from the federal government.

Sincerely,

William L. Pierron
Public Affairs Associate

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Mr. MICA. I will now recognize Mr. Charles Jackson, president of the National Association of Retired Federal Employees.

Mr. JACKSON. Thank you, Mr. Chairman. As president of NARFE, I appreciate the opportunity to participate in today's hearing, and I commend your interest in the feasibility of making long-term care insurance available as a Federal employment benefit.

Half of all women and a third of all men who are now 65 are likely to spend some time in the latter years in a nursing home at a cost in excess of $40,000 a year. Such statistics, and the age of NARFE members gives us an understandable interest in long-term care insurance.

In a survey of our members 8 years ago, only 12 percent said that they would be able to afford nursing home expenses above $30,000 per year. Although this survey is now dated, it remains a fact that absent adequate income or insurance, individuals who need long-term care are required to impoverish themselves to qualify for Medicaid nursing home benefits. For individuals with enough income, private long-term care insurance has been an alternate to Medicaid. However, such insurance is very expensive and offers limited coverage. This is especially true with respect to policies sold to individuals instead of groups, and as Consumer Reports magazine wrote in October 1997, long-term care insurance is one of the most complex types of insurance.

Today an increasing number of employers are offering group term care insurance. In fact, half of the current Fortune 500 companies make private long-term care insurance available to their workers. The advantages of employer-sponsored long-term care insurance are obvious as any group insurance is usually less costly than buying it as an individual, and company benefits specialists can assist in cutting through the marketing hype and selecting a reputable insurance carrier.

At a minimum this subcommittee should establish that the Federal Government can offer long-term care insurance with cheaper premiums and better coverage than employees or annuitants could buy on their own. Beyond this, there are several parameters that must be built into any long-term care insurance program offered.

First, policies must be made available to Federal annuitants as well as active employees. Underwriting costs and resulting premiums for annuitants will be higher, but such policies could still be attractive to annuitants if the premiums for a group are lower than the individual policies on the private market, and if employees are to be asked to bear the full premium cost of long-term care insurance, then annuitants should have the same option.

Second, the decision to select long-term care insurance should not mean that employees or annuitants would be forced to forgo other benefits. Since employees and annuitants are likely to pay 100 percent of the cost of long-term care insurance, there is no reason why they should give up retirement, health or life insurance benefits.

Third, the dollar amount of benefits payable under a new policy must be sufficiently indexed for inflation. Without this protection, the cash benefits purchased today by a 40-year-old would be substantially eroded when they are needed most.

Fourth, insurance carriers must have reasonable standards for making enrollees eligible for long-term care benefits. So-called benefit triggers rely on a policyholder's inability to perform a list of activities of daily living. Policyholders who fail to perform two or more activities of daily living should qualify for long-term care benefits. Moreover, some individuals may be able to perform activities of daily living, but have a medical condition that prevents them from taking care of themselves. Benefits ought to be triggered by medical necessities as well. Often we find the greatest need for long-term care is a person with a cognitive disorder like Alzheimer's, yet many plans exclude coverage for this or other mind-robbing illnesses. We believe it is a must.

Fifth, long-term care plans need to be flexible. Individuals who want home- and community-based care should have that choice. Plans could be tailored to needs by allowing enrollees to receive benefits in the form of services or cash.

Sixth, plan portability would be necessary for those who leave Federal service. In today's society, career mobility is not the exception, but the rule. If long-term care plans are to attract enough workers, portability is essential.

Seventh, the number of long-term care plans offered should be limited to ensure that enough individuals join a plan to build a satisfactory risk pool. It is hard to convince potential employees to buy an insurance product they cannot imagine ever needing. For instance, I have an age advantage of most of you here, yet I have difficulty believing today that I might need long-term care even tomorrow. And so perhaps not showing a level of wisdom my age should guarantee, I have not bought a long-term care policy. I suppose I cannot justify paying the premium costs for something I find hard to realize I may ever need. If I am a hard sell, just think how difficult it will be to persuade a 30-, 40- or 50-year-old Federal employee to buy long-term care insurance.

Besides these parameters, I must comment on the tax deductibility of long-term care. NARFE welcomed a mandate in the Health Insurance Portability and Accountability Act to treat long-term care insurance as a medical expense. However, the problem is that taxpayers cannot deduct long-term care premiums unless they exceed 7.5 percent of adjusted gross income.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Jackson follows:]

Charles R. Jackson, President
National Association of Retired Federal Employees

Charles R. Jackson was elected President of the National Association of Retired Federal Employees (NARFE) at the Association's 1994 National Convention in St. Louis, Missouri, and re-elected in Houston, Texas in September 1996 for another two year term.

A native of Fairfield, a small town in southern Illinois, Jackson's early life work experience included the Illinois State Police and 5 years of military service. During his military service he served with an anti-tank company and spent four years with military intelligence.

Prior to employment with the United States Postal Service, he spent eighteen months with the United Nations Relief Agency, under the famed Mayor LaGuardia of New York City. His 23 years of service with the Post Office Department included 14 years as Training Director for Arkansas, Iowa and Missouri. Following his retirement from the government, he and his wife, Clara, remained in St. Louis where he spent several years in hotel and property management before retiring a second time.

A member of NARFE since 1973, Charles Jackson served in almost all positions of his local chapter and state federation, including chapter President, State Legislative Chairman and President of the Missouri Federation of NARFE Chapters. He also served four years as Field Vice President of NARFE's Region V, which includes Iowa, Kansas, Minnesota, Missouri, Nebraska, North Dakota, and South Dakota. In this position, he served as a member of NARFE's Executive Board, becoming Chairman of the Board upon his election as National President in 1994.

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Disclaimer

NARFE does not now, nor has it ever, received federal grants, contracts or subcontracts.

Mr. Chairman, I am Charles R. Jackson, President of the National Association of Retired Federal Employees (NARFE). I appreciate the opportunity to participate in today's hearing, and I commend your interest in the feasibility of making long-term care insurance available as a federal employment benefit.

Half of all women and a third of all men who are now 65 are likely to spend some time in their later years in a nursing home at a cost in excess of $40,000 year. Such statistics, and the age of NARFE members give our organization an understandable interest in long term care insurance. In a survey of NARFE members eight years ago, only 12 percent said they would be able to afford nursing home expenses above $30,000 per year. Although this survey is now dated, it remains a fact that absent adequate income or insurance, individuals who need long term care are required to impoverish themselves to qualify for Medicaid nursing home benefits. It is a gut wrenching experience to watch a disabled person consume their hard-earned life savings after a year or two in a nursing home.

For individuals with enough income, private long-term care insurance has been an alternative to Medicaid. However, such insurance is very expensive and offers limited coverage. This is especially true with respect to policies sold to individuals instead of groups. And as Consumer Reports magazine wrote in October 1997, "long term care insurance is one of the most complex types of insurance sold by an industry not known for the straightforwardness of its products or the veracity of its marketing."

Without an adequate national response to long term care needs, an increasing number of private and public sector employers are offering group long term care insurance to their employees. In fact, half of the current Fortune 500 companies make private long term care insurance available to their workers.

The advantages of employer-sponsored long-term care insurance are obvious. First, buying any form of insurance as a group is usually less costly than buying it as an individual. Second, company benefits specialists can assist in cutting through the marketing hype and selecting a reputable insurance carrier that will provide adequate coverage to policyholders. These advantages are critical if we are to succeed on the federal level.

At a minimum, this subcommittee must establish that the federal government can offer long-term care insurance with cheaper premiums and better coverage than federal employees or annuitants could buy on their own.

Beyond this goal, there are several parameters that we believe must be built into any long-term care insurance program offered by the federal government:

First, policies must be made available to federal annuitants as well as active employees. We realize that underwriting cost and resulting premiums for annuitants will be higher. Nevertheless, such policies could still be attractive to annuitants if the premiums for a group are lower than what is available to individuals on the private market. And, if employees are to be asked to bear the full premium cost of long-term care insurance, then annuitants should have the same option.

Second, the decision to select private long-term care insurance should not mean that federal employees or annuitants would be forced to forgo other benefits. Since employees and annuitants are likely to pay 100 percent of the cost of long-term care insurance, there is no reason why they should give up retirement, health or life insurance benefits. I mention this concern because of interest by some on Capitol Hill in creating a "cafeteria" benefit plan for federal employees.

Third, the dollar amount of benefits payable under any policy made available must be sufficiently indexed for inflation. Without this important protection factor, the cash benefits provided in a policy purchased today by a 40-year old employee would be substantially eroded years from now when they are needed most.

Fourth, insurance carriers must have reasonable standards for making enrollees eligible for long-term care benefits. So-called "benefit triggers" rely on a policyholder's inability to perform a list of "activities of daily living," which include eating, walking, getting in and out of bed or a chair, dressing, bathing, using a toilet and remaining continent. Policyholders who fail to perform two or more activities of daily living should qualify for long term care benefits.

Moreover, some individuals may be able to perform activities of daily living, but have a medical condition that prevents them from taking care of themselves. Benefits ought to be triggered because of medical necessities as well. And, all too often we find that the greatest need for long term care is for a person with a cognitive disorder like Alzheimer's disease. Yet, unfortunately many private plans exclude coverage for this or other mind-robbing illnesses. We believe it is a must!

Fifth, long-term care plans need to be flexible. Individuals who want home and community-based care instead of nursing home care should have that choice. Plans could also be tailored to individual needs by allowing enrollees to receive benefits in the form of services or cash.

Sixth, plan portability would be necessary for those who leave federal service. In today's society, career mobility between the private and public sectors, as well as among individual employers, is not the exception, but the rule. We believe that if long-term care plans are to attract enough workers to make premiums affordable, portability is essential.

Seventh, the number of long term care plans offered to federal employees and annuitants should be limited to ensure that enough individuals join a plan to build a satisfactory risk pool. Unlike conventional health plans, it is hard to convince potential enrollees to buy an insurance product they cannot imagine ever needing.. For instance, I have an age advantage to most of you here, yet I have difficulty believing today that I might need long term care--even tomorrow. And so perhaps not showing a level of wisdom my age should guarantee, I have not bought a long-term care policy. I suppose I cannot justify paying the premium cost for something I find hard to realize I may ever need. Now, if I'm a hard sell, just think how difficult it will be to persuade a 30, 40 or even 50 year-old federal employee to buy long -term care insurance. Younger employees should be rewarded with lower premiums for buying early into a long-term care plan. Nonetheless, it will still be necessary to initially limit the number of plans available to build a sufficient risk pool.

Finally, a major effort to educate federal workers and annuitants will be necessary to assure an adequate pool of plan enrollees. Such an effort should include an information and referral service such as private-sector employers frequently provide to their employees along with long-term care insurance. Beyond the insurance policy itself, information and referral service counselors must be capable of telling employees and annuitants about the full range of long-term care services available to them. This knowledge will help individuals make informed decisions about long-term care options.

Besides these parameters, I must also comment on the tax deductibility of long-term care . Please work with me on this, although I know that tax issues are outside the jurisdiction of this committee. NARFE welcomed a mandate in the Health Insurance Portability and Accountability Act (P.L. 104-191) to treat long-term care insurance as a medical expense for purposes of itemizing deductions. However, the problem is that taxpayers cannot deduct long-term care premiums unless their health expenses exceed 7.5 percent of adjusted gross income.

Public policy makers could encourage taxpayers to prepare for the future by making long term care premiums entirely tax deductible. While such a tax break would result in an initial cost to the federal government, savings should be achieved in the future, since a larger number of long-term care insurance policyholders would reduce the demand for Medicaid nursing home benefits. And whether it is through Medicaid, Medicare, or other federal safety nets, costs for long-term care, in one form or another, can only increase as the population ages and lives longer.

In closing, I want to commend you, Mr. Chairman, for recognizing our critical need for private long term care insurance. While I know you are understandably eager to move legislation, it is our wish that the subcommittee take its time to gather sufficient information on lessons learned from private and public employer long-term care insurance programs.

Obviously, NARFE cannot endorse any legislation proposal in advance of its introduction and specifics. We are, however, generally supportive of your efforts to hold more hearings and draft a proposal. We would welcome the opportunity to contribute to this process. Thank you again for inviting us to testify.

Mr. MICA. I thank you, Mr. Jackson, and all of our panelists this morning for your testimony. I have several questions. I wanted to start out with Mr. Jackson, who has raised, I guess, one of the primary barriers between employees or individuals, retirees and others securing long-term care insurance, and that is the cost. We have 1.9 million Federal employees and 2.2 million Federal retirees. Mr. Martin, is that a pretty good size group to get a group rate?

Mr. MARTIN. Certainly unmatched in my experience. I think certainly looking at what you would expect, and I think Dave Brenerman touched on this, there is a message that is sent just by the very fact that the Government can extend coverage to its employees. But the type of coverage that would be offered, I think you would be able to fashion a plan that is comprehensive, that does the best for employees and their families and also has administrative savings that would make this a very good benefit.

Mr. MICA. I have also heard that corporations do offer this as an option, a growing number of corporations now. A couple of questions in that regard. I guess the corporate rate with larger numbers also provides a better group rate than if an individual goes out. Is there some savings you could estimate, either Mr. Brenerman, Mr. Martin?

Mr. BRENERMAN. Well, typically, a group plan, because there are administrative savings, the premiums are deducted from the person's paycheck, for example, rather than having to set up——

Mr. MICA. What kind of savings can there be to the individual if you go outside—again, our Federal employees right now can go out and buy their own.

Mr. BRENERMAN. The savings are in the range, I think, of about 10 to 20 percent.

Mr. MICA. With a group rate.

