

LONG TERM CARE

HEARING
BEFORE THE
SUBCOMMITTEE ON HEALTH
OF THE
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
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LONG TERM CARE

TUESDAY, APRIL 19, 2005

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The Subcommittee met, pursuant to notice, at 4:19 p.m., in room 1100, Longworth House Office Building, Hon. Nancy L. Johnson (Chairman of the Subcommittee) presiding.

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
April 12, 2005
No. HL-5

CONTACT: (202) 225-3943

Johnson Announces Hearing on Long Term Care

Congresswoman Nancy L. Johnson (R-CT), Chairman, Subcommittee on Health of the Committee on Ways and Means, today announced that the Subcommittee will hold a hearing on long term care. **The hearing will take place on Tuesday, April 19, 2005, in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 4:30 p.m.**

In view of the limited time available to hear witnesses, oral testimony at this hearing will be from invited witnesses only. Witnesses will include officials from the Congressional Budget Office (CBO) and representatives from the provider and insurer communities. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

BACKGROUND:

As our society ages, the question of how we finance long term care services will become even more pressing. About 9 million adults currently receive long term care assistance, either in community settings or in nursing homes. Over 80 percent of those adults reside in the community, not in institutions. Among those 85 and older, about 55 percent require long term care assistance. Nearly 60 percent of elderly persons receiving long term care assistance rely exclusively on unpaid caregivers, primarily children and spouses. Only 7 percent of the elderly rely exclusively on paid services.

In 2004, according to CBO, approximately \$135 billion was spent on long term care for the elderly. Sixty percent of this amount was financed through Medicaid and Medicare, one third through out-of-pocket payments, and the remainder by other programs and private insurance. This funding excludes the significant resources devoted to long term care by informal caregivers (primarily spouses and children). The CBO estimates that informal care is the largest single component of long term care.

In announcing the hearing, Chairman Johnson stated, "As the Baby Boom generation ages, increasing strain will be placed on our system of long term care. We must find new and innovative ways to encourage individuals to prepare for their long term care needs. It is important for us to develop a thorough understanding of how the current system is financed, how care is delivered, and what challenges we face in helping individuals plan for their long term care needs."

FOCUS OF THE HEARING:

The hearing will focus on current financing for long term care services; the range of services available in the continuum of care from home- and community-based services to nursing home care; private long term care insurance options, including the Long Term Care Partnership programs; and the challenges ahead in financing needed services for an aging population.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Any person(s) and/or organization(s) wishing to submit for the hearing record must follow the appropriate link on the hearing page of the Committee website and complete the informational forms. From the Committee homepage, <http://waysandmeans.house.gov>, select "109th Congress" from the menu entitled, "Hearing Archives" (<http://waysandmeans.house.gov/Hearings.asp?congress=17>). Select the hearing for which you would like to submit, and click on the link entitled, "Click here to provide a submission for the record." Once you have followed the on-line instructions, completing all informational forms and clicking "submit" on the final page, an email will be sent to the address which you supply confirming your interest in providing a submission for the record. You **MUST REPLY** to the email and **ATTACH** your submission as a Word or WordPerfect document, in compliance with the formatting requirements listed below, by close of business Tuesday, May 3, 2005. **Finally**, please note that due to the change in House mail policy, the U.S. Capitol Police will refuse sealed-package deliveries to all House Office Buildings. For questions, or if you encounter technical problems, please call (202) 225-1721.

FORMATTING REQUIREMENTS:

The Committee relies on electronic submissions for printing the official hearing record. As always, submissions will be included in the record according to the discretion of the Committee. The Committee will not alter the content of your submission, but we reserve the right to format it according to our guidelines. Any submission provided to the Committee by a witness, any supplementary materials submitted for the printed record, and any written comments in response to a request for written comments must conform to the guidelines listed below. Any submission or supplementary item not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All submissions and supplementary materials must be provided in Word or WordPerfect format and MUST NOT exceed a total of 10 pages, including attachments. Witnesses and submitters are advised that the Committee relies on electronic submissions for printing the official hearing record.
2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.
3. All submissions must include a list of all clients, persons, and/or organizations on whose behalf the witness appears. A supplemental sheet must accompany each submission listing the name, company, address, telephone and fax numbers of each witness.

Note: All Committee advisories and news releases are available on the World Wide Web at <http://waysandmeans.house.gov>.

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202-225-1721 or 202-226-3411 TTD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Chairman JOHNSON OF CONNECTICUT. Good afternoon, everyone. Today I am pleased to Chair this hearing on long-term care. The issues surrounding long-term care, how to prepare for it, how it is delivered, how it is financed, will become ever more pressing as the baby-boom generation retires. As a result we must find new and innovative ways to encourage people to prepare for their long-term care needs as part of the broader examination of retirement security. Some of you may be surprised to learn that long-term care is not just institutional care, but encompasses a whole range of services. According to the Congressional Budget Office, about 9 million adults over the age of 18 currently receive long-term care assistance, with more than 80 percent receiving care in

the community, not in institutions. Among those 85 and older, about half, 55 percent, require long-term care. Informal unpaid care by children and spouses is a critical component of long-term care. More than half of elderly persons receiving long-term care assistance rely exclusively on unpaid care givers, while only 7 percent of the elderly rely exclusively on paid services. The Congressional Budget Office (CBO) estimates that informal care is the largest single component of long-term care, and as we move forward in consideration of this subject and what the public policy ought to be in regard to long-term care, I believe we absolutely must never lose sight of the fact that informal care is the largest single component of long-term care.

Thus, as we consider this issue, we must consider the impact not only on public and private finances, but on families and communities. The formal financing of long-term care to date has fallen largely on the public sector, primarily Medicare and Medicaid. CBO estimates these two programs financed 60 percent of formal long-term care spending on the elderly in 2004. Nearly one-third of our Medicaid benefit spending goes for long-term care services, and three-quarters of that one-third is spent for beneficiaries who are dually eligible for both Medicare and Medicaid. Thus, the interrelationship between these two streams of financing must be considered when looking at this issue. Most of the remainder of formal financing for long-term care is made up through out-of-pocket payments by beneficiaries themselves. To date, private long-term care insurance has not played a significant role in financing long-term care. For many years now, I have sought to draw attention to the issue of long-term care and the burden it places on individuals and families by introducing legislation to provide tax incentives for the purchase of private insurance and to provide relief for family care givers. Although sales of private long-term care insurance are increasing, it still covers a small portion of the population and, therefore, a small portion of overall long-term care costs. Without a significant change in the market for private insurance or in the product itself, the burden of long-term care costs is likely to continue to fall largely on the public sector and on families. Ironically, the very existence of public sector programs serves as a disincentive to some individuals to purchase private insurance and will reduce the drive for greater innovation in private insurance products. Thus, as we move forward in examining the issue, we need to consider the interplay of public and private financing and the incentives created by each in order to develop a comprehensive solution for the long-term care system.

I am pleased to have an outstanding array of witnesses here today to help us lay the foundation of knowledge necessary to understand the current state of long-term care and the changes we face in the future. We will begin by hearing from Douglas Holtz-Eakin, the Director of the Congressional Budget Office. Dr. Holtz-Eakin will provide us with an overview of long-term care financing, an update on the report CBO did last year on long-term care financing for the elderly. And our second panel will begin with Dr. Gerety. Dr. Gerety is President of the American Geriatric Association and will provide a broad overview of demographic and aging trends, how the baby boomers will change the long-term care sys-

tem, and how the industry will need to respond to meet increased long-term care needs. Buck Stinson, President of the Genworth Financial's Long-Term Care Division, will provide us with a view from the private insurance market. Genworth is the longest-tenured provider of long-term care insurance in the United States and is the largest provider of individually purchased long-term care insurance. Mark Meiners, professor and director of the Center for Health Policy, Research, and Ethics at George Mason University, has done extensive research on long-term care and directed the Robert Wood Johnson grant for the Long-Term Care Partnerships. Dr. Meiners will discuss the partnership programs and issues arising from the interrelationship between Medicare and Medicaid in long-term care financing. David Gehm, President and chief executive officer of the Lutheran Homes of Michigan, will give us a provider's perspective by discussing the full continuum of long-term care services that are available today, including institutional and home- and community-based services, along with the challenges care providers face in navigating various financing mechanisms. And, finally, we will hear from Judy Feder, Dean of the Georgetown Public Policy Institute. Dr. Feder will discuss the Georgetown Long-Term Care Project that she is co-directing, which has issued seven background papers and is currently in the process of reviewing a wide range of proposals for long-term care financing, and whose report we look forward to reviewing when it is published in, I hope, the not-too-distant future.

This hearing will lay the foundation of knowledge that this Committee needs to consider the enormous challenge of long-term care for the baby-boom generation. But I hope this hearing will also be followed by those of you who know about small, significant expandings where improvements are being made, where new thoughts are being played out, and I hope to have some futurists meet with our Committee to clearly elucidate how current changes in medical science and those we can conceive of will affect in 10 years or 20 years the nature of the long-term care needs of our seniors and the structure of services that they may need. I believe this is a very important hearing for the Members of the Committee. It may in the end prove to be as far as we can go. But it should be a beginning. In other Congresses it has been an end. So, I thank those who are testifying today, and I hope as they listen to each other and as others listen to this hearing that you will consider this a beginning, because I do not believe we know how to provide long-term care services for the size population that is going to need them in 10 years, and even more so in 20 years. And if we do not begin to get ourselves more focused, realistic, and profoundly knowledgeable about this, we will not be able to adjust policies to begin to prepare for the future. So, with that much introduction, let me yield to my colleague and friend, Mr. Stark.