Now, let me ask about these corporate plans and what the private sector is doing. Are they paying a portion of the premium, or is all of this left up to the employee? What is your experience, Mr. Brenerman, Mr. Martin?

Mr. MARTIN. Certainly the vast majority of larger employers offer this as an employee-pay-all. The employer does what you would call the due diligence, selecting the carrier or carriers that will be providing the coverage, works oftentimes with national consulting houses in fashioning the plan of benefits. There is quite a bit of negotiation over the price, what the choices will be, not making them overly complicated. There are employers who do contribute toward the premium, and I think in the smaller market there are actually employers, Dave has more experience in that, where the premium is paid fully to a certain level by the employer.

Mr. MICA. Mr. Brenerman, what is the trend?

Mr. BRENERMAN. I think, generally speaking, in groups under 500 employees, I would say about 40 percent of the employers pay a portion or all of the premium. But in the larger groups, like the companies that Mr. Martin mentioned before, IBM, et cetera, those are usually employee-pay-all plans.

Mr. MICA. I think in your testimony you said that right now for long-term care we sort of go through this process of individuals using up all of their savings and then eventually getting into Med-

icaid, which seems to be the trend for those who require long-term care. They expend all of their personal resources so the Government ends up paying. Do you see any benefit to us taking an initiative and making this available now, particularly given the statistics that I think we were quoted today about the demographics and the aging population?

Mr. BRENERMAN. Well, I think the American Council of Life Insurance has just done a study on the impact of the purchase of a long-term care policy on the cost of Medicaid. Mr. Martin could speak to that. I think there is a significant savings to the Medicaid Program if people own an insurance policy for long-term care rather than expending all of their resources and then ultimately relying on Medicaid to pay for a nursing home.

Mr. MICA. I think also you caught my attention by mentioning—I believe it was you who said that one of the biggest unfunded potential liabilities we have is this long-term care question and cost. Right now it can go anywhere, for instance, in Florida, $16,000 to $40,000 a year in costs are some of the estimates I have seen. You talked about an unfunded liability. What is that going to be like in the future?

Mr. BRENERMAN. Well, I can't put a total on it, but given the fact that we have a growing number of elderly, baby boomers will soon reach the age where they will be thinking about long-term care and actually needing long-term care ultimately. Those numbers are so large that if you take $40,000 a year in today's dollars and look at it 20 years from now, 30 years from now, it is such an extraordinary number if people are not protected, an extraordinary number for the government to try to protect and pay for.

Mr. MICA. Well, again, I started out by saying the only thing that stands between an employee and this type of coverage is the cost. I think we have heard testimony here where Mr. Jackson said that it is also difficult when you have to get 7 percent, I guess, to get to a deductible level. If we had MSA's—I don't know if you are familiar with that. I understand under some of the provisions that we passed, that money could be taken from the MSA's to pay for a premium like that. Would that provide some avenue for resources to cover these expenses on an annualized basis? Mr. Martin, are you familiar with this?

Mr. MARTIN. Yes, and I think that is an excellent point. I think that HIPAA certainly went a long way toward legitimizing private long-term care insurance by giving it tax-favored status in exchange for hitting certain standards and including consumer protection provisions. If you could go further and include favorable provisions within MSA's, or perhaps, I think as Mr. Jackson touched on, lift the 7.5 percent requirement, you would be doing what some of the States are doing following HIPAA, and that is putting in tax credits and deductions at the State level that will further, I think, focus people on the need for this. I think when you legitimize a product like this that has such wide appeal given the demographics, you really further send a message that this is something you need to think about; that in the Tax Code you are saying you will give something at least for preparing for your own future.

Mr. MICA. Mr. Brenerman, any ideas on creative financing mechanisms to help pay for this?

Mr. BRENERMAN. Well, I guess if I knew that, I would be in Congress. I think, I guess, what we are saying today is that private long-term care insurance is one way for individuals to try to protect themselves without having to wait for Medicaid or wait for Congress to pass some program that would cover all Americans, which would be prohibitively expensive. I think a partnership between private insurance and State governments and the Federal Government through tax incentives, through employees being allowed to purchase private insurance are two ways to try to address this issue. Maybe there needs to be more research on what other private-public partnerships would be necessary to try to encourage people to plan for their futures.

Mr. MICA. While I can't change the tax laws from this subcommittee, what we can do is ask that this be made an option available to our Federal employees. You all have testified, those of you in the industry, that we should be able to get a good group rate, and make this available for those who do want to get that coverage. That is probably the first step that we can take in the markets available and fairly competitive; is that correct, Mr. Martin?

Mr. MARTIN. Yes. I would agree absolutely.

Mr. MICA. Mr. Brenerman.

Mr. BRENERMAN. Yes, I agree. And you may want to explore whether companies that sell individual policies, because the Federal group is so large, could also provide a policy that is less expensive than if people bought it across a kitchen table from an agent.

Mr. MICA. Mr. Fronstin did you want to comment?

Mr. FRONSTIN. I would say that is a first step. Offering it is necessary, but it is not sufficient. The next step is getting people to actually buy the policy.

Mr. MICA. If you can buy it at a reduced rate and make it available and then find some creative financing. I like my MSA idea on a very limited basis, Mr. Jackson, just to see how it works. Did you want to comment, Mr. Jackson?

Mr. JACKSON. Well, comment on the group or the MSA?

Mr. MICA. Any and all of the above, sir. You are recognized.

Mr. JACKSON. Mr. Chairman, first of all, you have to remember that most annuitants, such as me, are unlikely to build up the cash in an MSA that would afford a long-term care policy. I do agree with the group policy, and it is our feeling that on the group policy, the fact that it is like buying anything in bulk at a grocery store or for an organization: if you buy in bulk, you are probably going to get a cheaper price. I just yesterday received in the mail from an organization that I belong to offering a group discount policy, but it was on car accident, and it was on travel. But I was shocked at the price that they were quoting me per month for my wife and myself, and it is a policy that I could afford because I had no idea that it was out there, that it was that cheap. But it is because that organization is so large, and they are offering it as a group policy. I think that would be the secret of it. Would it be that it would reduce the premiums?

Mr. MICA. I thank you, each of you, for your responses.

I would like to recognize now, Mr. Cummings.

Mr. CUMMINGS. I also want to thank you all for your testimony. You have done a good job of informing us about a number of issues.

Mr. Martin, I take it that State and local governments offer this kind of insurance?

Mr. MARTIN. Yes. Some do. I think it is just beginning, but most recently the State of Washington has decided to put in a long-term care program.

Mr. CUMMINGS. Now, do you know if they are paying a large portion of the premiums, all of the premium?

Mr. MARTIN. They are offering it on an employee-pay-all basis, similar to what would be in regular programs.

Mr. CUMMINGS. So the employee pays the entire——

Mr. MARTIN. That is correct.

Mr. CUMMINGS. As I listened to Mr. Jackson, he was talking about his situation where you would think that someone in his position would be purchasing or have this kind of insurance if it is offered. How do you suggest, and maybe any of you, that you educate people to even buy it?

Mr. MARTIN. I think that is one of the points that we certainly raised in our testimony, education. I think Mr. Jackson touched on that as well. There is, I think, a denial aspect of this that exists in all of us. I think it is only human. We think that a lot of things that both insurers and public institutions can do, public service announcements telling people perhaps when they become eligible for Medicare or when they are approaching that, maybe doing something when people turn 50, anything that can raise the awareness of the need for it. I think pulling the focus back a bit and realizing this doesn't just happen to older people, a lot of younger people require long-term care services, too. So I think anything could be done to raise public awareness. We do a lot of that when we are talking to people whether they are individuals or groups. But that is a key issue, I think.

Mr. CUMMINGS. One of the other things that you said that—you said that Federal employees should obtain coverage from financially sound companies. Are any of the 125 companies that offer long-term care insurance in financial difficulty?

Mr. MARTIN. I don't believe so. Our point was certainly that as you look at this, that there should be some criteria applied so that you have assurances that the carriers are meeting the standards that you expect for the employees and their families.

Mr. CUMMINGS. Now, Mr. Jackson raised some very interesting issues, and one of them was about qualifying; he also mentioned Alzheimer's, correct me if I am wrong, Mr. Jackson, that if one came up with Alzheimer's, they might have a problem even though they had a policy?

Mr. JACKSON. There are some policies that are offered on long-term care that will accept an Alzheimer's patient, but there are many that do not. That is one of the problems on long-term care policies. If you have Parkinson's or Alzheimer's, then it is difficult, because there is also in many instances in the policies that we have reviewed, in some of it, it requires a waiting period also. How do you determine whether a waiting period, if you had essential tremors, as to whether it is actually Parkinson's or essential tremors? And so some of the people cannot get policies. They order them.

They buy the policy. They give a payment. Then they get the policy and they find out that they have something and they may not be covered. So it is a problem.

Mr. CUMMINGS. Do you think that in the scenario you just stated, do you think that there is a failure on the part of some insurance companies to spell out——

Mr. JACKSON. If I were an insurance company, I would be the same way. I can understand that, because they have to be very careful on what they are accepting. What I am merely saying is that one of the problems in people getting long-term care is that there are many things in a long-term care policy that are not covered.

Mr. CUMMINGS. Mr. Brenerman, you stated in your testimony that the potential of the current system is not as efficient and equitable as it could be. What do you mean by that?

Mr. BRENERMAN. What I mean is Medicaid—we have one essential Federal program that covers people. We have what we all know about, Medicaid. You cannot qualify for that unless you are destitute. Medicare covers some medically necessary home care for short periods of time. The cost of that program, just like the Medicaid Program, has gone beyond what I think Congress has ever projected. Five percent of the public has long-term care insurance. I guess what I am saying is this is sort of a hit-or-miss method for covering long-term care in this country. That is why I made that statement.

Mr. CUMMINGS. Could you explain the proposed structure for Federal long-term care insurance plan and who pays the cost, administration cost?

Mr. BRENERMAN. Well, typically the employer would pay the administrative costs. I mean, that is something that could be negotiated. But typically the employer would pay for providing information to employees about the plan that is being offered to them. Again, we have employers ask for all types of plan design, and some employers want to do more than others in educating their employees about the plan. So I would guess that the Federal Government would have to cover some or all of the cost of administering the program.

Mr. CUMMINGS. Under the Federal Employee Health Benefit Plan, insurance companies must offer certain basic health benefits. Would a set of basic services be provided under a long-term care benefits package?

Mr. BRENERMAN. Yes. I think, Congressman, that when this program is designed, I think the Federal Government needs to, at least, outline some benefits that it wants its employees to be offered. We need to be flexible in what the companies offer, but at the same time we want to make sure that people have nursing home coverage, home care as an offer, assisted living, as three examples of the types of care that people might want to have, and then we can get into the details of how much coverage a person should have under each of those areas, what the elimination period should be before you qualify for coverage. Those are all items that we need to agree upon before the program can ever be offered.

Mr. CUMMINGS. Mr. Fronstin, how would a Federal long-term benefit program affect the private sector, private market?

Mr. FRONSTIN. I am not sure exactly what you are getting at?

Mr. CUMMINGS. I am talking about the private insurance; how would it affect it, the market in this area?

Mr. FRONSTIN. I am not sure that it would. It may make it more competitive, may bring some more insurance companies into the market if there are more people eligible for plans. It would take some time before that would happen.

Mr. CUMMINGS. How do you determine today what kind of long-term benefits you are going to need 20 or 30 years from now?

Mr. FRONSTIN. I think that is very difficult. It may be even longer than that if we are talking age 70 or 80 for a worker who is just coming out of college. They have to think about what kind of plan they want. Certainly they may want inflation protection. But I think in the back of their mind they are hoping they never need it even if they are willing to buy it. That is not a difficult decision to make.

Mr. CUMMINGS. Thank you.

Mr. MICA. I thank the gentleman.

I have a couple of questions. First of all, if we are going to set this up for Federal Government and Federal employees, there are probably a couple ways to go. One of those methods would be sort of a self-insurance plan with the Government having someone as an administrator, probably from the private sector. Another method would be multiple providers such as we have with our Federal Employees Health Benefit Program where we open it up to competition, set some basic parameters.

Mr. Martin, Mr. Brenerman, maybe Mr. Fronstin, you can tell us a little bit of what you think would be best, and why and how it would affect costs, premiums, administration?

Mr. Martin.

Mr. MARTIN. I thank you. I think, certainly, to have a number of insurers introduce an element of both competition and choice in terms of plans that I think is healthy for everyone. The sheer size of the eligible population, I think, argues for that.

I think at the same time the type of coverage standards, the plan design, what the benefit triggers are, comprehensive plans that cover all types of facilities, those are the types of things I think you would want to think about in fashioning the plan design options that would be available.

At the same time, whether it is a group arrangement or an individual one, there can be discounts. It may be more appropriate for certain segments of the population to buy group coverage. Others might want to have a tailored plan that can more often happen in an individual setting where older people perhaps might want to look at something that is more tailored. But the savings, I think, could exist however you set it up, and certainly the Government, as it contracts or sets policy for what is permissible, has, I think, a great deal of control over how the pricing—what pricing is acceptable and making sure it is affordable.

Mr. MICA. Mr. Brenerman, what do you recommend?

Mr. BRENERMAN. I don't differ much from what Dave Martin just said. I think having multiple providers introduces an element of competition, which I think is useful for the consumer, and also offering a combination of group coverage and perhaps individual cov-

erage for those people who would like to take advantage of the individual plans where the employees may have more choices of programs than you might get in the group coverage where the employer makes a number of decisions for the employee. Other than that, I don't have anything to add, Mr. Chairman.