Mr. STARK. Thank you, Madam Chair. Today's hearing on long-term care addresses a problem that is important and complex, and like you, I hope that this may be the first in a series of hearings that might lead to some action, although it seems to me Dr. Feder and I will be able to remember the Pepper Commission of some years back. And I think we went through this once before.

Chairman Thomas has said that he thinks long-term care should be part of the discussion on Social Security, and so perhaps it is time to revisit the issue and look into a variety of options. Medicare and Medicaid probably combine to be the largest payer for long-term care services in the United States, and if non-paid care is factored in, then individuals and their families and friends clearly have their greatest burden. But I think we have to remember that our family structures, as when we were children most women did not work outside the household, and now it seems with the ability for the nuclear families to disperse geographically, we lack the neighborhood cohesiveness of the family structure that often provided bed and board for Grandpa or Grandma by all the relatives in the neighborhood. And that is changing. So, I guess my question would be: Could we determine what the Government role should be in the years ahead? I personally think that long-term care is the poster child and few benefits are better suited for social insurance. It to me is the classic problem. Everyone might need it. Only some actually do need it. It is probably actuarially impossible to determine within age groups who is apt to need it. The expense can bankrupt the family, even though our bankruptcy bill did not do much to address that. It should be a program, in my opinion, into which everyone pays a small amount and everyone might or may benefit. In addition, I suppose a social benefit for long-term care could relieve some of the Medicaid pressures on the States, and, of course, that would be welcome today.

So, I think there is a strong case that can be made that this should be social insurance. The tax incentives for private insurance I think are a weaker case. The private market is flawed, it is failing. Without non-forfeiture protection, most people are better off playing the slot machine or the office baseball pool than they are buying private long-term care insurance. But it is fine with me if people who can afford it want to buy it and it supplements a core benefit. That would be all right, I suppose, but I do not think that we should offer tax incentives to purchase the insurance. That is throwing billions of dollars at a flawed product which the market has rejected. So, if we really believe in the marketplace, let's let it work. To contemplate spending tax money when we are poised to cut Medicaid really seems like we would be setting up robbing me to pay Paul, and I think that is unwise. So, if we can really engage in the issue of what the government role should be, what the benefits should be for every American, we might reopen that dialog of 15 or 20 years ago when we nibbled around the edges of it. When we were in the majority, we had not much luck, so maybe it is your turn. Thank you, Madam Chair.

Chairman JOHNSON OF CONNECTICUT. I would just remind you, I answered that Commission that Congressman Baird chaired and how many times we wrote bills to provide prescription drugs for seniors and how long it finally took us to do it. I think the time has come for us to really sink our teeth into the challenge of long-term care that the retirement of the baby-boom generation poses to Americans. So, I welcome you all here today. I am very pleased and I want to congratulate the Committee Members for coming in early to attend this hearing. I appreciate your doing it because it is hard in the very busy days that we have in Washington to get

such attendance. So, thank you very much for making it your business to be here. Dr. Holtz-Eakin?

**STATEMENT OF DOUGLAS HOLTZ-EAKIN, PH.D., DIRECTOR,
CONGRESSIONAL BUDGET OFFICE**

Mr. HOLTZ-EAKIN. Chairman Johnson, Congressman Stark, and Members of the Committee, the Congressional Budget Office thanks you for the opportunity to be here today. As the Chairman mentioned in her opening remarks, we did produce a report in this area last year. We have submitted a written summary of that with an update as our written testimony. I will devote my opening remarks to four points regarding that report. Number one, with the aging of the baby-boom generation, the United States will likely face rising demands for long-term care services. Number two, the corresponding resource demands will rise above their already substantial levels. Currently, these are about 2 percent of gross domestic product, something that is in the neighborhood of \$25,000 per senior with impairments. Distributing the burden for this care is a key aspect of both the policy design and the long-term budget outlook.

And, finally, the fourth point is that currently financing is heavily influenced by rules that discourage people from making their own financial preparations. Left unchanged, those incentives will add to the financial demands for other Government programs in the face of rising demographic changes and rising health care costs. And so this problem must be addressed within the context of these other demands. So, I thought I would sketch the aspects of this problem. The aspects are familiar to this audience because you are familiar with health care programs, and they always break into two parts: what will be the costs and how will those costs be financed. The future costs of care are driven largely by demographics. Our baseline projections suggest that the costs will rise over the next four decades from about 2 percent of GDP to 2.3 percent of GDP. That is a rise of about 15 percent. It is something that does not look as large as the roughly 50-percent rise of Social Security benefits under current law, but it is quite significant. It is driven by the rising share of the population that is the oldest old. The share that is 85 or older is going to more than triple from 1.5 percent to 5 percent by 2050. That group is the very dark line at the bottom of that chart that I am showing you.

But our assumption that costs rise by that much assumes that we get continued improvement in the incidence of impairment among the people in this population. Impairment has declined at about 6 percent per decade over the 20th century. In the absence of that kind of improvement, costs could grow by 65 percent and rise to 3.3 percent of GDP. So, it seems clear that there will be rising demands for resources in this area and that the risks are largely on the upside if we fail to see continued improvements in impairment. Now, what will be the sources of financing for this care? A good starting point is the current allocation of spending and how it is financed in the United States. As the Chairman mentioned in her opening remarks, of the roughly \$25,000 per impaired senior, private, non-market-donated care forms the vast majority. It is about \$9,000. It is the largest. It is extremely difficult to value. The

aggregate estimates range from \$50 billion to \$200 billion. We include it in our estimates because it is clearly a very important aspect of the current financing of long-term care. A figure of that is in our report where over 50 percent—51 percent of highly impaired individuals rely exclusively on informal care for their long-term care services.

Going forward, the demographics may affect the supply of this kind of care as well as the demand. As Congressman Stark mentioned, the demographics will affect both total family sizes and also the availability of care givers given labor force participation of women and divorce. Moving to the other sources in the private sector, self-insured or out-of-pocket care is about \$5,000, and the key issue here is the degree to which individuals will accumulate more in personal saving than they do at the moment. It is unlikely that all but a significant minority could afford to face long-term care expenses of any magnitude by relying on this source. Private market long-term care insurance is a small aspect of the financing at the moment. Under 10 percent of people have policies, and this low utilization is one of the striking features of the current market. Instead, the vast majority comes in Medicare and Medicaid, as mentioned at the outset, and these public programs are bearing the largest fraction of the non-donated care.

So, going forward, what issues will remain? Well, first, the larger budget context suggests that dollars will be scarce. I don't have to repeat the litany of financial demands that will be placed under current law. It will be the case that Federal dollars will be scarce and need to be used wisely. This will require balancing the programs as they stand, balancing home- and community-based care versus nursing homes and Medicaid; balancing Medicaid versus Medicare, which has become a de facto long-term care program. Or it may involve limiting those Federal programs by revising income and asset tests in Medicaid, by providing more cost sharing in Medicare. Or it could take the form of encouraging a greater reliance for those who can use long-term care insurance provided by the private sector.

The current low rates of utilization beg for an explanation. A variety have been offered. High administrative costs and the potential for adverse selection lead some to believe that the policies are simply so unfavorable as to be unwise to take up. Alternatively, it could be that premium instability and the difficulty of insuring against large health care cost shocks is underneath the problem. Or other research suggests that some policies do look to be at least actuarially fair, particularly for women, and the still low rates of take-up are indicative of other sources being available, be they private sources or public insurance programs, Medicaid and perhaps Medicare. In any event, going forward, rebalancing this mix to make sure that the dollars are used in the most appropriate fashion is a pressing policy problem. The only good news that I can offer to this group on this front is in the demographics, where in contrast to most of the programs which rise with the top line as people reach 65 and older, the largest incidence of impairment is with the bottom line, those 85 and older. To the extent the public policies can be molded and put in place, we have a bit more time for people to adjust and for the budget to take advantage of those

new policies. I thank you for the chance to be here, and I look forward to your questions.

[The prepared statement of Mr. Holtz-Eakin follows:]

Statement of Douglas Holtz-Eakin, Ph.D., Director, Congressional Budget Office

Chairman Johnson and Members of the Subcommittee, thank you for the opportunity to be here today to discuss the cost and financing of long-term care (LTC) services. A Congressional Budget Office (CBO) report from April 2004, *Financing Long-Term Care for the Elderly*, examines these issues in greater detail. Long-term care is the personal assistance that enables people with impairments to perform daily routines such as eating, bathing, and dressing. Such services may be provided at home by family members and friends; through home and community-based services such as home health care, personal care, and adult day care; or in institutional settings such as nursing or residential care facilities.

In my statement today I want to make the following points:

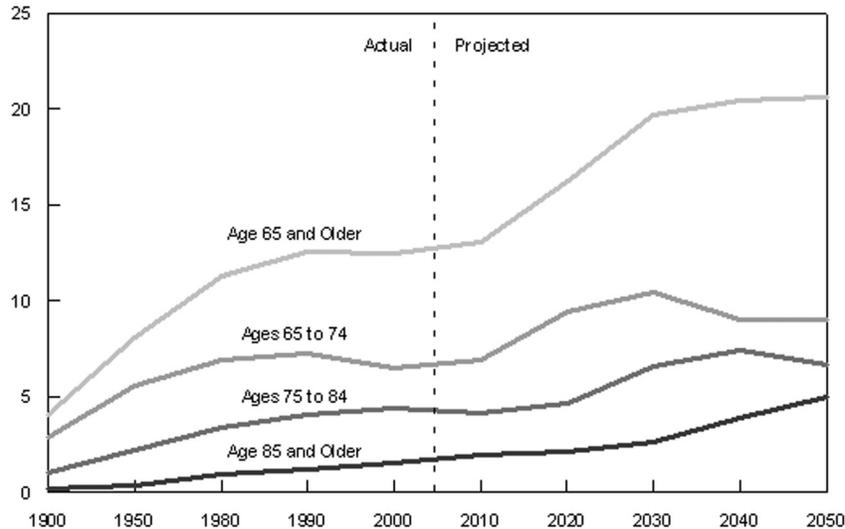
- With the aging of the baby-boom generation, the United States' elderly population is expected to grow rapidly over the next several decades. The surge in the number of seniors will increase the number of people with impairments and, in turn, the demand for long-term care services.
- The resources devoted to long-term care services are already substantial. CBO estimates that spending on such care for the elderly (including the value of donated care) totaled over \$200 billion in 2004—or approximately \$24,000 per senior with impairments. In reporting estimates of LTC spending, CBO chose to include the value of donated care because it is an integral part of long-term care, even though measuring it accurately is difficult.
- Currently, donated care is the largest source of financing for long-term care costs, followed by the combined public programs—Medicaid and Medicare—and out-of-pocket expenditures. Private long-term care insurance is a small portion of the current financing.
- Financing patterns for long-term care are heavily influenced by the rules governing public LTC programs. Those rules create incentives that discourage people from making their own financial preparations and encourage them to rely on government assistance. If left unchanged, those incentives will add to the financial demands that government programs for retirees are already facing as a result of demographic changes and rising health care costs.

Demographic Trends

The oldest members of the baby-boom generation become eligible for early retirement under Social Security in 2008. According to estimates by the Bureau of the Census, the number of elderly people (those age 65 and older) in the United States will increase by two and a half times between 2000 and 2050. The share of the population claimed by the oldest seniors, those age 85 and older—and those most likely to use long-term care—will reach about 5 percent by 2050, more than triple the 1.5 percent share they had in 2000 (see Figure 1). By comparison, the proportion of the population accounted for by working-age people (ages 20 to 64) will grow by only about 35 percent by 2050.

Figure 1. People Age 65 and Older as a Share of the U.S. Population, Selected Years from 1900 to 2050

(Percent)



Source: Congressional Budget Office based on Bureau of the Census, *U.S. Interim Projections by Age, Sex, Race, and Hispanic Origin*, Table 2a, "Projected Population of the United States, by Age and Sex: 2000 to 2050" (March 2004), available at www.census.gov/ipc/www/usinterimproj/natprojt02a.pdf.

Although the number of the oldest seniors will rise, declines in the prevalence of functional impairment could offset some of the effects of that increase. Impairment among seniors appears to have waned significantly during the 20th century. From 1910 to the early 1990s, the overall prevalence fell by about 6 percent per decade. From the early 1980s to the present, the prevalence of impairment may have fallen even faster, according to research findings from the *National Long-Term Care Survey*. In contrast, some types of impairment, such as those requiring the use of a cane to walk, have been increasing. Impairment among people under age 65 may also be increasing, which could eventually lead to higher future rates of impairment among seniors. In fact, one recent study projects that the currently declining trend in the prevalence of impairment among seniors will reverse in the future, leading to greater rates of institutionalization than those that exist today.¹ As those conflicting trends suggest, projecting the prevalence of impairment in future years and basing estimates of spending on those projections are both difficult and subject to a high degree of uncertainty.

Demographic changes may affect the composition of LTC financing in the future as well. Smaller families, lower fertility rates, and increasing divorce rates may make donated LTC services less common in the future. The size of the average family has declined, reducing the number of adult children available to care for their elderly parents. Family size fell from 3.8 members in 1940 to 3.1 members in 2000; if current trends continue, it will decline to 2.8 people by 2040. At the same time, the rate at which women participate in the labor force will probably continue to grow, at least until 2010, further reducing the availability of donated care. Those family-related trends, in sum, could further stimulate the demand for formal, or paid, services.

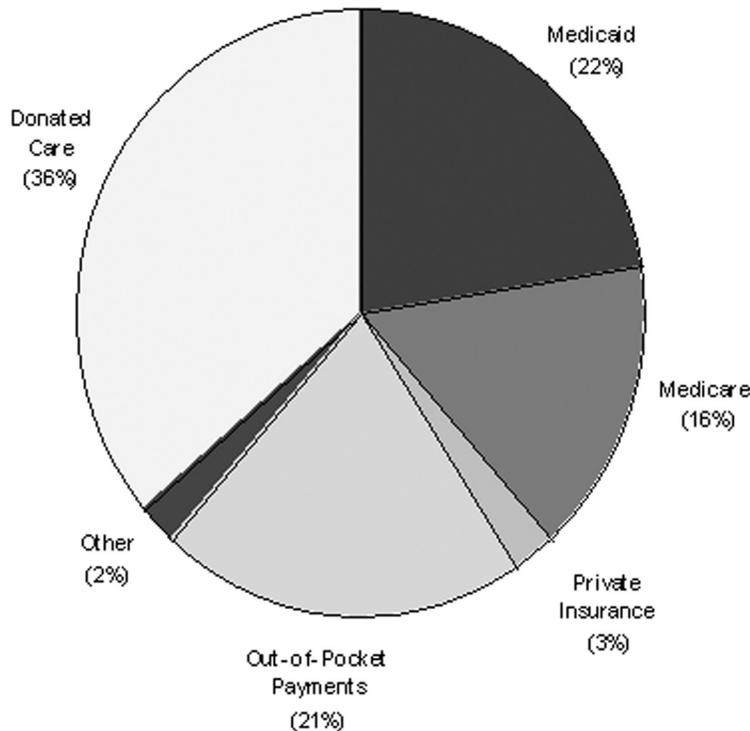
Sources of Long-Term Care Financing

Long-term care is financed with both private resources and public programs (see Figure 2). Private resources include donated care, out-of-pocket spending, and pri-

¹Darius Lakdawalla and others, "Forecasting the Nursing Home Population," *Medical Care*, vol. 41, no. 1 (2003), pp. 8–20.

vate insurance. Public programs include primarily Medicaid and Medicare, although the Department of Veterans Affairs and the Social Services Block Grant program also fund long-term care.

Figure 2. Estimated Shares of Spending on Long-Term Care for the Elderly, 2004



Source: Congressional Budget Office.

Private Sources

Most seniors with impairments who reside in the community, including those with severe impairments (unable to perform at least four activities of daily living, or ADLs), rely largely on donated care from friends and family. And many people who pay for care in their home also rely on some donated services.

The economic value of donated care is significant, although estimates of it are highly uncertain. In 1998, the Department of Health and Human Services estimated that replacing donated LTC services for seniors with professional care would cost between \$50 billion and \$103 billion (in 2004 dollars). Another analysis, in 1997, estimated the value of donated care for people of all ages who had impairments—measuring it as the forgone wages of caregivers—at \$218 billion.²

Out-of-pocket spending in 2004 accounted for about one-fifth of total LTC expenditures, or roughly \$5,000 per senior with impairments (see Table 1). The federal government subsidizes a portion of out-of-pocket spending through the tax code. Taxpayers with impairments (or taxpayers who have dependents with impairments) may deduct LTC expenses from taxable income along with other medical and dental costs, but only the portion of total medical costs (LTC, medical, and dental expenses) that exceeds 7.5 percent of adjusted gross income.

²Peter S. Arno, Carol Levine, and Margaret M. Memmott, "The Economic Value of Informal Caregiving," *Health Affairs*, vol. 18, no. 2 (1999), pp. 182–188. CBO converted their estimate of \$196 billion in 1997 dollars to \$218 billion in 2004 dollars.

Table 1. Long-Term Care Expenditures for the Elderly, by Source of Payment, 2004

(Billions of dollars)

	Institutional Care	Home-Based Care	Total
Public Programs			
Medicaid	36.5	10.8	47.3
Medicare	15.9	17.7	33.6
Private Resources			
Donated Care	0	76.5	76.5
Out-of-Pocket Payments	35.7	8.3	44.0
Private Insurance	2.4	3.3	5.6
Other ^a	2.0	2.5	4.4
Total	92.4	119.0	211.4

Source: Congressional Budget Office.

Notes: Donated care is measured as the cost of replacing that care with professional services.

Numbers may not add up to totals because of rounding.

a. Includes local public programs, minor federal spending, charity care, and so forth.