Mr. MICA. Mr. Fronstin.

Mr. FRONSTIN. I would just raise the question of whether it is in your best interest to self-insure this type of program. Even though Medicare and Medicaid are not employee benefits for workers, they are self-insured by the Government, and every few years we revisit those programs because the costs increase faster than expected. And in a self-insured environment, you may experience the same type of—you may have the same experience. So, I think, in terms of the question is do you really want to assume that risk or not.

Mr. MICA. Thank you.

Mr. Jackson, what do you think our Federal retirees, who insist on being included, would like to see as the way this is administered and operated?

Mr. JACKSON. Well, we would certainly welcome anything in long-term care. As it so happens, Mr. Chairman, our Retirement Life magazine in May will run an article on long-term care insurance because we have found that so many of our annuitants have questions on this particular subject. They don't know what policies are the best to take. So what we have done is begun an education program on this in the month of May, as it so happens.

And we do not get a lot of correspondence concerning this subject, but it is on the minds, and I think one of the problems is that it is in my age group, and my age group is dying off, so to speak. But we grew up in an era that we learned, or it was instilled into us, that we took care of Mother and Dad. I am the class of this group in my age group. The younger people that are coming up today, I am not sure that my daughter is going to take care of me, if I come to the point that I can't take care of myself. I need that policy, I know that. But in my age group, if you are in good health, you believe you are never going to need it. That is one of the problems that we have.

So, I think, it is important for the Federal workers particularly to realize the importance of this because they have a different lifestyle than the group in my age group. And I commend you for what you are doing with regard to this and the hearing on this because it opens up something that needs to be done.

Mr. MICA. Thank you, Mr. Jackson. I want to ask again, do you think when we set this up we should have the Federal Government do a self-insurance plan and have basically one plan available, and maybe bring in an administrator? Or, do you think that we should have multiple choices such as we have in FEHBP?

Mr. JACKSON. I personally would prefer multiples such as we have the opportunity in the FEHBP program.

Mr. MICA. The other thing, too, Mr. Jackson has raised some points. The Consumer Reports reviewed long-term health care insurance policies in their 1997 October issue, and an article in Consumer Reports concluded, and let me quote, "Long-term care insurance is one of the most complex types of insurance sold by an in-

dustry not known sometimes for the straightforwardness of its products or the veracity of its marketing."

Mr. Brenerman, what is your reaction to this statement, in particular, and the whole article in general?

Mr. BRENERMAN. Well, the article generated a response from HIAA which I would like to introduce into the record, because——

Mr. MICA. Without objection, we will make that a part of the record.

[The information referred to follows:]

Health Insurance Association of America

November 4, 1997

Bill Gradison
President
Letters to the Editor
Consumer Reports
101 Truman Avenue
Yonkers, New York 10703

To the Editor:

Your story on long-term care (LTC) insurance, "How will you pay for your old age?" (October 1997) provides valuable information for consumers thinking about buying such protection. But the article contains several inaccuracies that must be addressed.

For a magazine dedicated to providing its readers with complete, objective anlaysis, Consumer Reports displays a disturbing bias against tax-qualified LTC insurance policies, and it appears compelled to dissuade readers from considering such policies by omitting information critical to any purchase decision.

First, the article fails to mention how its recommendation not to purchase tax-qualified LTC insurance policies potentially could have negative effects on consumers. People who purchase non-tax qualified LTC policies face the possibility of having their benefits taxed as income. There is no such risk with tax-qualified plans.

Second, the assertion that, because such policies lack a medical necessity trigger, tax-qualified LTC policies are more restrictive than non-qualified plans is a careless generalization with no basis in fact. The absence of a medical necessity trigger *does not* indicate a more restrictive policy. Tax-qualified LTC insurance policies pay benefits based on more objective and appropriate measures of the need for LTC, such as the inability to perform activities of daily living and cognitive impairment.

Third, it is irresponsible to tell consumers that they can disregard an insurance company's financial stability because state guarantee funds will pay claims for policy-holders insured by failed companies. There are no guarantees that such funds will cover all of the obligations of failed LTC insurers. To suggest that consumers can rely on a government check, and therefore forego careful shopping to select the most financially sound company, seems to undermine the very mission of your publication.

Sincerely,

Bill Gradison
President

ess/BG

555 13th Street, NW Suite 600 East, Washington, DC 20004-1109 202-824-1623 Fax 202-824-1719

HIAA Talking Points on October 1997 Consumer Reports Article on Long-Term Care Insurance Policies

ISSUE: Who needs long-term care insurance (LTCI)?

CONSUMER REPORTS RESPONSE: If you're poor, Medicaid pays. If you can set aside about $160,000 at compounded interest solely to pay for nursing home care, you don't need LTCI.

HIAA RESPONSE: HIAA fully agrees with Consumer Reports that LTCI is not for everyone. If you currently qualify or will soon qualify for Medicaid, you clearly do not need LTCI. However, who needs LTCI beyond this point is much more difficult to quantify. A figure of $160,000 for an expected nursing home stay of 4 years and depending on where you may be insufficient for many people. LTCI allows you to protect yourself for an indefinite amount of time (e.g., lifetime coverage).

The financial advantage of buying insurance rather than putting aside $160,000 today is compelling. For example, the average annual cost of an LTCI policy for a 65-year old[1] is $1,881. By the time this person reaches 85, he would have paid about $37,620 in premiums, less than one-fourth of the $160,000 recommended by Consumer Reports. (Or even paying until age 95, where total premiums paid would be about $56,430, only about 35 percent of $160,000.) This person would end up with generally the same type of coverage Consumer Reports recommends, and still have access to an extra $120,000 (or an extra $100,000 if a person pays till age 95) which he may use for other needs or to enhance his retirement lifestyle.

ISSUE: Why buy LTCI?

CONSUMER REPORTS: The principal reason to buy LTCI is to preserve from a Medicaid "spenddown," the assets that a spouse may need to live on or that you are determined to leave to children and grandchildren.

HIAA RESPONSE: Protection of assets is an important reason to buy LTCI. However, it is not the only reason nor is it the primary reason why people purchase LTCI. An HIAA survey of 2,601 buyers of LTCI revealed that people

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[1] This is a average cost for a LTCI policy covering $100 a day in a nursing home costs and at least $50 in home health care costs, with a 20-day deductible period, with a 5 percent compounded inflation protection feature and covering up to four years of coverage.

bought LTCI for many reasons, not only to protect their assets. When respondents were asked to choose the single most important reason behind their purchase decision, the reason cited most frequently was to avoid having to depend on others and to preserve independence. Protection of assets and standard of living was the next most cited response. In addition, fully 25 percent of the respondents cited "other reasons" as the single most important reason for purchase. These numbers clearly show that there is diversity in the LTCI purchase motivation. To limit the reason for purchasing LTCI to protection of assets only, understates and disregards people's real motives for purchasing LTCI.

ISSUE: How important is the inflation protection feature for LTCI policies?

CONSUMER REPORTS: You must add inflation protection to your LTCI. Buy only a policy with 5 percent compounded inflation protection. Anything less may leave you short, and you could end up on Medicaid anyway.

HIAA RESPONSE: HIAA agrees that inflation protection is an important feature in LTCI policies, and that every potential purchaser must consider this feature. However, the benefit may not be for everyone. Consumers should always be given the option to purchase inflation protection, and depending on several factors, like the insured's age, priorities and financial status, the choice of purchasing inflation protection and the type of protection to purchase ultimately becomes the purchaser's decision.

For example, it may be a wise decision for a 50-year old to purchase a 5% compounded inflation protection. However, a 79-year old purchaser may want to trade-off the premium for 5% compounded inflation protection for a lower cost 5% simple inflation protection, a higher daily benefit, a shorter deductible period or a longer benefit duration period. Assuming that such benefits are less important for certain purchasers and pre-empting that person's ability to decide which is more valuable to him, undercuts his choice and undermines his ability to decide which benefits are most suitable for him. Finally, Consumer Reports has failed to point out that a benefit amount purchased today, even if it may not fully cover costs in the future, is still some protection that would help offset future costs. Some protection is better than no protection.

ISSUE: How important is the medical necessity trigger?

CONSUMER REPORTS: Beware of (tax-qualified) LTCI policies that do not contain a medical necessity trigger.

HIAA RESPONSE: This is irresponsible advice. Most states and the federal government, through enactment of HIPAA, do not include or mandate the use of medical necessity, because it is viewed by many as unreliable, subjective and unfair. More importantly, correlating tax-qualified policies, because they do not contain the medical necessity trigger, as policies consumers should beware of, while not alerting consumers to the possible serious negative tax implications of non-qualified LTCI is irresponsible behavior. (See additional comments on tax-qualified LTCI below.)

ISSUE: Tax-Qualified LTCI policies

CONSUMER REPORTS: Beware: They are far more restrictive than many non-qualified plans.

HIAA RESPONSE: The generalization that tax-qualified policies are more restrictive than non-qualified policies has no basis in fact. As we mentioned earlier, the absence of a medical necessity trigger does not indicate a more restrictive policy. Tax-qualified LTCI policies will pay benefits through triggers such as the inability to perform ADLS and cognitive impairment, viewed by many as the more objective and appropriate measures for the need for LTC. The inclusion of a 90-day certification of disability for tax-qualified LTCI policies, is in fact, a certification, not a requirement that the disability last 90 days nor is it a deductible period before benefits can begin. As the article points out, one LTCI policy is different from another. Depending on the policy one chooses to purchase, one policy may have more benefits and the benefits may be easier to access than another policy. The policy features of individual policies serve as the distinguishing factors for judging whether a policy is more restrictive or less restrictive. The tax status of the particular policy one has chosen dictates how premiums and benefits are treated for these policies and is NOT the benchmark for how restrictive a policy is.

The authors of this article display a strong bias against tax-qualified LTCI policies. HIAA feels that Consumer Reports has acted irresponsibly by not mentioning in the article that the IRS has not ruled on the status of non-qualified LTCI policies and that purchasers for these policies may face very serious consequences if the IRS determines that benefits from such policies would be considered income and therefore be taxable to the insured. In addition, while it is true that few people itemize medical deductions, it is important to remember that as age increases and/or incomes become more limited, the ability to deduct a portion of your LTC premiums become important to a significant number of people.

CONSUMER REPORTS: The insurance industry lobbied hard for these tax incentives. ...the policy limitations dictated by law will save insurers money in benefits that should have gone to policyholders in need of care.

HIAA RESPONSE: The implication the insurance industry lobbied for restrictions for LTCI in the tax provisions of HIPAA to increase profitability is completely false. It is true that the industry lobbied to get tax breaks for consumers. However, the industry did NOT lobby for restrictions in HIPAA. Why would the industry lobby for restrictions in a fledgling market where such restrictions could impinge growth instead of stimulate growth in the LTCI market?

ISSUE: At what age should you purchase LTCI?

CONSUMER REPORTS: It makes little sense to buy LTCI before 55.

HIAA RESPONSE: No rationale is provided in the Consumer Reports article as to why it makes little sense to purchase before age 55. On the other hand, it makes a lot of sense for a lot of people. Premiums are much lower and people's health are generally better at younger ages. Affordability is less of a problem and the guarantee that a change in your health status later in life will not make you ineligible for LTC coverage are compelling reasons to purchase a policy before age 55.

ISSUE: How important is a company's financial stability?

CONSUMER REPORTS: A company's financial instability, does not necessarily put policyholders at risk..... States maintain guaranty funds – which pay claims from policyholders insured by failed companies. Those holding LTC policies can look to the guaranty funds for help.

HIAA RESPONSE: The implication that state guaranty funds will cover all the obligations of failed LTC insurers is inaccurate and probably one of, if not the most, disturbing features of this article. The suggestion that relying on guaranty funds instead of careful shopping and selection of a financially strong insurance company is irresponsible advice.

ISSUE: Consumer Reports' value index as the gauge for premium stability

CONSUMER REPORTS: A better gauge (for whether premiums will go up) than the actual premium is the value index in the ratings.

HIAA RESPONSE: There are many complexities in the pricing of each type of LTCI policy. Unless all these pricing and actuarial assumptions from all the

policies are analyzed thoroughly, which the Consumer Reports article did not seem to undertake, the value index is an unreliable indicator of whether a company will raise future LTCI premiums.

ISSUE: How agents sell LTCI

CONSUMER REPORTS: They (agents) limit your choices, impart misinformation, and almost never explore the complexities of a policy.

HIAA RESPONSE: HIAA strongly believes that consumers have a right to appropriate insurer and agent sales and marketing practices. LTCI is considered by many agents a complicated product and requires expertise and product knowledge to sell responsibly. In fact, HIAA, through its education program, offers a certification program on long-term care and other health insurance products to better educate agents and others. A few "bad" agents should not be a generalization for all LTCI agents. It does a disservice to the majority of LTC agents who responsibly market the product.

ISSUE: Long-term care for ALL people

CONSUMER REPORTS: The US still needs a universal system for all medical care—including long-term care – funded by a broad based tax ....

HIAA RESPONSE: HIAA believes that social insurance proposals for long-term care are prohibitively costly and unwarranted given the potential of the private market. Moreover, research has shown that social programs are an ineffective use of public dollars. The marginal benefits from such programs assist the elderly who need it least – those with higher income and asset levels. HIAA supports a comprehensive approach to financing long-term care which utilizes the inherent strengths of both the private and public sectors. HIAA believes that given the knowledge and opportunity, the vast majority of Americans would prefer to make provisions for their own long-term care needs through private savings mechanisms, especially those involving risk pooling. HIAA also believes that given competing national priorities, this nation cannot afford to pay for a long-term care program financed entirely out of taxpayer dollars. HIAA also recognizes that the private sector cannot realistically meet the entire need and that there is a significant need for public sector involvement. HIAA believes that government should target its assistance to those who are in greatest need.