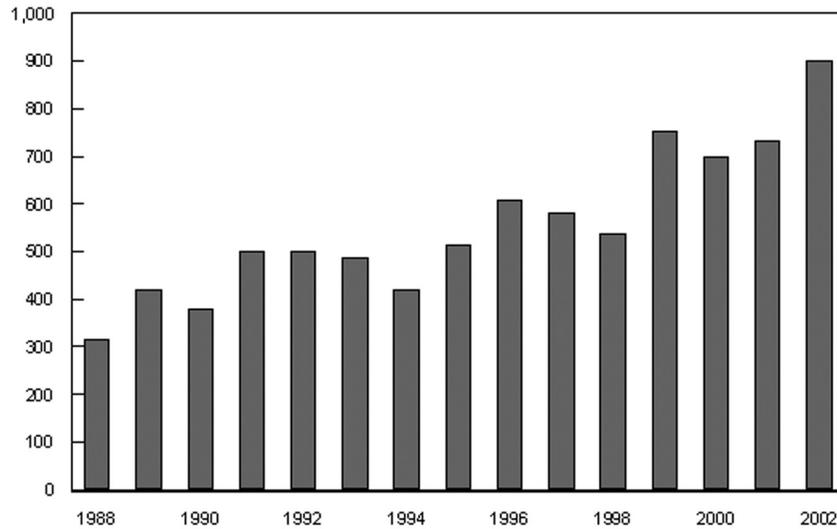
Private insurance for long-term care is a relatively recent development and pays for only a small amount of care at present. Few elderly people currently have private coverage—no more than 10 percent.³ However, that source of financing is growing—although the precise extent of the growth is difficult to measure accurately. The data on private LTC insurance generally capture payments that insurers make directly to providers but do not always pick up insurers' reimbursements to policyholders for covered services that policyholders initially pay for out of pocket. Thus, estimates of LTC insurance payments—and of out-of-pocket spending—should be interpreted with caution because the former may be underestimated and the latter overestimated.

In 1995, private insurance paid about \$700 million for LTC services for seniors, or 0.8 percent of all such expenditures. In 2004, such spending totaled about \$6 billion, CBO estimates, or about 3 percent of total expenditures. According to America's Health Insurance Plans, the number of policies written yearly increased from about 300,000 in 1988 to more than 900,000 in 2002 (see Figure 3). About 9.2 million policies were sold from 1987 through 2002; roughly 72 percent of them are still in force.

³Jeffrey R. Brown and Amy Finkelstein, *The Interaction of Public and Private Insurance: Medicaid and the Long-Term Care Insurance Market*, Working Paper No. 10989 (Cambridge, Mass.: National Bureau of Economic Research, December 2004).

Figure 3. Annual Number of Policies of Private Long-Term Care Insurance Sold, 1988 to 2002

(Thousands)



Source: America's Health Insurance Plans, *Research Findings: Long-Term Care Insurance in 2002* (Washington, D.C.: AHIP, June 2004), p. 15.

A typical LTC insurance policy pays the cost of nursing home care and home and community-based care but specifies a maximum daily benefit (such as \$100 or \$150) and may impose other limits. Policies with so-called inflation protection increase the dollar value of their benefits by a contractually specified percentage each year, usually 5 percent. Although some policies offer coverage for an unlimited period, most commonly cover services for a shorter time, such as four years, or until benefit payments for a policyholder reach a preestablished maximum lifetime amount. Policyholders typically become eligible to collect benefits when they reach a specific minimum level of impairment, usually defined as being unable to perform two or three ADLs or having a cognitive impairment significant enough to warrant substantial supervision.

Premiums for LTC insurance reflect the cost of services and the risk that policyholders will require long-term care as they age. In 2002, the average annual premium for a typical policy with no inflation protection or nonforfeiture benefit was \$1,337 if the policy was purchased at age 65; with those two added features, the premium rose to \$2,862. Premiums were three to four times higher if the policy was purchased at age 79 (see Table 2). The lower premiums offered to younger people reflect the lower risk of their requiring LTC services at younger ages and the expectation that younger policyholders will pay premiums over a longer period than will people who purchase coverage when they are older. Thus, the average annual premium for the same policy with inflation protection and a nonforfeiture benefit purchased by a 40-year-old would be only \$1,117 and by a 50-year-old, \$1,474.

Table 2. Average Annual Premiums for Long-Term Care Insurance, 2002

(Dollars)

If Purchased at Age	No Inflation Protection or Nonforfeiture Benefit	With 5 Percent Compounded Inflation Protection	With Nonforfeiture Benefit	With Inflation Protection and Nonforfeiture Benefit
40	422	890	537	1,117
50	564	1,134	715	1,474
65	1,337	2,346	1,646	2,862
79	5,330	7,572	6,479	8,991

Source: America's Health Insurance Plans, *Research Findings: Long-Term Care Insurance in 2002* (Washington, D.C.: AHIP, June 2004), p. 32.

Note: These premiums are for policies offering a \$150 daily benefit for four years of coverage and a 90-day elimination period.

In fact, fixed premiums are a key feature of LTC insurance policies—that is, the premiums do not increase as the policyholder grows older or as his or her health deteriorates, even though the risk of requiring services rises. Instead, insurers calculate premiums to ensure that the premiums' total, paid over the life of a policy, plus the interest that accrues from investing them will be sufficient to cover both the claims of the policyholder and insurers' profits and overhead costs. However, insurers reserve the right to increase premiums for a specific group, or rating class, of policyholders—such as all policyholders in a state—if new data indicate that expected claims will exceed the class's accumulated premiums and their associated investment returns.

Government Programs

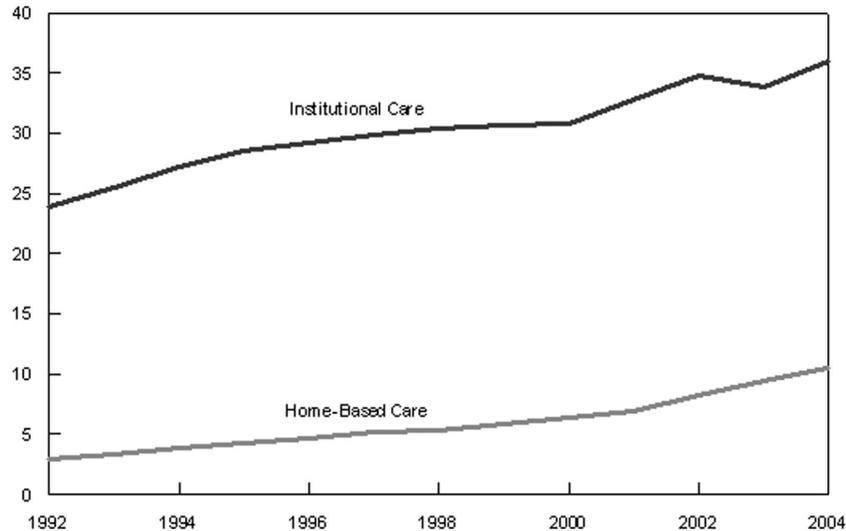
Medicaid is the biggest government source of payment for long-term care. Jointly funded by the federal and state governments, Medicaid is a means-tested program that pays for medical care for certain groups of people, including seniors with impairments who have low income or whose medical and long-term care expenses are high enough that they allow those seniors to meet Medicaid's criteria for financial eligibility. Within broad federal guidelines, the states establish eligibility standards; determine the type, amount, duration, and scope of services; set the rate of payment; and administer their own programs. The share of each state's Medicaid expenditures that is paid by the federal government is determined by a statutory formula; nationwide, the federal share of the long-term care portion of Medicaid spending is about 56 percent.

Medicaid generally pays for services provided both in nursing facilities and in the home, although the specific benefits that the program provides differ from state to state, as do patterns of practice, the needs and preferences of beneficiaries, and the prices of services. In total, Medicaid's expenditures for long-term care for elderly people since 1992 have grown at an average annual rate of about 5 percent (see Figure 4). CBO estimates that in 2004, Medicaid's payments for institutional care for seniors, including both state and federal expenditures, totaled about \$36.5 billion. Accounting for about 40 percent of total expenditures on nursing facilities, Medicaid's payments cover the care of more than half of all elderly nursing home residents.⁴

⁴See Celia S. Gabrel, *Characteristics of Elderly Nursing Home Current Residents and Discharges: Data from the 1997 National Nursing Home Survey*, Advance Data no. 312 (Centers for Disease Control and Prevention, National Center for Health Statistics, April 25, 2000). The disparity between Medicaid's share of total spending on nursing facilities (40 percent) and the proportion of patients covered by Medicaid (56 percent) may result from one or more factors: Medicaid's low average reimbursement rates; differences between the severity of Medicaid enrollees' conditions and the conditions of patients using other sources of payment; and enrollees' cost sharing, which counts as out-of-pocket spending.

Figure 4. Medicaid Long-Term Care Expenditures for Elderly Beneficiaries, Fiscal Years 1992 to 2004

(Billions of dollars)



Sources: Personal communication by Brian Bruen of the Urban Institute, and the Congressional Budget Office's estimates.

Medicaid's expenditures for home and community-based services (HCBS), which include home health care, personal care services, and spending under HCBS waiver programs, are much smaller than its spending for nursing homes—HCBS expenditures constitute only about 23 percent of total Medicaid LTC spending. (Under the waiver programs, states have the option of providing people with impairments with enhanced community support services not otherwise authorized by the federal statutes.) Since 1992, Medicaid spending for home-based care for seniors has grown faster than spending for institutional care, rising by about 11 percent annually, on average, compared with about 3 percent growth for care in nursing facilities.

Many people who are not eligible for Medicaid while they live in the community become so immediately or shortly after being admitted to a nursing facility because of the high cost of institutional care. (Nursing home costs in 2004 averaged about \$70,000 annually for a private room.) According to a 1996 study, about one-third of discharged nursing home patients who had been admitted as private-pay residents became eligible for Medicaid after exhausting their personal finances; nearly one-half of current residents had similarly qualified for coverage.⁵ Medicaid coverage is especially common among nursing home patients who have been institutionalized for long periods.