Mr. MICA. If you want to summarize your response, please.

Mr. BRENERMAN. We felt that the Consumer Reports article disturbingly took a biased position against long-term care insurance policies, particularly tax-qualified policies under HIPAA, and tried to dissuade readers from considering those types of policies. We also thought that the article misled consumers about the importance of the financial stability of the company that you are buying a policy from, saying that that does not matter. So we submitted a letter because we felt that the article was not—did not fairly characterize the current long-term care insurance market.

Also I believe that, not to disagree with Mr. Jackson, but most policies do cover Alzheimer's disease under the term of cognitive impairment. A dozen companies cover about 80 percent of the—sell 80 percent of the policies, and all of those companies cover cognitive impairment, which would include Alzheimer's. So that was another issue that was raised in the Consumer Reports article. I would like to offer those to the committee.

Mr. MICA. Thank you. We will include that by unanimous consent.

You answered another question I had about Alzheimer's disease coverage.

Again, we oversee several millions of Federal employees and retirees. We can have a very significant group. We can offer a substantial discount. I don't see any reason why we can't do that.

Let me ask you this, gentlemen from the private sector. I come from the private sector, so I am somewhat handicapped, because if I had a group, I would go out and negotiate, and we would make it available, and it would be done posthaste. Here we study it to death, beat around the bush, and we never get to the issue, or we block it in some way.

If you were to sit down with the Office of Personnel Management and negotiate making options available, how long do you think this would take? I know we have a bigger group, but give me some parameters. Would it take 6 months, 3 months, a year? Or if you were in the private sector and had a pretty significant group, how soon could we make a package available to those individuals? Mr. Martin? Is this a lifetime endeavor, or can it be done within——

Mr. MARTIN. Thankfully it is not a lifetime endeavor, Mr. Chairman. But that is a very good question because this is exactly what happens when we install large groups now. The period can be short. It could be 6 months, a year. It need not be longer than that. I think what you don't want to do is do it in like 2 months; do it so quickly that you can't educate people, let them know again and again that this program is coming. You want to be able to select the plan design. That will take some doing. But certainly you will get a lot of expertise from companies that write the business.

In terms of the enrollment period, you need to think about when this would become available, how that would work, and again not have people deciding at the last minute, tied in with whatever you think the enrollment period should be, give them time to talk with their families about it.

Mr. MICA. Mr. Brenerman, how long do you think it would take?

Mr. BRENERMAN. I think it would take probably 6 months to a year. I think there are a lot of decisions that need to be made. In

the private sector, sometimes the human resources departments, personnel departments or the president of the companies can make decisions and not have to ask a lot of questions before they do that.

This may take a lot, a longer period of negotiation and decision-making. Ultimately though, as I think every panelist has said, when this is offered to employees, education of the employees is so vital, and so we need to come up with, jointly, some way to make sure that the employees understand the reason why Congress has decided that this ought to be offered to them and why they should begin to plan for the future by buying the policy.

Mr. MICA. Mr. Fronstin, did you have anything to add?

Mr. FRONSTIN. I would add that even if it takes only 6 months or a year, education is the key, and it may take much longer than that before you start seeing high participation rates, especially if it is an employee-pay-all type of plan.

Mr. MICA. I am not sure what participation we would have based on the experience in the private sector, but the testimony seems to indicate that making it available would probably take 6 months to a year. So if we passed a resolution directing OPM to make it available by December 1999, that would be feasible. What do you think, Mr. Martin?

Mr. MARTIN. Yes, I would think so. That would give ample time.

Mr. MICA. OK. That is what we will do. I thank this panel very much for your participation, for your contributions today. We will dismiss this panel, and I will welcome our second panel today.

I would like to welcome the second panel today. Again, no stranger to this subcommittee, Mr. William Flynn III, associate director of Retirement and Insurance Services for the Office of Personnel Management. We also have Bob Williams, deputy assistant secretary for Long-Term Care and Disability Policy with the Department of Health and Human Services.

We are going to swear in our two witnesses.

[Witnesses sworn.]

Mr. MICA. The record will reflect both of our witnesses answered in the affirmative.

Again, we try to limit our oral testimony to 5 minutes. Mr. Flynn, you are familiar with that routine. Mr. Williams, welcome.

I will recognize first Mr. Flynn for 5 minutes.

STATEMENTS OF WILLIAM E. FLYNN III, ASSOCIATE DIRECTOR, RETIREMENT AND INSURANCE SERVICE, OFFICE OF PERSONNEL MANAGEMENT; AND BOB WILLIAMS, DEPUTY ASSISTANT SECRETARY FOR LONG-TERM CARE AND DISABILITY POLICY, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. FLYNN. Thank you Mr. Chairman and members of the subcommittee, for inviting me here today. In addition to my prepared statement, I would like to make just a few remarks and then be available for any questions you might have.

You have heard from the first panel a lot of the demographic background information leading up to the interest in employer-sponsored long-term care insurance. I won't go back through that today, just perhaps offer a few points of perspective as an employer, a potential employer sponsor.

Today long-term care can be expensive, and the expense depends on the amount of care needed and its setting. Partly as a reflection of that, one estimate is that nearly 2 million working adults provide significant levels of unpaid care to elderly relatives. The strain on employees who provide this care, in addition to their other home and family responsibilities, affects the workplace in a variety of ways and adds a further dimension to the cost of long-term care that an employer like the Government should not ignore.

Insurance to cover long-term care expenses has been available since the 1980's, and we have observed its evolution as an employee benefit. The early products were individual policies, included a number of benefit limitations, and lacked many of the consumer protections that are available today.

About 10 years ago, in June 1986, OPM testified about long-term care insurance for Federal employees. We concluded then that the keys to developing this type of benefit would be a mechanism for long-term funding in combination with a broad risk pool. And with assistance from insurance industry representatives, we subsequently developed and submitted a proposal to offer long-term care coverage using the group life insurance model as an example. We transmitted this proposal to Congress in 1987, and it was introduced then in both the House and Senate. It envisioned voluntary participation for employees age 50 and older, with no new Federal funding, but with group rates to help finance the new benefit. Employees would be given a chance to trade a portion of their basic life insurance coverage for long-term care coverage. The proposal enabled OPM to set criteria for insurer participation, to determine benefits packages, establish premiums, and maintain reserves.

In the next Congress the administration withdrew its support for the proposal over a number of concerns that had surfaced. Because of demographic factors mentioned earlier and passage of the Health Insurance Portability and Accountability Act of 1996, interest in long-term care insurance for Federal employees has been rekindled. Also, one of OPM's strategic goals is the establishment of a modernized performance-oriented total compensation system that includes a competitive benefits package for Federal employees. We believe the idea of a Federal employee long-term care program should be revisited as part of this effort.

The Department of Health and Human Services has also been interested in developing a long-term care insurance program for Federal employees to demonstrate its potential. Beginning in 1995, they invited us to participate in a cooperative research effort with them, and we have done so. In the fall of 1996, we also decided to survey Federal employees to gauge their interest in long-term care insurance. The survey results clearly demonstrate that the design of a long-term care program for Federal employees must recognize the tradeoff between cost and age at initial participation in order to work.

Last fall OPM engaged a benefit consultant to research emerging benefit trends among large private and non-Federal, public employers. Long-term care insurance is a component of that review. Using the contractor's report as a foundation, we plan a broad discussion of benefits and delivery strategies. A consensus developed through

this review will likely lead to several proposals in the benefits area, although it is too early to comment today on what they might be.

With the Department of Health and Human Services, we are also awaiting a study of employer-sponsored group long-term care insurance being conducted by the Lewin Group. The project results, which are expected in the summer of 1999, should offer added insight on the design of a successful long-term care insurance program.

Finally, Mr. Chairman, you asked me to comment on the merits of self-insured long-term care insurance. I think the evidence clearly demonstrates significant evolution in this insurance market and State regulation of it since 1987. Given that evolution, competition among qualified private insurers seems a reasonable approach.

Government sponsorship of a long-term care insurance program for the Federal workforce, we think, could provide leverage for premium discounts and policy enhancements.

This concludes my statement. I would be happy to answer any questions you might have.

[The prepared statement of Mr. Flynn follows:]

STATEMENT OF
WILLIAM E. FLYNN, III
ASSOCIATE DIRECTOR FOR RETIREMENT AND INSURANCE
U.S. OFFICE OF PERSONNEL MANAGEMENT

before the

SUBCOMMITTEE ON CIVIL SERVICE
COMMITTEE ON GOVERNMENT REFORM AND OVERSIGHT
U.S. HOUSE OF REPRESENTATIVES

on

GROUP LONG TERM CARE INSURANCE
FOR FEDERAL EMPLOYEES

March 26, 1998

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

THANK YOU FOR CONVENING THIS HEARING TO DISCUSS THE DESIRABILITY OF INCLUDING GROUP LONG TERM CARE INSURANCE IN THE FEDERAL EMPLOYEE BENEFITS PACKAGE.

MEDICAL ADVANCES AND OTHER FACTORS IN RECENT DECADES HAVE DRAMATICALLY IMPROVED AVERAGE LONGEVITY. AS AGE INCREASES, THE NEED FOR LONG TERM CARE, WHICH CAN INCORPORATE PERSONAL CARE, HOME HEALTH CARE, ADULT DAY CARE, AND NURSING HOME CARE, NATURALLY INCREASES. REPORTEDLY, THERE ARE OVER 3 MILLION AMERICANS OVER 85 YEARS OLD TODAY. THESE NUMBERS ARE PROJECTED TO INCREASE BY FOUR TIMES TO OVER 13 MILLION BY 2020.

LONG TERM CARE ITSELF CAN BE EXPENSIVE , DEPENDING ON THE AMOUNT OF CARE NEEDED AND THE SETTING. MEDICARE, MEDIGAP INSURANCE , AND MAJOR MEDICAL HEALTH INSURANCE GENERALLY PROVIDE EXTREMELY LIMITED COVERAGE OR NONE AT ALL. MEDICAID PROGRAMS COVER NURSING HOME CARE AND SOME COMMUNITY-BASED SERVICES FOR PERSONS WHO MEET POVERTY GUIDELINES FOR INCOME AND ASSETS. NONETHELESS, BY ONE ESTIMATE, NEARLY 2 MILLION WORKING ADULTS ARE PROVIDING SIGNIFICANT LEVELS OF UNPAID CARE TO ELDERLY RELATIVES. THE STRAIN ON EMPLOYEES WHO PROVIDE THIS CARE, IN ADDITION TO OTHER HOME AND FAMILY RESPONSIBILITIES, AFFECTS THE WORKPLACE IN A VARIETY OF WAYS AND ADDS A FURTHER DIMENSION TO THE COST OF LONG TERM CARE THAT AN EMPLOYER SHOULD NOT IGNORE.

INSURANCE TO COVER LONG TERM CARE EXPENSES HAS BEEN AVAILABLE SINCE THE 1980's AND WE HAVE OBSERVED ITS EVOLUTION AS AN EMPLOYEE BENEFIT. THE EARLY PRODUCTS WERE INDIVIDUAL POLICIES AND INCLUDED A NUMBER OF BENEFIT LIMITATIONS, AND LACKED MANY CONSUMER PROTECTIONS OFFERED TODAY, SUCH AS INFLATION ADJUSTMENTS AND NONFORFEITURE PROVISIONS. IN JUNE 1986, OPM TESTIFIED AT A JOINT HEARING CONVENED BY TWO SUBCOMMITTEES OF THE HOUSE COMMITTEE ON POST OFFICE AND CIVIL SERVICE ABOUT LONG TERM CARE INSURANCE FOR FEDERAL EMPLOYEES. WE CONCLUDED THAT THE KEYS TO DEVELOPING THIS

TYPE OF BENEFIT WOULD BE A MECHANISM FOR LONG-TERM FUNDING IN COMBINATION WITH A BROAD RISK POOL--CHARACTERISTICS WHICH THE FEDERAL EMPLOYEES' GROUP LIFE INSURANCE (FEGLI) PROGRAM EXHIBITS.

WITH ASSISTANCE FROM INSURANCE INDUSTRY REPRESENTATIVES, WE SUBSEQUENTLY DEVELOPED A PROPOSAL TO OFFER LONG TERM CARE COVERAGE USING THE FEDERAL EMPLOYEES' GROUP LIFE INSURANCE PROGRAM AS A SPRINGBOARD. WE TRANSMITTED THIS PROPOSAL TO CONGRESS IN SEPTEMBER 1987 AND IT WAS INTRODUCED IN BOTH THE HOUSE AND THE SENATE. IT ENVISIONED VOLUNTARY PARTICIPATION FOR EMPLOYEES AGE 50 AND OLDER WITH NO NEW FEDERAL FUNDING, BUT WITH ATTRACTIVE GROUP RATES. TO HELP FINANCE THE NEW BENEFIT, EMPLOYEES WITH AT LEAST 10 YEARS OF GROUP LIFE PARTICIPATION COULD ELECT TO TRADE A PORTION OF THEIR BASIC LIFE INSURANCE COVERAGE FOR LONG TERM CARE COVERAGE, AND THE CORRESPONDING GOVERNMENT CONTRIBUTION AND RESERVE ACCUMULATION WOULD APPLY TOWARD REDUCING THE LONG TERM CARE PREMIUMS. THE PROPOSAL ENABLED OPM TO SET CRITERIA FOR INSURER PARTICIPATION , DETERMINE BENEFIT PACKAGES, ESTABLISH PREMIUMS , AND MAINTAIN RESERVES.

CONGRESS TOOK NO ACTION ON OUR LONG TERM CARE PROPOSAL. THOUGH THE PROPOSAL WAS REINTRODUCED IN THE NEXT CONGRESS, THE

ADMINISTRATION WITHDREW ITS SUPPORT. THE ADMINISTRATION'S POSITION HAD CHANGED, IN PART, BECAUSE OF NATIONAL DEBATE ON SUCH ISSUES AS WHETHER THE BENEFITS FROM LONG TERM CARE MERITED THE SAME PREFERENCE UNDER THE TAX CODE AS WAS PROVIDED FOR HEALTH AND LIFE INSURANCE BENEFITS, AND IF SO , HOW TO ABSORB THE ASSOCIATED LOSS OF TAX REVENUE. CONCERNS ALSO DEVELOPED INVOLVING FEATURES OF THE PROPOSAL ITSELF-- APPROPRIATE INDEXING OF LONG TERM CARE BENEFITS, THE VALUE FOR INDIVIDUALS IN THE PROPOSED LIFE INSURANCE TRADE OFF, AND THE BUDGET IMPLICATIONS OF DIVERTING FEGLI RESERVES.

ULTIMATELY, THE DECISION ON TAX TREATMENT FOR LONG TERM CARE INSURANCE OCCURRED WITH PASSAGE OF THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY OF 1996. FOR QUALIFIED LONG TERM CARE INSURANCE CONTRACTS OFFERED BY AN EMPLOYER, ELIGIBLE PREMIUMS ARE DEDUCTIBLE MEDICAL EXPENSES SUBJECT TO IRS RULES, AND BENEFITS RECEIVED ARE GENERALLY EXCLUDABLE FROM GROSS INCOME.

OPM HAS ESTABLISHED THE OBJECTIVE OF ACHIEVING A MODERNIZED PERFORMANCE-ORIENTED TOTAL COMPENSATION SYSTEM THAT WOULD INCLUDE A COMPETITIVE BENEFITS PACKAGE FOR FEDERAL EMPLOYEES. WE BELIEVE THE IDEA OF A FEDERAL EMPLOYEE LONG TERM CARE PROGRAM SHOULD BE REVISITED AS PART OF THIS TOTAL COMPENSATION SYSTEM. THE

DEPARTMENT OF HEALTH AND HUMAN SERVICES HAS ALSO BEEN INTERESTED IN DEVELOPING A LONG TERM CARE INSURANCE PROGRAM FOR FEDERAL EMPLOYEES TO DEMONSTRATE ITS POTENTIAL. BEGINNING IN 1995, THEY INVITED US TO PARTICIPATE IN A COOPERATIVE RESEARCH EFFORT. WE ATTENDED SEVERAL HHS-SPONSORED MEETINGS TO HEAR PRESENTATIONS ON EXISTING EMPLOYER GROUP PLANS. IN THE FALL OF 1996, WE DETERMINED THAT THE NEXT LOGICAL STEP WOULD BE TO SURVEY FEDERAL EMPLOYEES TO DETERMINE THEIR INTEREST IN A LONG TERM CARE PRODUCT.

WE INCLUDED QUESTIONS IN THE 1997 FEDERAL EMPLOYEES HEALTH BENEFITS CUSTOMER FEEDBACK SURVEY TO DETERMINE INTEREST IN COVERAGE, AND IF SO, WHETHER FOR SELF, SPOUSE, CHILDREN, AND PARENTS/IN-LAWS. WE ASKED IF EMPLOYEES WOULD WANT NURSING HOME CARE, HOME CARE, OR BOTH. WE LISTED REPRESENTATIVE PREMIUMS AT VARIOUS AGES AND ASKED RESPONDENTS ABOUT AFFORDABILITY.

FOURTEEN PERCENT OF THE RESPONDENTS EXPRESSED NO INTEREST IN LONG TERM CARE COVERAGE. REMAINING RESPONDENTS WERE MOST INTERESTED IN COVERAGE FOR SELF, AT 36 PERCENT, AND SPOUSE , AT 25 PERCENT. SIXTY-THREE PERCENT OF RESPONDENTS DESIRED BOTH INSTITUTIONAL AN D HOME CARE. OPINIONS ON THE AFFORDABILITY OF PREMIUMS VARIED WITH THE AGE AT WHICH THE PRODUCT WAS PURCHASED. FOR EXAMPLE, AT AGE 25, 12

PERCENT FELT THE PREMIUM WAS TOO HIGH, BUT AT AGE 65, 57 PERCENT FELT THE COST WAS TOO HIGH. THIS CLEARLY DEMONSTRATES THAT THE DESIGN OF LONG TERM CARE COVERAGE, TO RECOGNIZE THE TRADE-OFF BETWEEN COST AND AGE AT INITIAL PARTICIPATION, WOULD HAVE TO BE CAREFULLY STRUCTURED IN ORDER TO BE A VIABLE PROGRAM WITHIN A TOTAL BENEFITS PACKAGE CONTEXT.

CONSIDERATION OF LONG TERM CARE INSURANCE IS ALSO A COMPONENT OF OPM'S BENEFITS VISION STUDY BEGUN LAST FALL. WE HAVE ENGAGED A PRIVATE BENEFITS CONSULTANT TO RESEARCH EMERGING BENEFIT TRENDS AMONG LARGE PRIVATE AND NON-FEDERAL PUBLIC EMPLOYERS. THIS INFORMATION IS NEEDED TO ENABLE THE FEDERAL GOVERNMENT TO REMAIN A COMPETITIVE EMPLOYER BY STRUCTURING CONTEMPORARY BENEFIT PACKAGES WITHIN A TOTAL COMPENSATION FRAMEWORK. USING THE CONTRACTOR'S REPORT AS A FOUNDATION, WE PLAN A BROAD DISCUSSION OF BENEFITS AND DELIVERY STRATEGIES. THE CONSENSUS DEVELOPED THROUGH THIS REVIEW WILL LIKELY LEAD TO SEVERAL PROPOSALS IN THE BENEFITS AREA, THOUGH IT IS TOO EARLY TO COMMENT ON WHAT THEY MIGHT BE.

LASTLY, I WANT TO MENTION OUR COLLABORATION WITH THE DEPARTMENT OF HEALTH AND HUMAN SERVICES IN A STUDY OF EMPLOYER-SPONSORED GROUP LONG TERM CARE INSURANCE, BEING CONDUCTED BY THE LEWIN

GROUP FOR THE DEPARTMENT. THE PROJECT INVOLVES THREE PHASES. PHASE I WILL ASK EMPLOYERS WHOSE LONG TERM CARE PROGRAMS REFLECT BENEFIT INNOVATION OR HIGH TAKE-UP RATES AMONG ELIGIBLE PARTICIPANTS TO COMPLETE A SURVEY ABOUT FACTORS WHICH CONTRIBUTED TO THE EMPLOYER'S DECISION TO OFFER GROUP LONG TERM CARE COVERAGE, PARTICIPATION AND BENEFIT FEATURES OF THEIR LONG TERM CARE PROGRAM, AND ITS RELATIONSHIP TO OTHER EMPLOYEE BENEFITS. PHASE II WILL CONSIST OF AN ACTUARIAL ANALYSIS TO IDENTIFY AND ANALYZE BEST PRACTICES, AND TO PRICE OUT ALTERNATIVE BENEFIT DESIGNS. THE THIRD PHASE IS AN EDUCATIONAL EFFORT ON LONG TERM CARE ISSUES. WE UNDERSTAND A PRELIMINARY ANALYSIS OF THE SURVEY DATA WILL BE READY IN FEBRUARY 1999 AND THE PROJECT WILL BE COMPLETED LATER THAT SUMMER..

FINALLY, YOU ASKED ME TO COMMENT ON THE MERITS OF SELF-INSURED LONG TERM CARE INSURANCE. THE EVIDENCE CLEARLY DEMONSTRATES SIGNIFICANT EVOLUTION IN THIS INSURANCE PRODUCT, AND STATE REGULATION OF IT SINCE 1987. GIVEN ITS EVOLUTION, COMPETITION AMONG QUALIFIED PRIVATE INSURERS SEEMS A REASONABLE APPROACH. GOVERNMENT SPONSORSHIP OF AN LONG TERM CARE INSURANCE PROGRAM FOR THE FEDERAL WORKFORCE COULD PROVIDE LEVERAGE FOR PREMIUM DISCOUNTS AND POLICY ENHANCEMENTS.

THIS CONCLUDES MY STATEMENT. I WILL BE GLAD TO ANSWER ANY QUESTIONS THE SUBCOMMITTEE MAY HAVE NOW.

Mr. MICA. I will now recognize Mr. Bob Williams, Deputy Assistant Secretary for Long-Term Care and Disability Policy with HHS. You are recognized, sir.

Mr. WILLIAMS. Thank you. I am Bob Williams, the Deputy Assistant Secretary for Disability, Aging and Long-Term Care Policy in the Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation.

I am pleased to appear before you and offer the Department's perspective on private long-term care insurance. We believe that policymakers must begin to plan now for the social and economic implications of population aging. One of these implications will be increased demand for long-term assistance for those with chronic illness and disability.

A major success of the 20th century is increased longevity and improved health among older individuals. In 1990, the number of Americans 65 years of age and older was about 32 million, or about 12 percent of the population. In a little over 25 years, we expect the Nation's elderly population to nearly double to over 62 million people, about 18 percent of the population. The fastest growing population will be people 85 years or older.

While aging need not lead to disability and dependency, the likelihood of chronic disability and thus the need for long-term care assistance significantly increases as we grow older. In 1994, about 12 percent of Americans age 65 to 74 needed help with one or more of the routine activities of daily living such as eating, bathing, or housekeeping or taking medications. However, 58 percent of Americans 85 and older needed this kind of help. About one-quarter of the long-term care population are in nursing homes or other residential care settings. Three-quarters live in the community in their own homes or the homes of relatives.

Many here today are aging baby boomers who have yet to experience the need for long-term care. Many already know the demands of caring for an older relative. About two-thirds of older people with long-term care needs receive part or all of their care from unpaid caregivers, predominantly spouses and middle-aged children. There are about 7.6 million persons providing unpaid care to older people with disabilities. Close to half of adult daughters or daughters-in-law who provide informal care are also in the labor force. Balancing work and caregiving responsibilities is no easy task. A national study found that working women who are primary caregivers spend about 18 hours per week providing unpaid elder care.

The need for long-term care can be a significant economic and emotional burden. Private long-term care insurance is not a silver bullet, but it can help protect against the high costs of nursing home care, which now average about $46,000 a year. Equally important, it can help middle-income elders with long-term care needs remain at home by making their own money go further. The availability of private long-term care insurance does not eliminate the need for informal help, but it can go a long way to making it easier both for older Americans and their families.

Today, only 5 percent of seniors have private long-term care insurance. One of the reasons so few people participate is that most people do not buy it until they are older. By so doing, they must pay more for their policies. For example, in 1995, it cost a 50-year-

old $1,124 a year to buy a comprehensive policy, paying $100 a day for nursing home care, $50 per day for home care, with nonforfeiture and inflation protection. An identical policy purchased at age 65 costs $2,560, over twice as much. Eighty percent of the policies sold to date have been to persons 65 years or older.

We believe that employer-sponsored group insurance is the best vehicle for making high-quality coverage more affordable. It encourages people to enroll at younger ages. It is also typically 15 percent cheaper than individual policies since selling costs are lower. There may be other advantages. While disability increases with age, it happens to much younger people, too. Group insurance may be offered to employees without underwriting requirements, while individual buyers usually must first be screened by a doctor. Individual buyers may also find it hard to evaluate competing plans. Employees know that an employer-sponsored product has been vetted by professional benefits specialists. Finally, employer-sponsored insurance can often be paid through payroll deductions. This makes it fairly easy to plan ahead to protect against a future risk. A 1997 survey by the National Council on Aging and the John Hancock Co. found that respondents said they would be more likely to buy long-term care insurance if an employer-sponsored group plan were available.

HHS has contracted with Lewin to survey the employer group long-term care insurance market. Since some products seem more successful than others in terms of employee participation, a main purpose of the study is to understand best practices. This research will also assist in any pricing and design matters relating to a Federal employee offering. We have asked OPM to collaborate with us on this study so that they can learn from the experience of the private group market.

The Department also has another long-term care study with LifePlans to examine the actual experience of long-term care insurance claimants. The study is still in the field; however, early information suggests that home care and nursing home claimants and their informal caregivers are satisfied with their insurance benefits. Final results will be available in the fall.

The Department has developed an excellent working partnership with our colleagues at OPM. Within the administration, OPM is responsible for Federal employee benefits. Together we are generating information that will help inform Congress and the administration about the feasibility and desirability of providing the Federal work force with a voluntary long-term care benefit. The Federal health program is widely recognized as a model for other employers. We are hopeful that if it proves feasible, the Federal Government can play a similar leadership role with respect to private long-term care insurance.

The Department also has a broader interest in the role of private long-term care products. If affordable high-quality insurance products become more widely available, we can expect a larger share of 21st century Americans to be better able to purchase the care

they need to remain in their own homes and communities and to protect themselves against the risk of catastrophic nursing home costs.

We thank the subcommittee for inviting us to testify and will be happy to answer questions.