Medicare, the nation's health insurance program for the elderly, covers care provided in skilled nursing facilities (SNFs) and at home, but its benefits are designed primarily to help beneficiaries recover from acute episodes of illness rather than to provide care for long-term impairment.⁶ Medicare covers up to 100 days per spell of illness for SNF care, and the stay must be preceded by a hospitalization lasting at least three days. In contrast, Medicare's home health benefit, while originally conceived to finance short-term rehabilitation, has evolved into what some observers have described as a *de facto* LTC benefit. To be eligible for reimbursement under

⁵Joshua M. Wiener, Catherine M. Sullivan, and Jason Skaggs, *Spending Down to Medicaid: New Data on the Role of Medicaid in Paying for Nursing Home Care* (Washington, D.C.: AARP Public Policy Institute, June 1996). Those proportions differ because discharged residents include people who were institutionalized for only a short time, and the sample of current residents includes more people who stay for extended periods.

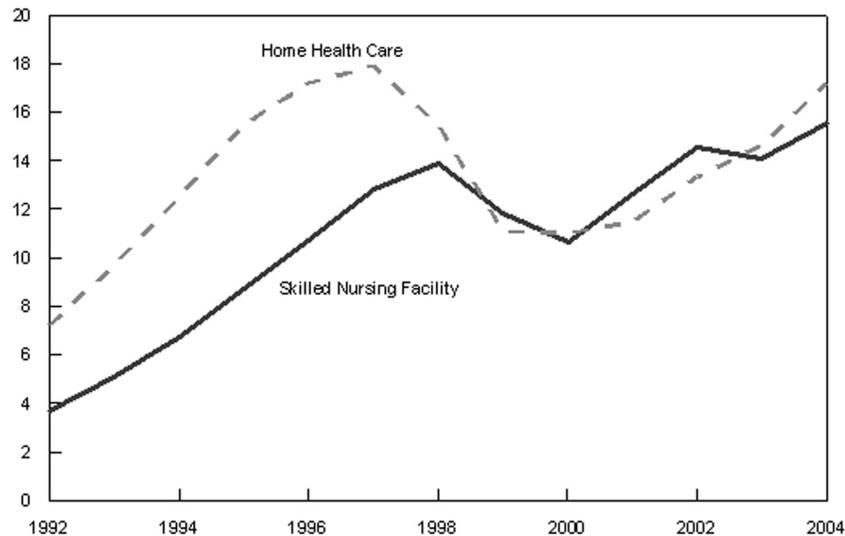
⁶Medicaid's nursing facility benefit (institutional care), in addition to covering skilled care provided in a SNF, also covers nonskilled care that may be provided in a SNF or nursing home. Medicare's SNF benefit, however, covers only skilled care provided in skilled nursing facilities.

the home health benefit, the beneficiary must be homebound and require intermittent care provided by a licensed professional, such as a registered nurse or physical therapist. If those conditions are met, Medicare will cover services provided by a home health aide, in addition to skilled care; aide services are the assistive services that typify long-term care.

By CBO's estimate, Medicare's LTC spending for seniors in 2004 totaled about \$16 billion for care in skilled nursing facilities and \$18 billion for home health care (see Figure 5). Although the program's outlays for those categories grew rapidly from the late 1980s to the mid-1990s, expenditures actually declined near the end of the past decade. A combination of factors was responsible, including changes to reimbursement methods imposed by the Balanced Budget Act of 1997, increased federal activities to counter providers' fraud and abuse of the program's payment systems, and delays in processing claims. CBO projects steady growth in spending for SNF and home health care over the 2006–2015 period, averaging approximately 5 percent annually.

Figure 5. Medicare Spending for Skilled Nursing Facility Care and Home Health Care for Elderly Beneficiaries, Fiscal Years 1992 and 2004

(Billions of dollars)



Source: Congressional Budget Office.

Issues in Controlling Federal Long-Term Care Spending

CBO has projected that total LTC expenditures for seniors (including the value of donated care) will rise from about \$195 billion in 2000 (2.0 percent of gross domestic product, or GDP) to \$540 billion (in 2000 dollars) by 2040, or 2.3 percent of GDP.⁷ That estimate of a relatively modest increase in use of long-term care services incorporated the assumption that the prevalence of impairment would decline at a rate of about 1.1 percent per year. If impairment levels instead remain about the same as they are today, use of services will rise faster, to \$760 billion by 2040, or about 3.3 percent of GDP. Demand for care could be even higher if, as some researchers believe, the prevalence of impairment actually increases in the future.

The current mix of financing for long-term care, in which a significant share of financing comes from government programs, adds to the pressures that the federal budget will experience with the aging of the baby-boom generation. Contributing to the strains that government LTC programs will face are incentives created by those programs that diminish the attractiveness of using private resources—especially private insurance—as a means for seniors to finance their care. Changes in those in-

⁷ Congressional Budget Office, *Projections of Expenditures for Long-Term Care Services for the Elderly* (March 1999).

centives might encourage more people to make their own preparations for financing their care rather than rely on governmental assistance.

Direct Approaches to Limiting Federal Spending for Long-Term Care

One approach to relieving the pressures on federal finances would be to directly reduce the role of Medicaid and Medicare, the programs responsible for the bulk of government-financed care. The most commonly discussed options are tightening the financial qualifications for people applying for Medicaid coverage and reducing Medicare's coverage of home health care.

Medicaid's spending for long-term care could be constrained by making it more difficult for middle-income people to qualify for coverage by spending down their resources. The intent of Medicaid's current rules is to restrict applicants to those who are destitute. Yet despite that intention, many applicants manage to protect a significant portion of their personal wealth and still qualify for Medicaid coverage by taking advantage of certain rules regarding the disposition of assets, a practice known as Medicaid estate planning. Strengthening the rules to reduce the use of such strategies would delay the point at which some people became eligible for benefits and would prevent others from qualifying. It could also discourage some people from going through the application process. However, it is unlikely that imposing those additional restrictions would have more than a modest impact on Medicaid's expenditures.⁸

Medicare's home health care benefit is relatively generous. Once a person meets the physical qualifications for coverage, there are no copayments or other coinsurance requirements. A modest cost-sharing requirement for beneficiaries could decrease the program's LTC expenditures because beneficiaries would probably reduce the amount of care they used in response to that kind of financial incentive.

Challenges in Encouraging Private Financing of Long-Term Care

Future federal spending on long-term care could be lessened by encouraging people to rely more on private resources for their LTC needs. Out-of-pocket spending and donated care already account for a very substantial share of LTC services, but private long-term care insurance currently finances very little such care. CBO estimates that the proportion of LTC spending that private insurance pays will rise to about 17 percent in 2020; that share would be less than the shares of either Medicaid or Medicare. Several factors underlie the limited rise that CBO projects for the use of private insurance. Some factors affect the availability and quality of insurance: they include issues related to administrative costs, the instability of premiums, adverse selection, and the inability to insure against certain risks unique to long-term care. A final factor—the interaction of private insurance and Medicaid—is critical in the way it affects demand for private insurance.

Administrative costs. Administrative costs contribute a substantial amount to LTC insurance premiums because most policies are sold individually rather than as group (employer-sponsored) policies.⁹ The costs of marketing to and enrolling individuals are about double those for groups, for which fixed administrative costs may be spread over more people.

On average, administrative costs as a percentage of premiums are likely to fall in the future as group policies make up a larger share of the private LTC insurance market. In 2002, group policies constituted nearly one-third of new LTC policy sales.¹⁰ (By comparison, nearly 90 percent of people with private health care insurance hold group coverage.¹¹) But group policies are accounting for an increasing share of the LTC insurance market, a trend that is likely to continue if more employers offer LTC coverage as an employee benefit. If employers offer such a benefit, any part of the premiums for their employees' LTC coverage that they pay for, like their contributions for regular health insurance, is not included in employees' taxable income.

Instability of Premiums. Although LTC insurers typically offer premiums that do not automatically increase as the policyholder grows older or experiences deteriorating health, state insurance regulators allow insurers to increase premiums for all holders of a given type of policy in a state (known as a rating class) if they find

⁸ Congressional Budget Office, *An Analysis of the President's Budgetary Proposals for Fiscal Year 2006* (March 2005). CBO estimated that the President's proposal to change the penalty period for illegal asset transfers would save \$3 billion over 10 years.

⁹ America's Health Insurance Plans, *Research Findings: Long-Term Care Insurance in 2002* (Washington, D.C.: AHIP, June 2004), p. 11.

¹⁰ America's Health Insurance Plans, *Long-Term Care Insurance in 2002*.

¹¹ Carmen DeNavas-Walt, Bernadette D. Proctor, and Robert J. Mills, *Income, Poverty, and Health Insurance Coverage in the United States: 2003*, Current Population Reports, Series P60-226 (Bureau of the Census, August 2004).

that they have miscalculated the expected cost of their claims. Some insurers have boosted premiums several times for that reason, leading many policyholders to cancel their coverage and in all likelihood deterring some potential purchasers from acquiring LTC coverage.¹² However, premiums may be stabilizing: a survey of top-selling LTC insurance carriers by the Health Insurance Association of America observed fairly steady premium levels from 1997 to 2001 after a sustained decline in average premiums from 1990 to 1996.¹³

Policyholders can obtain some protection against large jumps in premiums by purchasing nonforfeiture benefits with their policy. That feature enables policyholders who cancel their coverage to recoup from the insurer at least some of the premiums they have paid. Nevertheless, although policyholders might get a proportion of their premiums back, they do not receive the associated returns on the investment of that money.

Adverse Selection. The relative newness of the market for LTC insurance and the still fairly small number of policies being sold suggest that the market may be affected by adverse selection. People who purchase LTC insurance have greater expectations than nonpurchasers of using services in the future, and those greater expectations are not captured in the information that insurers collect as they enroll purchasers of their policies. If insurers believed that adverse selection was occurring, it might lead them to set premiums higher than a policyholder's health status would suggest so as to incorporate the greater likelihood that that policyholder would use the insurance. In turn, the higher premiums might deter people who would purchase coverage if the premiums reflected their relatively lower expectations of using LTC services.