[The prepared statement of Mr. Williams follows:]

TESTIMONY OF BOB WILLIAMS,
DEPUTY ASSISTANT SECRETARY FOR PLANNING AND EVALUATION
FOR DISABILITY, AGING, AND LONG-TERM CARE POLICY
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

TESTIMONY FOR THE U.S. HOUSE OF REPRESENTATIVES COMMITTEE ON GOVERNMENT REFORM AND OVERSIGHT
SUBCOMMITTEE ON CIVIL SERVICE

MARCH 26, 1998

My name is Bob Williams. I am Deputy Assistant Secretary for Disability, Aging, and Long-Term Care Policy in the U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation.

Background

The Department of Health and Human Services' perspective on private long-term care insurance starts from the premise that policymakers must begin to plan now for the social and economic implications of population aging. One of these implications will be increased demand for long-term assistance for those with chronic illnesses and disability.

Disability and associated long-term assistance needs increase at older ages. In 1994, approximately 12 percent of Americans aged 65 to 74, 27 percent of Americans aged 75 to 84, and 58 percent of Americans aged 85 and older required long-term assistance with one or more Activities of Daily Living such as bathing, dressing, transferring, toileting, and eating and/or Instrumental Activities of Daily Living such as housecleaning, meal preparation, shopping, laundry, medication and money management.

About one quarter of elderly persons with long-term care needs are in nursing homes or other specialized residential care settings. Three quarters live in the community, either in their own homes or the homes of relatives.

On January 1, 2011 --13 years from now -- the baby boom generation will begin turning 65. By 2030, one in five Americans will be 65 or older and there will be more Americans over 65 than under 18. But even before baby boomers begin to develop their own age-related long-term care needs, they will likely experience the demands and trade-offs of caring for an older relative. By 2010, it is estimated that there will be twice as many elderly aged 85 and older as there were in 1990.

The U.S. system of long-term care is today heavily reliant on informal caregivers, predominantly spouses -- some of whom have health problems of their own -- and middle-aged children caring for their elderly parents. Close to half of adult daughters or daughters-in-law who provide informal eldercare are in the labor force. Balancing work with caregiving and other family responsibilities is no easy task. A nationally representative study found that employed women who are the primary caregivers for disabled elderly relatives spend, on average, 18 hours per week providing unpaid eldercare, in addition to other home and family tasks.

Currently, there are two main sources of funding for formal long-term care: out-of-pocket payments by the elderly themselves and/or their families and Medicaid. Medicaid financing is, of course, only available to the poor, including those who have "spent-down" by exhausting their ability to pay privately for medical or long-term care.

At mild to moderate levels of disability, most disabled elders are able to rely exclusively on informal help from family, friends, and neighbors or on informal help supplemented by a few hours a week of paid assistance. However, severely disabled elders -- such as those who have 3 or more ADL disabilities -- typically require 75 or more hours per week of assistance in a home care setting. For many severely disabled elders, this level of assistance is beyond what the family alone can supply, especially when family caregivers are employed or live too far away to provide regular assistance.

Disabled elders who are unable to access sufficient in-home assistance from relatives and/or paid helpers are at high risk of nursing home admission. Among Americans who live to at least age 65, almost one quarter (23%) can expect to spend a year or more in a nursing home at some point prior to death.

Currently, the average annual private pay cost of nursing home care is estimated to be around $46,000 per year. At this rate, middle income elders rapidly deplete their life savings and the longer their nursing home stays, the more likely they are to eventually spend-down to Medicaid eligibility. It is estimated that between one quarter to one third of nursing home residents currently on Medicaid were originally admitted as private pay residents.

Advantages of Employer Group Long-Term Care Insurance

Over the long-term, private long-term care insurance may provide protection against catastrophic out-of-pocket nursing home costs. Also importantly, it may help certain upper-middle income elders with long-term care needs remain at home as long as possible, by making their own money go further. While the availability of private long-term care insurance does not necessarily obviate the need for informal help from family members, it may make it easier for employed family caregivers to balance work

with eldercare and other family responsibilities.

Today only 5 percent of elderly Americans have private long-term care insurance coverage. An important reason for this relatively low rate of participation is that 80 percent of all policies sold to date have been individual or group association sales to persons already aged 65 or older. High quality coverage purchased at older ages can be expensive. In 1995, the average annual premium for a comprehensive policy (paying $100 a day for nursing home care, $50 per day for home care), with nonforfeiture and 5% compounded annual inflation indexed benefits was $2,560. An identical policy purchased at age 50 cost $1,124.

It is important to provide a note of caution about long-term care insurance products, which vary in their protective quality, costs, eligibility requirements, and triggers. Long-term care insurance products must, for example, be scrutinized for the availability of inflation protection, for the extent to which pre-existing conditions exclude potential insurees, portability, to ensure that there are adequate protections against forfeiture, to minimize the use of employee premiums for marketing and distribution costs, and to determine whether there is an adequate supply of services to be purchased with or without such insurance.

We believe that employer-sponsored group insurance is the best vehicle for making high quality coverage more affordable because individuals are encouraged to enroll at younger ages and because group policies are typically 15 percent cheaper than identical policies sold individually. Employer-sponsored insurance also has several other advantages over individual insurance. First, although disability is more common at older ages, it can occur at any age. Moreover, group insurance may be offered to active employees without underwriting requirements -- whereas individual purchasers usually must be examined by a physician before their application for coverage will be accepted.

Second, individual purchasers often find it confusing and difficult to evaluate competing plans whereas employees know that an employer-sponsored product has been vetted by professional benefits specialists. Third, policy premiums can often be paid via payroll deductions. Thus, obtaining long-term care insurance coverage is a relatively easy way for individuals to plan ahead to protect themselves against a risk that may not occur until far in the future. In fact, respondents in a 1997 national survey sponsored by the National Council on Aging and the John Hancock Mutual Life Insurance Company said that they would be more likely to purchase long-term care insurance if an employer sponsored group plan were available. Finally, employer-sponsored group insurance may be more likely to discourage "churning" practices to which individual purchasers may be more susceptible.

Research Underway

It is estimated that only 12 percent of all private employers (but 21 percent of employers with 500 or more employees) offer private long-term care insurance. Almost all such employer-sponsored long-term care insurance is offered on a voluntary (i.e. employee-pay-all) basis. However, spouses, parents, and other relatives are often permitted to take advantage of the group offer.

The Department has contracted with The Lewin Group to survey the employer group long-term care insurance market. Because some group products have been more successful than others in terms of employee participation, a main purpose of the survey is to understand as much as we can about "best practices" in the employer market.

We expect the results of this survey to be of great interest to other large employers, including the Office of Personnel Management, with whom we are collaborating on the survey design. The Federal government is, after all, the largest and most visible employer. What we do with respect to employee benefits can have considerable influence over other large employers. Accordingly, we are working with OPM to provide them with information reflecting the "state-of-the-art" regarding private long-term care insurance among public and private employers. In addition to the employer survey, our contract with the Lewin Group also provides for access to actuaries and other consultants who have specialized expertise in long-term care insurance.

The Department also has another major research project underway to study the efficacy of long-term care insurance. We have contracted with LifePlans, an insurance company, to carry out a study of the experience of private long-term care insurance claimants. Nine private long-term care insurance companies agreed to participate in the research project by allowing LifePlans to interview a statistically representative sample of their policyholders who have triggered benefits. The study also involves a telephone survey of policyholders to determine whether some policyholders who may be entitled to benefits have failed to file a claim or attempted to file a claim and were denied benefits.

The claimant survey focuses primarily on users of home care benefits, with a smaller supplemental sample of claimants who have accessed nursing home or other residential care benefits. The main purpose of this research is to determine whether and to what extent individuals who purchased private long-term care insurance policies and their family caregivers are satisfied with their coverage once the policyholders have met eligibility triggers and begun to access benefits. The study is still in the field interviewing stage; however, early anecdotal information from some interviewers indicate that both home care and nursing home claimants and their informal caregivers appear satisfied with their insurance benefits. Patterns of reliance on formal and informal home care among private long-term care insurance claimants will be compared with those of other similarly disabled elders in a nationally representative survey of disabled elders living in the community. Final results are expected to be available early next fall.

Conclusion

In conclusion, the Department is pleased that our excellent working partnership with our colleagues at OPM has led to the development of a research agenda that will help inform policymakers with respect to the feasibility and desirability of a long-term care insurance optional benefit for federal workers. Within the Administration, OPM has the lead on questions related to federal workers' employer-sponsored benefits. The Department of Health and Human Services has a broader and longer-range interest in how employer sponsored long-term care insurance plans can help meet the growing demand for cost-effective formal long-term care services. Specifically, we hope that if affordable insurance coverage becomes more widely available, a larger share of 21st century older Americans will be better able to afford the paid home care that could enable them to remain in the community, as well as protect themselves against the risk of catastrophic out-of-pocket costs for nursing home or other residential care, and reduce their reliance on Medicaid.

We thank the subcommittee for inviting us to testify and will be happy to answer questions.

Mr. MICA. Thank you Mr. Williams, Mr. Flynn, for your testimony.

I have a couple of questions. I will start with Mr. Flynn. In your testimony you indicated studies that are ongoing that are looking at long-term care. I thought you said one study, is that it, that you have a consultant started last fall. Is that OPM—and I guess there is another study going on in conjunction with HHS. How long have those studies been going on, and how long will they take?

Mr. FLYNN. Well, Mr. Chairman, I will defer to Mr. Williams on the study that the Department of Health and Human Services has contracted for, but last fall we engaged a benefit consultant to work with us in terms of developing what we call a benefit vision; a view of what Federal employee benefits in the context of total compensation ought to look like over the course of the next 5 to 10 years so that we could be assured that we are offering a contemporary benefits package that is competitive; that enables the Government to attract and retain the employees that it needs to do the work of Government.

We have the first deliverable from that contractor. That came to us in December. It is essentially a compendium of benefit practices of other large private and non-Federal public employers in terms of the types of programs they offer and in terms of the particular delivery structures that they have. We are working with that. I expect that we will have vetted that within the Government later this year.

Mr. MICA. Well, OK. We are vetting, and we have been vetting since you said it came in January.

Mr. FLYNN. December.

Mr. MICA. When can we expect the termination of the vetting?

Mr. FLYNN. As I say, Mr. Chairman, I think we will have the results of that. And that——

Mr. MICA. June, July, August, September? How long is it going to be vetted and digested?

Mr. FLYNN. I am afraid, Mr. Chairman, I can't be more specific than that.

Mr. MICA. Is there more coming out of your study, or is that it?

Mr. FLYNN. Is what it?

Mr. MICA. You said you had sort of the preliminary. Is there more study being done, or is it completed? You are now studying the study, vetting the study?

Mr. FLYNN. No, Mr. Chairman. What we are doing is we are looking at what the practices of other employers are and how those are delivered in terms of a benefits package. What really needs to——

Mr. MICA. You have been doing that since December?

Mr. FLYNN. Yes, sir.

Mr. MICA. Is there more? Is this consultant charged with going out to get anything else? Is there more study to come in?

Mr. FLYNN. We will be asking the consultant to assist us with exposing the results of this study to a broader audience. We expect to have, as I say, sometime this year, some recommendations to make with respect to further evolution of the total benefits package available to Federal employees.

Mr. MICA. Can you get us a copy of that? Do we have a copy of that? Could you get us a copy of that, or is it confidential, top secret?

Mr. FLYNN. There is not anything confidential that I am aware of. I would be happy to make a copy available to the subcommittee.

[NOTE.—The information requested was never received.]

Mr. MICA. We can't get an exact date. You said sometime this year you will be through vetting?

Mr. FLYNN. That is correct, Mr. Chairman.

Mr. MICA. OK. Mr. Williams, when did your study begin?

Mr. WILLIAMS. We expect findings of the Lewin study to be available in the autumn or winter at the latest. It will require OMB clearance.

Mr. MICA. Thank you.

Well, you heard testimony today, Mr. Flynn, that if we moved to a competitive system and made this available, it might take 6 months to a year to make some plan available, a benefits package available. Do you think you could work in that timeframe, or given the size, the scope, the coverage area, that might not be possible?

Mr. FLYNN. I am not aware of anything, Mr. Chairman, that makes that estimate unrealistic for the Federal Government.

Mr. MICA. So if we vet the rest of this year, and next year we negotiate, by my timetable of December 31, 1999—if we pass a resolution of Congress directing OPM to make this option available, do you think we could make it?

Mr. FLYNN. Mr. Chairman, if there were agreement between the Congress and the administration on moving forward with this, we would move it forward as quickly as we possibly can.

Mr. MICA. Is there any objection that you know of from within the administration to making this available on a group basis and competitive basis to our Federal employees and retirees?

Mr. FLYNN. I think that it is clearly the case within the administration that we recognize the importance and desirability of providing for the long-term care needs of individuals in the future. We would want to look, obviously, at a specific proposal in order to be able to make a specific judgment on it.

Mr. MICA. Mr. Williams, given the timetable that I outlined, and given the study that you have concluded so far, do you think that we should be offering this option and benefit to our Federal employees, and can we do it within the timetable I outlined?

Mr. WILLIAMS. I think that offering this type of coverage is an appropriate role for the Federal Employees Health Benefits Program and will most likely help leverage some similar change in the private long-term care insurance economy market as well.

Mr. MICA. The second part of my question, Mr. Williams, is that OPM is studying this, or has studied this, had consultants study this. They are now digesting and vetting this. I understand that HHS has been studying this and is digesting their studies. If we spend the rest of 1998 studying and vetting and digesting, do you think that by the end of 1999, we can adopt this as a benefit to our Federal employees?