One recent study suggests, however, that although adverse selection does exist in the LTC insurance market, it may not be producing higher overall claims costs.¹⁴ According to that study, the higher costs of policyholders with greater-than-average expectations of using services in the future are offset by the lower costs of policyholders who are averse to risk and whose probability of using services in the future is actually lower than the average for the population at large. Because of the market's youth, there are no clear data to resolve the question of adverse selection.

The Inability to Insure Against Certain Risks. Private LTC insurance may be unattractive to some consumers because it does not, in general, insure against the risk of significant price increases for long-term care. Most policies promise to provide contractually specified cash benefits in the event that a policyholder becomes impaired. To protect themselves against LTC price inflation, consumers can purchase a rider to their policy under which the policy's benefits grow at a specified rate each year (usually 5 percent); however, such riders offer no protection against additional costs if prices rise at a faster pace. Concerns about price increases of that kind are not unjustified: Medicaid's average reimbursement rates for nursing facilities grew at an average annual rate of 6.7 percent from 1979 to 2001.¹⁵ Over a 20-year period, a nursing facility benefit of \$100 per day in today's dollars would grow to \$265 per day with an annual inflation protection rider of 5 percent. But the benefit would need to grow to \$366 per day to keep up with a 6.7 percent annual growth rate, should costs continue to grow that fast in the future.

An additional risk is that a policy could become obsolete at some point in the future. LTC services, and the private insurance policies that cover such care, are steadily evolving as the LTC insurance market matures. That fluidity may give some consumers pause, and indeed, one prominent rating agency recommended in 2000 that people purchase LTC coverage no earlier than age 60 to avoid the problem of obsolescent coverage.¹⁶ Some consumers might also be reluctant to purchase LTC insurance if they believed that changes in public policy at some point could render their coverage obsolete.

The Availability of Medicaid. The availability of Medicaid poses a substantial disincentive for people considering the purchase of private long-term care insurance. Although Medicaid in general serves people with very low income and assets, it also

¹² Ann Davis, "Shaky Policy: Unexpected Rate Rises Jolt Elders Insured for Long-Term Care," *Wall Street Journal*, June 22, 2000, p. A1.

¹³ Susan A. Coronel, *Long-Term Care Insurance in 2000-2001* (Washington, D.C.: Health Insurance Association of America, January 2003).

¹⁴ Amy Finkelstein and Kathleen McGarry, *Private Information and its Effect on Market Equilibrium*, Working Paper No. 9957 (Cambridge, Mass.: National Bureau of Economic Research, September 2003).

¹⁵ Congressional Budget Office, *Financing Long-Term Care for the Elderly* (April 2004), p. 19.

¹⁶ See Weiss Ratings, Inc., *Long-Term Care Policies Vary Drastically in Cost to Consumers* (Palm Beach Gardens, Fla.: Weiss Ratings, Inc., April 5, 2000). Weiss Ratings evaluates the financial condition of insurers (including companies that sell life, health, property and casualty, and LTC insurance) as well as banks and savings and loan institutions.

provides assistance to people with impairments who exhaust all of their private sources of financing for their long-term care. Even people who have set aside significant savings may eventually become eligible for Medicaid assistance. In that way, Medicaid serves as an alternative form of insurance for people who do not have private coverage and who are impaired for a significant period. Indeed, Medicaid's impoverishment requirement may discourage people from saving because the less they have, the more quickly they will qualify for coverage. It also creates an incentive for people to give away or hide their assets so that they can qualify for Medicaid.

There are substantial drawbacks to Medicaid coverage for long-term care. As a means-tested program, Medicaid requires eligible applicants to rely on out-of-pocket spending until they use up all of their savings. In addition, because Medicaid generally pays lower fees for services than those paid by private payers, beneficiaries may not receive the same quality of care that private policyholders receive. In some states, moreover, Medicaid might not be as flexible in the types of services it covers as private insurance would be; a person who has private coverage would probably have a broader choice of providers and types of care than a Medicaid beneficiary would have.

Those drawbacks to Medicaid's coverage are balanced by features that some people might consider advantageous. Medicaid is free from the perspective of the beneficiary. In addition, Medicaid has a defined-benefit structure—that is, it covers a specified set of services. Private insurance, by contrast, only ensures that a policyholder will have a specified monetary benefit to pay for care. It does not guarantee that the money will be sufficient to pay for desired services.

Although Medicaid's coverage differs in some respects from that of private insurance, it may nevertheless reduce the demand for private policies. Indeed, one recent study found that the availability of Medicaid constitutes a substantial deterrent to the purchase of private insurance, even for people at relatively high income levels.¹⁷ Medicaid's rules for financial eligibility affect people's decisions to purchase private LTC insurance as well as how much insurance they buy because the rules offer a low-cost alternative (by allowing people to qualify for the program's benefits) to making personal financial preparations for possible future impairment. People who buy private insurance or accumulate savings substantially reduce the probability that they will ever qualify for Medicaid's benefits, thereby forgoing the value of the government-provided benefits that they might otherwise have obtained. Thus, the availability of Medicaid raises the perceived cost of purchasing private insurance or of saving. That increase is small for relatively wealthy people who have little likelihood of ever qualifying for Medicaid coverage, but it can be substantial for others.

Conclusion

Currently, elderly people finance LTC services from various sources, including both private resources and government programs. Incentives inherent in the current financing structure have led to increased reliance on and spending by government programs and may have discouraged people from relying on private resources (savings, private LTC insurance, and donated care) to prepare for potential future impairment. The demographic changes projected for the coming decades will bring increased demand for long-term care and heightened budgetary strains.

Chairman JOHNSON OF CONNECTICUT. Thank you very much. I would point out that that group on the bottom are exactly the group that the Medicare Modernization Act aimed at, and the urgency of passing the bill was really not the prescription drug portion of the bill but the policy changes that will enable us to meet the needs of the over-85 population, most of whom have multiple chronic illnesses, so hopefully we will be able to bend that uniformly, and help the appearance of that chart. In your testimony, Dr. Holtz-Eakin, you mentioned that a recent study found that the availability of Medicaid constitutes a substantial deterrent to the purchase of private insurance even for people a relatively high income levels. This issue of the take-up rate of long-term care insurance has been a long-term concern of mine as the chief sponsor of

¹⁷Brown and Finkelstein, *The Interaction of Public and Private Insurance*.

that initiative. I would think that the greater prevalence now of long-term care insurance being a cafeteria option and it being now part of a Federal program that we might be seeing some increase in uptake. The group insurance does lower the administrative cost, it has a lot of advantages, and we do see some greater activity. How much greater activity do we see there, and what evidence does this report give that the disadvantage to providing yourself with long-term care insurance, that just the existence of the Medicaid offers is something that affects people at all income levels and it does work as a substantial deterrent?

Mr. HOLTZ-EAKIN. There has been some modest uptake in private long-term care insurance. We would be happy to work with you to get the numbers pinned down. The broader question of what are the deterrents of the choice to take up long-term care insurance in the private sector has been divided in the research literature to supply kinds of issues associated with really what amounts to unfair pricing from an actuarial point of view, and then demand issues which is the fact that there may be alternatives out there, be it Medicaid, the most direct substitute, or Medicare to the extent that that it is a substitute, and as a result people don't buy long-term care insurance.

The literature is not definitive on this and I think that is always frustrating when you don't have a clean solution, but the most recent research is suggestive in that for those instances where it appears that the supply problems, the pricing is one which provides actuarially fair premiums, and that would not likely be the men, but some of the women in these studies looked at their insurance and do not take it up. That then leads you to suspect there must be something else that could provide the insurance as a substitute. And then former models clearly show that in the presence of a choice between Medicaid and private long-term care insurance the Medicaid would crowd out the private market. So, former models and actual real-world experience are a bit apart, but it is a suggestive collection in recent research.

Chairman JOHNSON OF CONNECTICUT. I am going to yield to Mr. Stark now as we proceed. But that has always been a mystery to me. And I think the existence of the very large contingent of people who make a living learning to help people to spend down to Medicaid ineligibility indicates that in the long-term care area Medicaid has lost that sort of negative aura that clearly in the children's health care it has taken us years to battle. So, that is interesting. Mr. Stark.

Mr. STARK. I would just like, doctor, to have you elaborate. In your report and I guess in your testimony, you are suggesting that the reason that long-term care insurance is doing well is because everybody's waiting for Medicaid to bail them out and that they are planning to cheat and hide assets and do those sorts of things. Could you elaborate whatever data or theories you have that say that people don't buy long-term care insurance because they are counting on Medicaid?

Mr. HOLTZ-EAKIN. As I mentioned in my response to the Chairwoman, there isn't a definitive study or set of research in this area.

Mr. STARK. Is there any study?

Mr. HOLTZ-EAKIN. There are. The two most recent studies are by Jeff Brown and Amy Finkelstein, and that—

Mr. STARK. That wasn't peer-reviewed but go ahead.

Mr. HOLTZ-EAKIN. That research does the following two things, roughly speaking. The first takes a look at a sample of actual policies and tries to determine the degree to which the premiums charged are actuarially fair or not, because clearly if buying a policy is an unfair bargain, people are not going to buy it. And their, on-average they are not actuarially fair, but the striking result is that they are far more fair, indeed probably roughly actuarially fairer for women, but take-up rates are the same. So, that is piece of evidence number one.