Mr. WILLIAMS. Yes. My colleague has just said if there is agreement that this is the direction we should go in, then the adminis-

tration will certainly make every effort to do so with deliberate speed.

Mr. MICA. Thank you, Mr. Williams. Deliberate speed on the issue is music to my ears.

Mr. Flynn, if the insurance product that you came up with is to be offered and financed entirely through employee premiums, why do we need OPM studies as a prelude to offering the product? Further studies?

Mr. FLYNN. Mr. Chairman, I think what we want to try and do is make sure that we can deal with a number of the issues that you heard from the panel members who testified at first. There are some issues associated with benefit design, things like making sure that we have got, for example, home health care and nursing care considered, inflation protection, issues related to benefits elimination periods and things of that nature, so that we have a package that is as easily understandable as it can be because of the importance of the educational effort with respect to employees. So that is one area.

A second area that I think is important, as people have mentioned also during the first panel, is that we have a relatively young market here. We have premiums that are somewhat advantaged in group offerings, but not a lot of experience in terms of the cost of providing long-term care and whether or not those premiums have been set appropriately. We want to make sure that we don't get into a situation where perhaps we start out with premiums that people regard as reasonable, and then as we gather experience, we find them increasing and things like that.

These are just a couple of examples of the kinds of things we want to make sure we have got covered because, as I said earlier, the success of any program like this involves broad participation at an early age because that is the way in which people in effect save for the long-term—in this case, save for the long-term care needs.

Mr. MICA. Well, just finally, Mr. Flynn, I would like to try and see if we can get things done. It sounds like we have hired the professionals to do the study. You are now examining, digesting the study to make certain that the considerations that have been brought forward by the panel members, and that you have just pronounced to the subcommittee today, are addressed. Hopefully that can be done this year, and then by the end of next year we can make this as an option available. And it will probably be at no cost to the Federal Government and reduced cost versus what is available in the open market to our Federal employees and retirees based on the size of the group that we can offer. Do you think that is all possible?

Mr. FLYNN. As I said earlier——

Mr. MICA. With a little kick in the butt from up here?

Mr. FLYNN. Or from other sources as well, possibly. I think—assuming agreement—we would want to work as quickly as we could.

Mr. MICA. I have taken so much time, I want to yield to my distinguished ranking member.

Mr. CUMMINGS. I just have a few questions. Mr. Flynn, how would OPM undertake to administer a long-term care insurance program?

Mr. FLYNN. Mr. Cummings, you heard also from the first panel and then just real briefly in my remarks, I think that the private market, at a minimum, sort of quasi-Federal Employees Health Benefit Program model, might be an appropriate administrative model to use here. As Chairman Mica indicated, assuming we can reach agreement, we would want to move quickly toward implementation. It is probably that model that would get us there most quickly.

Mr. CUMMINGS. A little bit earlier the witnesses said that—at least one of the witnesses said that there could be a 10 to 20 percent savings. Do you agree with that?

Mr. FLYNN. Yes, sir, I do.

Mr. CUMMINGS. Should the Federal Government share the cost of premiums for this kind of insurance?

Mr. FLYNN. Well, Mr. Cummings, that is a question that I think we really do need to look at from the standpoint of the benefits package as a whole, as part of the compensation package as a whole. As you heard from the first panel this morning, in the small-employer market, you do see a fair amount of employer participation in this particular product. But at the larger-employer level, IBM and others, this is all employee-paid. I think, quite honestly, that is not a reflection so much of a specific decision made with respect to long-term care insurance in the large-employer market but, rather, a set of benefit design decisions that involve corporate strategic decisions about where an employer wants to invest its dollars, in the benefit package or in the salary package.

That is a difficult question to answer. I would say, though, that an offering like this could be made without an employer contribution, and we have seen initial take-up rates in the 5 to 7 percent range.

Mr. CUMMINGS. I don't have anything else.

Mr. MICA. I don't have any further questions this morning. But we would like to get a copy of the OPM study and any information that can be provided by HHS to the subcommittee. I will leave the record open for 10 days, and we will have some additional questions that we would like to submit in writing to some of the panelists today.

[The information referred to follows:]

Health Insurance Association of America

April 13, 1998

The Honorable John L. Mica
Chairman
Subcommittee on Civil Service
Committee on Government Reform and Oversight
United States House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

I would like to thank you again for inviting me to testify on behalf of the Health Insurance Association of America at your Subcommittee's March 26, 1998 hearing, on offering long-term care insurance to federal employees. The hearing was a very positive first step in addressing our nation's long-term care financing problem. The long-term care insurance industry commends the Subcommittee for bringing this issue to the forefront and recognizing the important role that the private long-term care insurance market can play in solving our nation's long-term care dilemma.

We also received your letter that contained additional questions on the long-term care insurance market. Below are HIAA's responses to these questions.

1. Please describe the roles that Medicare, health insurance, HMOs and Medicaid play in paying the costs associated with long-term care?

"Long-term care," refers to a wide range of health and personal care services provided to individuals who have lost some or all capacity to function independently due to a chronic illness or condition and who are expected to require these services for an extended period of time. By its nature, long-term care services are typically custodial and not medical.

Medicare, generally does not and was not intended to cover long-term care expenses. Medicare pays for some nursing home and home health care, but only for instances where such care or services are medically necessary, post-acute and short-term. Private health insurance or HMOs, also typically do not cover long-term care. Like Medicare, some nursing home and home health care are covered under health insurance, but only when such care or services are medical in nature. Medicaid is the primary payer for long-term care expenses.

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However, the program only finances long-term care services after an individual has spent-down his or her assets to the poverty level. This level varies by state.

About 70 percent of the non-institutionalized elderly with long-term care needs receive all their help from family members and friends. Because of this, quantifying national long-term care expenditures has been difficult. The best estimate of costs associated with long-term care can be derived from the Health Care Financing Administration's (HCFA) statistics on national health expenditures. HCFA does not have a specific item for long-term care, however, it does track nursing home and home health care expenditures. Below is a breakdown of these expenditures and the percentage that the different sources of payment represent.

Expenditures for Nursing Home and Home Health Care Services, by Source of Payment, 1996

Source of Payment	Nursing Home		Home Health Care	
	in Billion $	Percent	in Billion $	Percent
Medicare	8.9	11.3	13.6	45.0
Medicaid	37.5	47.8	4.1	13.6
Other Public	1.8	2.3	0.1	0.3
Out - of - Pocket	25.1	32.0	5.9	19.5
Private Insurance	3.7	4.7	3.2	10.6
Other Private	1.4	1.8	3.3	10.9
TOTAL	78.5	100.0	30.2	100.0

SOURCE: Health Care Financing Administration, Office of the Actuary, National Health Statistics Group

2. What out-of-pocket costs are generally born by individuals in need of long-term care services?

A year's stay in nursing homes averages about $41,000 today. In high cost areas of the country, costs can easily double that amount. Home health care, depending, on what type of care is received, can easily cost half the annual nursing home expenses, and even equal or exceed them if care received in the home requires professional or medical services. This is especially true in cases where skilled home care is needed on an extended basis (i.e., 24 hours a day). Such costs, without long-term care insurance, are generally all borne by the individuals and or their families who need the care. Medicaid steps in only when the individual has impoverished himself.

3. For employer-based plans, what is the typical range of premiums?

HIAA has not recently tracked average premiums in the employer-sponsored market. However, we do track premiums in the individual market and premiums of some employer-sponsored plans. To provide you with some estimate of average premiums that may be available in the employer sponsored market today, below is a table that provides an average of premiums from: (1) the top twelve individual carriers and (2) two long-term care employer-sponsored plans.

AGE	BASE	W/ 5 PERCENT COMPOUNDED INFLATION PROTECTION (IP)	W/ NONFORFEITURE BENEFITS (NFB)	W/ IP & NFB
40	$209	$503	$264	$634
50	$328	$665	$415	$866
65	$964	$1761	$1166	$2124
79	$3803	$5276	$4384	$6200

(NOTE: These are based on preliminary estimates for premiums of 1996 leading sellers and from two LTC employer-sponsored plans. Such premiums do not specifically exist for any one insurer or a specific employer LTC plan. Premiums are generally for a $100/$50nursing home/home health coverage, 4 years coverage, and 20-day elimination period)

SOURCE: HIAA LTC Market Survey, 1997.

4. What are the main factors that determine premium amounts?

The main factors that determine premiums for long-term care insurance are the age of the insured and benefit designs selected. Some of these benefit variations are: the type of coverage (i.e., nursing home and/or home health care); daily benefit levels (i.e., $100 daily benefit amount for nursing home and/or $50 daily benefit for community-based and home health care); benefit duration period (i.e., 2, 3, 4, 5 years or lifetime coverage); optional features (i.e., inflation protection and/or nonforfeiture benefits); and elimination or deductible periods (i.e. 0,20, 30, 40, 60, 90, 120, 180 days).

5. What is the relationship between the level of benefits selected and premium amounts?

As the level of benefits selected increases, so do premiums for long-term care insurance. Based on premium figures collected by HIAA, below are rough estimates of how certain benefit designs generally affect long-term care

insurance premiums. (Please note that these are just estimates and that premium differences may vary from company to company depending on other factors.):

- Daily Benefit Amounts: As the daily benefit amounts increase, so do premiums. Generally, premiums increase proportionately to daily benefit amounts. For example, a 50 percent increase in daily benefit amounts corresponds to a 50 percent increase in premiums.

- Type of Coverage: Coverage for additional benefits increases premiums. For example, a policy covering for nursing home only would cost less than a policy that covers both nursing home and home health care costs. The difference in premiums also varies by age. In general, HIAA has observed that the addition of some level of home health care coverage in long-term care insurance policies increases premiums by about 5 to 50 percent, depending on the age of the insured.

- Elimination or Deductible Periods: The longer the elimination period, the lower the premium. For example, a long-term care insurance policy that pays benefits after a 100-day elimination period has been met will cost less than a policy that pays benefits after a 20-day elimination period. In general, elimination periods available in the market today are 20, 30, 40, 60, 90, 100, 120, 180 days. Premium variances between each elimination period are between 3 to 10 percent.

- Inflation Protection: The addition of an automatic inflation protection feature increases LTCI premiums. These increases vary depending on the age of the insured. Common inflation protection features available today are either annual 5 percent simple increases, 5 percent compounded increases, or CPI-indexed increases. HIAA tracks only 5 percent compounded lifetime increases. HIAA data reveal that such inflation protection would cost more for a younger individual than for an older individual. Depending, on the insured's age, premiums for this additional benefit can increase anywhere from about 220% for a 30-year old (and possibly more for a younger insured), to about 35 percent for a 79-year old (and possibly less for an older insured).

- Nonforfeiture Benefits: The addition of a nonforfeiture benefit increases LTCI premiums. The most common type of nonforfeiture currently being offered in long-term care insurance policies today is the NAIC-recommended shortened benefit period approach. Depending on the age of the insured and some variances in the shortened benefit period a company is offering, increases in premiums may range from 10 to 50 percent.

*6. **What is the range of administrative costs incurred and administrative responsibilities assumed by the private sector employers in offering long-term care insurance benefits to their employees?***

The administrative costs incurred by the employers offering a long-term care insurance plan to their employees is minimal. Generally, the insurer is responsible for the majority of these administrative costs. The insurer is typically responsible for the following: production of enrollment kits; sponsorship of and participation in employee informational meetings; production of marketing and informational material; underwriting costs for eligible participants; and other related activities.

The administrative costs borne by the employer are minimal and generally relate to collection of premiums (through payroll deduction); personnel costs for initial selection of the long-term care plan; costs associated with maintenance of the long-term care plan (i.e., tracking of enrollees and provision of plan information to employees who leave the company and may want to maintain their long-term care coverage individually); and expenses for producing any employer endorsements or additional information on the long-term care insurance plan that the employer may wish to provide to its employees.

I hope these responses help you in moving forward with your proposal to make long-term care insurance available to all federal employees, retirees and their dependents. If you have any questions, please feel free to contact me at (207) 770-4311 or Susan Coronel at (202) 824-1697.

Sincerely,

David Brenerman Jr.

David H. Brenerman
HIAA LTC Committee &
Second Vice President
Government Relations
UNUM Life Insurance Company
of America

American Council of Life Insurance

April 14, 1998

The Honorable John L. Mica
Chairman
Subcommittee on Civil Service
Committee on Government Reform and Oversight
United States House of Representatives
Washington, D. C. 20515

Dear Mr. Chairman:

I want to thank you for your invitation to testify before the Subcommittee's hearing on March 26, 1998 on behalf of the American Council of Life Insurance (ACLI) and its member companies. It was certainly my pleasure to appear before the Subcommittee, both to offer testimony in support of your efforts to offer private long-term care insurance to federal employees, retirees, and their families and to answer questions from the Subcommittee. In your letter dated April 6, 1998, you requested further information, which I have included in this letter.