Mr. STARK. I guess what I want to hear though is why you are suggesting that it is Medicaid that keeps them from doing this because they think Medicaid is going to bail them out?

Mr. HOLTZ-EAKIN. It is far more conclusive—the suggestive evidence is that if it is not the pricing, then it must be the decision to buy, and presumably people value some sort of long-term care insurance. This looks to be an important financial risk. So, if you are not buying this insurance it could be because you have some other type of insurance. Medicaid is one—

Mr. STARK. What percentage of the Federal employees, let us say that people who are in the Federal Employee Health Benefit (FEHB) plan, what percentage of them buy long-term care insurance now under our Federal employee plan?

Mr. HOLTZ-EAKIN. I don't know that number off the top of my head, but I can certainly find out.

Mr. STARK. A small percent, 5 percent?

Chairman JOHNSON OF CONNECTICUT. Very small.

Mr. STARK. Very small. Now, most of these Federal employees know that they are going to have a fairly generous pension, right? They don't change that. In 30 years they will end up with 70, 80 percent of their 1-3. Most of the benefits that I see in the Federal long-term care have a maximum value of 100 grand, maybe 3 years 36,000 bucks a year. So, they are going to look at that and see if their pension is going to be anywhere near 50. I think they aren't going to get Medicaid, are they? Can you tell me a State where somebody with \$50,000 worth of income can qualify for Medicaid? Maybe I will move there.

Mr. HOLTZ-EAKIN. Well—

Mr. STARK. There aren't any. So, I just don't know who this person is that says that Medicaid will replace whatever responsibility they may have for building for their retirement, which I think people do, and if they can live comfortably in their retirement, many of them could figure out how to pay for—they aren't going to get Medicaid. I think that is a double dip and I am not sure it is fair, doctor, that is all. Absent any kind of studies, Medicaid is in enough trouble without having respected economists like yourself beating up on it. We are having trouble getting health care for little kids, and when experts like you begin to suggest that Medicaid is keeping us from getting long-term care insurance to the market, that borders on being a little bit irresponsible, not to the long-term care people—

Mr. HOLTZ-EAKIN. I take exception to that.

Mr. STARK. All right.

Mr. HOLTZ-EAKIN. I think that it is the responsibility of our office to examine all the potential interactions between the public sector and the private sector. It is well established that individuals will look at interactions between what their options are in the public sector and the private sector. As I have tried to make clear, I think a comprehensive review of the places that one would find—

Mr. STARK. I think you—

Mr. HOLTZ-EAKIN. —expenses.

Mr. STARK. —issues.

Mr. HOLTZ-EAKIN. I think we should comprehensively—

Mr. STARK. —abstinence training for high school students. That might bring up some interesting things that you would have a responsibility to report on.

Thank you, Madam Chair.

Chairman JOHNSON OF CONNECTICUT. Mr. McCrery.

Mr. MCCRERY. Thank you, Madam Chair.

Dr. Holtz-Eakin, we could spend a lot of time talking about why people aren't buying long-term care insurance. The fact is they aren't, at least not in very big numbers. Have you looked at—and I think you mentioned in your testimony that your projection for people purchasing long-term care insurance is not very optimistic. In other words, it is going to go up a little but not very much. Is that right?

Mr. HOLTZ-EAKIN. We don't have a formal projection for the take-up. We have a projection of the costs of care. The costs are growing. We currently have some long-term care, and we don't have an elaborate forecast of what would happen in, for example, to 2030 to the long-term care market. The question is, how would it evolve in the presence of more improved incentives?

Mr. MCCRERY. We provided some incentives in the past few years through the Tax Code. What has been the experience just in the last few years of people purchasing long-term care insurance? Has it gone up?

Mr. HOLTZ-EAKIN. I think it is up modestly, but I don't know the numbers off the top of my head. We can certainly give you the past couple of years.

Mr. MCCRERY. It would be interesting, Madam Chair, I think for us to explore a little more what the chances are of our being able to incentivize individuals to purchase private insurance for this purpose. I think you agree with me that that would be the most desirable solution to this problem, but clearly, what we have done so far hasn't worked. I am wondering if we could develop through some of our smart folks in government some conclusions as to how generous those incentives would have to be in order for people to purchase that. If we conclude that those incentives are so generous that we can't afford them, then obviously we have to look at elsewhere for a solution. I think this is an interesting discussion, but maybe our next panel, some of our next panelists will have some thoughts on this subject. Dr. Holtz-Eakin, what about Medicare's home health benefits? You mentioned that in your testimony, and how that has become kind of a de facto long-term care benefit for folks. Can you elaborate on that?

Mr. HOLTZ-EAKIN. For many individuals it does appear to be a substitute for Medicaid or some other form of long-term care insurance. To the extent that it will be of interest to directly control costs in that program, we have, for example, done a budget option where we studied it at a 10 percent co-pay per episode and showed the budget savings that came from that. If people perceive it to be similar to Medicaid, and if there is a genuine substitution of one kind of insurance for another, it could also fit into the larger outcomes we are seeing with choices of financing for long-term care costs. So, I do think it is important to look at these comprehensively and think about how they interact.

Mr. MCCRERY. Thank you.

Thank you, Madam Chair.

Chairman JOHNSON OF CONNECTICUT. Thank you.

Mr. Lewis?

Mr. LEWIS OF GEORGIA. Madam Chair, thank you very much. Thank you very much, Mr. Director, for being here today. In your written testimony you claim that Medicaid is a barrier to getting people to purchase long-term care insurance. You also said middle income people shelter their assets in order to qualify for Medicaid. However, you also said that there are drawbacks to Medicaid, like using all saving and limits choice. Now, with all of these drawbacks. With all of these drawbacks, wouldn't people want to avoid Medicaid? Isn't it possible that there are other reasons people don't buy long-term care insurance?

Mr. HOLTZ-EAKIN. Well, it is certainly the case that any of these decisions has many dimensions. So, it is neither the case that people don't purchase long-term care insurance exclusively because of the existence of Medicaid; neither would you view any difficulties in getting Medicaid as a deterrent from using it at all because in fact it is a wisely-used public program. Instead, the programs interact. It is the case that there is a large industry devoted to advising individuals about how to shelter their assets under Medicaid, and that while I think it is impossible to place a numerical estimate on the degree to which assets are sheltered, there is an enormous amount of smoke, and one would suspect that there is a fire. There are web pages devoted to calculators and how they shelter assets. There are web pages at Amazon.com showing the books on how to do it. So, we know that that is an aspect of the incentives presented by Medicaid, and it is a form of insurance that is available. As I have said several times, I don't think it is a panacea, it is not the exclusive solution to the problem for the long-term care market and may be the case that long-term care insurance in the private market is best suited for a fraction that is higher income, but they do interact and we simply wanted to highlight the potential for interaction.

Mr. LEWIS OF GEORGIA. Do you have evidence of people sheltering their resources or is this just based on limited evidence? Do you have data that would testify to the fact that we have wholesale sheltering, people hiding their resources?

Mr. HOLTZ-EAKIN. As I said, I don't—it is not a question of the sheltering, but there are—you can go to places that say, www.Medicaidhelp.com that gives you a calculator. You plug in your age and your assets and it tells you where you stand relative

to Medicaid and getting long-term care insurance. There are lots of books. There are well-known strategies, half-a-loaf strategies, where the moment you enter the Medicaid program you give away a fraction of your assets, half of them, and you get to shelter half very effectively with no risk. So, I don't know the net asset transfer that comes from that. I know that there is a lot of evidence of people thinking about those activities.

Mr. LEWIS OF GEORGIA. Let me just try and ask you this in another way, and maybe throw something else into here. As I see it, if there is someone going to a nursing home, Medicaid looks back 3 years to see if they have transferred any of their resources. If so, that person is disqualified from Medicaid benefits for a time. This means that in order to qualify for Medicaid, an applicant would have to have transferred their resources more than 3 years prior to doing long-term care service. This would take some kind of crystal ball for any of us, any of these seniors to know when they are going to need long-term care. Do any of us know? So, how can you prepare? Do we know in 2010 or sometime down the road we are going to need long-term care?

Mr. HOLTZ-EAKIN. Well, there is not a crystal ball, but it is the case that at the moment you enter the program you can shelter half without any risk.

Mr. LEWIS OF GEORGIA. That is what I am trying to ask, we don't know whether we are going to need it and then we don't know when, we don't know the date or the time. So, what does this seem to say, they must get rid of everything?

Mr. HOLTZ-EAKIN. What is going on—and the kinds of policies you might like to put in place. What is going on I think is a risk-free transfer of one half at the moment of entry. Three years in advance, no one has a crystal ball, there is some risk associated with that, there is no question. We know, for example, from the waiver application of the State of Connecticut, 30 percent of folks had undertaken some sort of asset transfer. So, there is evidence out there. As I said before, I don't think anyone has a firm numerical estimate of the pervasiveness and scale, but this is an activity that is provided—that the Medicaid program has provided an incentive to undertake.

Mr. LEWIS OF GEORGIA. Madam Chairman, I know my time is up. If I can have just a quick three seconds?

Chairman JOHNSON OF CONNECTICUT. Go ahead.

Mr. LEWIS OF GEORGIA. Mr. Director, you stated in your prepared report that Medicaid spending for home-based care for service was going faster than spending for institutional care. Could you give us I guess the nature of why? Most people would like to stay in their home and not go into a nursing home.