1. **Please describe the various types of long-term care insurance plans that employers are offering to their employees. Please include types of services covered, benefit amounts, premium costs, eligibility requirements, and protection from inflation.**

   There are two types of group long-term care insurance plans: disability (also known as "per diem") and reimbursement (also referred to as "indemnity"). A disability model policy provides money to be used at the discretion of the insured for covered services. Once the insured becomes eligible for benefits under a disability model policy, the claimant receives a daily maximum benefit payment, but need not incur charges in order to receive payment. A reimbursement model policy provides payment for covered services received up to the maximum amounts specified in the policy.[1]

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(a) Covered services may include, but are not limited to: nursing home care, home health care, and community-based services, such as adult day care. Other covered services include: alternate care facility, personal attendant services, assisted living facility, case management, chore/homemaker services, respite care, hospice care, durable medical equipment, prescription drug coverage, ambulance service, alternate plans of care, bed reservation, and caregiver training.[2]

(b) Benefit amounts can range from $25-$300 per day for nursing home care, and from $20-$200 per day for home health care under the reimbursement model. The typical John Hancock (reimbursement model) group policy would include a $100 nursing home daily maximum benefit (DMB) and a five-year lifetime maximum benefit (LMB). Disability model benefit amounts range from $1,000 to $3,000 per month for nursing home care, and $500 to $1,000 per month for home health care.[3]

(c) According to the most recent LIMRA industry survey, the average annual premium paid per participant in employer-sponsored long-term care plans was $429.00 in 1997.[4]

(d) Eligibility requirements are addressed in response to question three below.

(e) There are two approaches to inflation protection: Under both approaches, inflation protection is provided to insureds without further evidence of insurability.

(1) It may be offered at a 5 percent simple or compound rate. The compounded approach increases benefits 5 percent each year over the previous year's benefit, whereas the simple approach increases the benefit each year by the same dollar amount. The compounded approach grows benefits at a faster rate than the simple approach, and consequently, costs more.

(2) Inflation protection is usually offered as a future purchase option (FPO) that can be elected or declined by insureds over time. This approach gives the individual the option to purchase additional benefits periodically, usually tied to increases in the cost of care. This approach allows the plan to be offered at lower rates, making basic coverage more affordable to a wider range of eligible individuals. Under such an arrangement, each time an additional amount is selected, an additional premium is added to the initial premium; the additional premium reflects both the additional benefit and the age at which it is purchased. The combined amount becomes the new annual premium.[5]

2. What is the participation rate of employees in these employer-based plans?

Many factors impact participation: employee age, salary level, job classification, corporate culture and climate, the level of the sponsoring employer's support for the plan, and an effective communications and education campaign. A 1996 study by Towers Perrin of the two leading group long-term care insurers found the following participation rates by age:

Issue Age	Participation Rate
Under 30	5.8%
30-39	8.2%
40-49	11.9%
50-59	12.0%
60-69	11.0%

3. What typical eligibility requirements are found in employer-based plans?

Many employer-based long-term care plans guarantee issue of insurance to active workers during the initial enrollment period with limited or no medical underwriting. Others, such as retirees, spouses, parents, parents-in-law, and domestic partners are generally medically underwritten.[6]

Long-term care policies base claim eligibility on the insured's ability to perform activities of daily living (ADL) or on the cognitive abilities of the insured.

4. How is "guaranteed issue" addressed in group or individual plans?

Guaranteed issue is only available in the group market; individual policies are underwritten for all applicants. When offered, guaranteed issue applies only to actively at work employees to avoid anti-selection, and to new hires when they first become eligible for benefits.[7] It is offered during the initial enrollment period and at other periods mutually agreeable to the insurer and the employer. Guaranteed issue is only available when a single carrier has been authorized by the employer to solicit its population. In instances where multiple carriers are involved, either a modified or full underwriting approach is used, in order to avoid anti-selection.

5. What portability provisions are included in employer-based group plans?

Persons insured under a group long-term care insurance plan have full continuation of coverage (i.e., portability). Group long-term care plans generally provide that an individual may remain insured under the group plan after termination of employment on the same rate basis.

If an employer chooses to move its long-term care insurance plan from one carrier to another there is still full continuation of coverage; however, the original contract must anticipate transfer of built-up reserves that result from entry age-level premium in order to arrive at an equitable exchange.[8]

6. If policies are less restrictive now than in the past, what limitations still exist and what are the impacts of these limitations on employees?

Policies have, in fact, become less restrictive and more comprehensive in terms of what they cover. Consistent with the NAIC Long-Term Care Model Act and Regulation:

- Some carriers of long-term care insurance exclude coverage for those with certain pre-existing conditions.

- Other exclusions limit or exclude care that is needed due to acts of war, self-inflicted injury, alcohol or drug disorders, mental and nervous disorders of inorganic origin, for which reimbursement is available under a government program, or that is provided outside of the United States.[9]

9. On what do private long-term care insurance plans base benefit amounts?

Long-term care insurance benefit amounts are determined according to the types of care across the United States. For example, the average cost of a home health care visit is about 60% of the daily cost of nursing home care.[10] This proportion is reflected in the benefit levels of long-term care insurance plans. It is important to note that the construction of employer-based plans is often based on what the employer or consultant feels is appropriate for the employee population, based on demographics and affordability.

10. What is the relationship between the level of benefits selected and premium amounts?

Premiums are directly proportional to an increase in the Daily Maximum Benefit (DMB) amount selected. In the case of nursing home only coverage versus comprehensive coverage, nursing home only coverage is priced 30% or 40% less than comprehensive coverage. Differences in the number of years of coverage allowed by the lifetime maximum benefit (LMB) are not priced proportionally, rather they are based on expected benefit use.[11]

11. What percentage of cost do long-term care policies cover for nursing home care, assisted living facilities/residential care facilities, home health care, community care, and adult day care?

Most purchasers buy comprehensive long-term care insurance policies (i.e., benefits are payable for care both in conventional facilities as well as home and community-based care). Policies are available that will provide a benefit equal to the prevailing rate in the region where the care is received. Therefore, purchasers have the option of buying benefit amounts that will cover the full amount or some percentage of that amount. Generally, long-term care insurance policies pay benefits for confinement in a nursing home or similar facility at the rate of 100% of the daily maximum benefit elected by the insured; at a rate of 75% to 100% for confinement in an alternate care or assisted living facility; and at a rate of 50% to 100% for home or community-based care/adult day care. As noted in question 1 above, policies may provide limited coverage for some homemaking, personal care, and other services.

I hope the above responses are helpful to you and members of the Subcommittee and staff as you move forward with this important effort to make long-term care insurance available to federal employees. Should you have further questions, please feel free to contact me at 617 572-7497 or Ms. Angela J. Arnett, Senior Counsel, ACLI, at 202 624-2319.

Sincerely,

David S. Martin
Chairman
ACLI Long-Term Care Work Group &
Director
Contracts & Legislation
John Hancock Mutual Life Insurance Company

[1] Lewin VHI, *Ensuring Quality Products, Increasing Access to Coverage, and Enabling Consumer Choice*, February 1996, p. 11

[2] Lewin VHI, *Ensuring Quality Products, Increasing Access to Coverage, and Enabling Consumer Choice*, February 1996, pp. 12-14

[3] Lewin VHI, *Ensuring Quality Products, Increasing Access to Coverage, and Enabling Consumer Choice*, February 1996, p. 18.

[4] Life Insurance Marketing Research Association, *U.S. Employer Sponsored Group Long-Term Care Insurance*, 1997, p. 2.

5. Health Insurance Association of America, *Long-Term Care: Knowing the Risk, Paying the Price*, 1997, pp. 62-63.

[6] Employee Benefit Plan Reseach Institute, *Long-Term Care and the Private Insurance Market*, July 1995, p. 12

[7] The Advisory Board Company, *Group Long-Term Care Insurance*, April 1996, pp. 17-18.

8. Health Insurance Association of America, *Long-Term Care: Knowing the Risk, Paying the Price*, 1997, p. 69.

9. Health Insurance Association of America, *Long-Term Care: Knowing the Risk, Paying the Price*, 1997, pp. 60-61.

[10] Health Insurance Association of America, *Long-Term Care: Knowing the Risk, Paying the Price*, 1997, p. 23.

[11] John Hancock, 1998.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

Honorable John L. Mica
Committee on Government Reform and Oversight
US House of Representatives
2157 Rayburn House Office Bldg
Washington, DC 20515

Dear Congressman Mica:

We have received your letter of April 3, 1998 with questions on the topic of long term care insurance for federal employees. We appreciated the opportunity to testify on this matter at your hearing in March and look forward to working with you on this matter. Our responses are attached.

If you have further questions do not hesitate to contact John Cutler or Pam Doty of our staff at (202) 690-6443. Again, we thank you for the opportunity to answer these questions.

Respectfully,

Bob Williams
Deputy Assistant Secretary for
Disability, Aging and Long-Term Care Policy
Office of the Assistant Secretary for Planning and Evaluation

QUESTIONS ON FEDERAL EMPLOYEES LONG TERM CARE INSURANCE

Please estimate the number of individuals that are currently nursing home residents.

According to the 1995 National Nursing Home Survey, there were 1,529,525 nursing home residents in 1995, of whom 1,410,776 were aged 65 or older.

What was the average out-of-pocket expenses that these residents paid before they became Medicaid eligible?

It is difficult to get good data on this point. Many nursing home residents have short stays and never spend-down to Medicaid. Moreover, analysis of spend-down is complicated by the fact that some nursing home residents are admitted and discharged to nursing homes multiple times because of intervening hospital stays. However, based on work by Brenda Spillman of AHCPR, Joshua Wiener of the Urban Institute and others, it is estimated that 31 percent of nursing home residents who are initially admitted to nursing homes as private pay patients spend-down to Medicaid eligibility prior to their final discharge. One study in Connecticut, carried out by Leonard Gruenberg, found that nursing home residents who entered as private pay patients and subsequently spent-down to Medicaid had nursing home stays averaging 4.5 years in length, of which 1.5 years were wholly funded with private out-of-pocket payments. Thus, while costs vary from state to state, this would suggest that, at current private pay rates, nursing home residents who are currently in the process of spending down might expect to pay out, on average, $69,000 in personal income and savings before becoming Medicaid eligible.

It is important to bear in mind, however, that even after spending-down to Medicaid eligibility, nursing home residents must continue to dedicate all of their monthly income (less a minimum $30 personal needs allowance Medicaid permits them to retain) toward payment of their nursing home bill. Thus, private, out-of-pocket spending does not end with Medicaid eligibility.

Is it reasonable to assume that individuals can save a sufficient amount of money on their own to pay for their long-term care services without having to rely on Medicaid?

Deena B. Katz, a certified financial planner who heads the financial planning firm of Evensky, Brown, Katz, and Levitt has estimated the amount an individual would need to set aside to have an adequate level of assets for the sole purpose of covering long-term care costs. In 1998 constant dollars, the amount needed would be approximately $230,000 to pay for a 5 year nursing home stay. Assuming a 5% annual inflation rate for nursing home costs, this would mean that a 45 year old today might well have to save over three quarters of a million dollars ($750,000) by age 75 in order to adequately "self-insure."

Of course, relatively few Americans will spend five years in a nursing home. This is what makes the possibility that one might eventually need such high cost long-term care an "insurable risk." When viewed in this fashion it makes more sense to buy insurance against the risk of a lengthy stay in a nursing home than to save against it.

...describe the public policy benefits of having more people purchase private long-term care insurance.

There are two main sources of funding for long-term care: out-of-pocket payments by the elderly themselves and Medicaid. Medicaid financing is, of course, only available to the poor, including those who have "spent-down" by exhausting their ability to pay privately for medical or long-term care. Long-term care insurance, if properly structured, gives families an option to protect their savings and decrease the potential that they would become impoverished. Experts (e.g. Joshua Wiener of the Urban Institute, Lisa Alecxih of Lewin, and Marc Cohen of Lifeplans) agree that widespread availability of employer-sponsored long-term care insurance would be more likely to result in significant market penetration - hence greater savings from avoidance of Medicaid spend-down -- than if the private long-term care market continues to be based on sales of individual policies as is currently the case. . Estimates of Medicaid savings that could result are contingent on highly speculative assumptions about the level of market penetration that might be achieved over the next twenty years. Under pessimistic assumptions, Medicaid savings would be minor; under optimistic assumptions Medicaid savings could be significant.

Informal family care is also an option for individuals with long term care needs, but one that will increasingly come under pressure as a majority of middle-aged women -- who have traditionally been the primary care givers for widowed parents and parents-in-law -- are employed outside the home, as the population ages, and as family structures change. A nationally representative survey of female primary caregivers of the elderly found that employed primary caregivers could personally contribute, at most, half that amount of assistance - and still remain employed. For employed caregivers to provide personally 35 or so hours of informal assistance to a severely disabled elderly relative in addition to holding down a full or even a part-time paid job is clearly a very burdensome time commitment. Long term care insurance would allow this caregiver coverage to be supplemented or replaced.

...why does the Department believe that employer-sponsored group insurance is a good product for addressing long-term care needs?

Employer-sponsored group insurance may make coverage more affordable if it encourages individuals to enroll at younger ages. Also due to economies of scale and savings on the delivery method (for example, premiums can often be paid via payroll deductions), group policies are typically 15 percent cheaper than identical policies sold individually. Moreover, group insurance may be offered to active employees on a guarantee issue basis (that is to say, without underwriting). People also may be more favorably inclined to purchase coverage if an employer sponsored group plan were available, in part due to the lower price and in part due to the employer "blessing" of the product. However, to the extent that employer-sponsored long-term care insurance is purchased at earlier ages - long before the need to access benefits - these policies are vulnerable to erosion of benefits by inflation and to take this into account in the design of an offering.

Please describe what parameters you believe should be considered in drafting this legislation.

The design of a federal employer group long term care insurance option should position the product to succeed (i.e. achieve an acceptable "take up" rate of at least five percent). Policies should also meet quality standards and endeavor to offer better options than the individual market currently has available.

One of the real advantages of an employer approach could be to have some sort of guarantee issue product available for actively at work individuals.

Mr. MICA. There being no further business to come before the Subcommittee on the Civil Service, this meeting is adjourned.

Thank you.

[Whereupon, at 11:35 a.m., the subcommittee was adjourned.]

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