Mr. HOLTZ-EAKIN. If you divide costs into cost per person, more people—that seems largely to be driven by the entry of more beneficiaries into the home and community based care program, perhaps as a substitute for the informal care that had prevailed earlier because people would like to remain in their home.

Mr. LEWIS OF GEORGIA. Thank you.

Chairman JOHNSON OF CONNECTICUT. Thank you.

Mr. Johnson of Texas.

Mr. JOHNSON OF TEXAS. Madam Chairman, I would like to continue on that vein if I could. I think you are absolutely right that people are not buying insurance because of the reasons you state, and I just wonder—you point out again, and it has been stated two or three times that home health care under Medicare has become something of a defacto long-term health care benefit. What implications has this had on Medicare and how do home health benefits under Medicare and those provided under Medicaid relate to each other?

Mr. HOLTZ-EAKIN. Well, the implications for Medicare for 2004, the numbers that we presented today, the total outlays under Medicare are about \$32 billion. So, this is not an enormous share of the overall Medicare bill. Instead, it is about 16 percent of the financing for long-term care costs. It is an alternative to Medicaid, and, for that reason, I think it is probably best bought comprehensively in thinking about forward how are you going to do business.

Mr. JOHNSON OF TEXAS. Okay. Thank you. I don't have any further questions, Madam Chairman.

Mr. THOMPSON Thank you, Madam Chair, and thanks for holding this hearing. I want to—there are a couple of things that have already been asked. Specifically, the issue of the look back issue that Mr. Lewis mentioned. If you're still—you say if you go back 5 years as opposed to the three that the savings would be modest. So, and I want to stipulate that I think any effort to hide money or disposed of money to get away from paying your share is wrong. We ought to be able to figure out how to stop that if we can. But I just wonder how widespread the abuse is. If you add 2 years to the look back you only pick up modest savings.

Mr. HOLTZ-EAKIN. Our last answers are based on or discussions with the State-level Medicaid officials in charge of this. How we got the numbers associated with three versus five, I don't have off the top of my head, but I would be happy to work with you. We could walk through it with your staff.

Mr. THOMPSON. Well, we ought to try and figure out what is real and what is projected and not attainable, but at the same time figure out how to stop those practices from happening. On the home health care issue. It seems to me that is pretty inexpensive way to deal with the problem. I know in California, our in-home support services is about \$8,000 a year where facility care is about \$50,000 a year. So, that is a fairly substantial savings, and it seems to me we ought to be—and we know it is cheaper and to do in-home health care vis a vis some type of acute care. So, we probably should be looking at ways to expand that to help solve this problem.

Mr. HOLTZ-EAKIN. Certainly my message today—this happens to me all the time. I come. I talk about costs. There are some things that are worth it. Those are the benefits and that is certainly part of the picture. Designing this—I think the basic message is we have to pick things that make sense in a cost effectiveness send because, money will, in fact, be harder to come by going forward, and if we can find those policies that are most worth it, where the benefits are the highest, then that is the place to go.

Mr. THOMPSON. And then the other thing that has already been brought up and I don't want to beat a dead horse. But the

whole issue of tightening the Medicare eligibility to change behavior. I am skeptical of that thesis. And if you look back at the changes in Social Security in 1983, most economists will agree that benefactors realize a real decrease in benefits. So, using your theory, they would have saved more in order to deal with the decrease in benefits. But we know that that has not been the case. At the time that they '83 Social Security changes took place, the personal savings were about 11 percent of disposable income. And today, they are less than 2 percent. I think less than a percent and half. So, using that as a model would suggest that you can tighten these regulations or this eligibility all you want, but it is not going to in itself change the practices of individuals. And if you have any other data that suggest otherwise, I would like to see those.

Mr. HOLTZ-EAKIN. We will certainly work with you on that. Sure. I'm sympathetic to the notion that, as I said, that formal models are not the answer to all our policy questions—far from it. I am also sympathetic to the notion that explaining the U.S. savings rate is pretty hard. If I could explain the U.S. saving rate, I would be in a far better place than I am right now. But, there is I think a sensible approach to analyzing this important issue, which involves comprehensively surveying all the available sources of financing, comprehensively thinking about the incentives that the present, and, then to the extent possible, comparing the data—which is limited and is an issue—with the kinds of potential responses that incentives predict. I am with you on the notion that not all economic incentives turn out to be as powerful as economists might think, myself included. But that is ultimately a data base exercise.

Mr. THOMPSON. And I want to try and squeeze one more in. Is there some way that we can figure out the cost of Medicare expansion to include long-term benefits—kind of a menu. I know it already covers some things, and I am not suggesting that we move to expansion, but some folks are, and it may make sense. If there was a way to see a menu of what it would cost if we extended different benefits or how much for each benefit that we extended. That would be I think very helpful.

Mr. HOLTZ-EAKIN. Nothing would make me happier than to volunteer the staff's time. Why don't we figure out the—

[Laughter.]

Mr. THOMPSON. If looks could kill, you would be shot from behind. Thank you.

Chairman JOHNSON OF CONNECTICUT. Thank you, Mr. Thompson. Mr. Emanuel.

Mr. EMANUEL. Thank you, Mrs. Chair. With that answer, you may need a food taster at the next staff meeting. Let me ask you a question about your analysis on the partnership expansion. As I understand it, the whole notion of the Robert Wood Johnson—and I think there are about 10 States that do this. It was supposed to save money. And your analysis of the President's budget is that it actually cost Medicaid money. A, what was the basis of, I don't want it line by line, but what was the basis of why that is, and B, what do we got to do to get to the savings for Medicaid so the whole intention of this partnership was supposed to be a savings, not expenditure of greater resources.

Mr. HOLTZ-EAKIN. Well, two part answer. The first is that the analysis of the President's budget is economic changes from whatever the current is. So, to the extent that there were savings by instituting the program to begin with, that is already in the baseline. We are only looking at the expansion. With respect to the expansion, you can think of purchases coming from two sources: people who would have bought a private policy anyway and basically doesn't look any different, or those people who will come into this market, buy a partnership policy, and are new entrants and thus qualify for Medicaid for the first time, it is our expectation that the modest costs come from that group.

Mr. EMANUEL. Let me ask you based on the premise that the partnership should save money, do you think we will ever see that realization? Part of that whole premise—am I misunderstanding the premise?

Mr. HOLTZ-EAKIN. I guess compared to what. I am trying to figure out what—compared to what baseline. To the extent that the partnership policy and expansion of the type that, was proposed, those new people buying policies who ultimately qualify for Medicaid that will cost Medicaid money, because there will be new beneficiaries that would not have been there otherwise and extension of that on a regular basis. Now, that is one set of comparisons that you can make. A second set of comparisons might be what would a world look like with substantial private long-term care insurance, perhaps engendered by the partnership policies and with some pressures as a result on the delivery of services and savings rate there. That is a different question and not one that we have priced. I am sympathetic, but it is just past what that particular number would contain.

Chairman JOHNSON OF CONNECTICUT. Excuse me. Would the gentleman yield on this?

Mr. EMANUEL. Absolutely.

Chairman JOHNSON OF CONNECTICUT. And I'll take it on my turn. Partnership policies the insurance pays for the first 2 years of care, so what percentage of seniors as a whole use more than 2 years of nursing home care?

Mr. HOLTZ-EAKIN. I don't know. It is a number we will get back to you on.

Chairman JOHNSON OF CONNECTICUT. It is relatively small.

Mr. HOLTZ-EAKIN. It is relatively—

Chairman JOHNSON OF CONNECTICUT. Well, it is a sign that everybody who is bearing a partnership program is going to end up being—using Medicaid dollars is in my estimation—

Mr. HOLTZ-EAKIN. It's not an expansion of everybody. It is an expansion of the pool who will ultimately touch Medicaid dollars.

Chairman JOHNSON OF CONNECTICUT. And it is an expansion of a pool that won't touch Medicaid dollars until they have used 2 years of nursing home care, paid for by their insurance. So, that is a very different pool than just those who would be eligible for Medicaid, because it is those who will be eligible for Medicaid and need a third year of nursing home care. So, this is worth more conversation later.

Mr. HOLTZ-EAKIN. Certainly. You are right.

Chairman JOHNSON OF CONNECTICUT. I simply want to point out that I did not agree with the answer that you were providing to my colleague.

Mr. HOLTZ-EAKIN. Okay. We will be happy to work through the nuts and bolts of the estimate with you. I think the spiel of it, briefly and I won't oversell my expertise on the nuts and bolts, but these are large numbers to begin with so it is not as if everybody who touches this in the expansion is going straight on to Medicaid. There are these features that you pointed to, but it is the—the key features—it does make the net pool of people who have the potential to touch Medicaid larger because of the attractiveness of the policy. That is one of the features.

Mr. EMANUEL. I don't want to belabor a point and I look forward to when we do press this a little farther and have a discussion and obviously, you're right: it is what benchmark you are comparing it off of because it can change the picture. As I remember, the whole bells and whistles around the partnership was that there was going to be a savings, not a greater expenditure. And my only question is based on your analysis of the President's Budget, the partnership is A, costing more money on Medicaid rather than less; therefore, either we got sold a bag of goods as it relates to the bells and whistles on the partnership, or we did not understand it when we were dealing with it, and then we can press this point later on. We don't have to use a lot of time here. And maybe you have maybe a one staff person that doesn't mind a lot of work gave you answer right there.

Chairman JOHNSON OF CONNECTICUT. We will also have a member of the panel later who has done a lot of work in the partnership area.

Mr. EMANUEL. Oh. That is fine.

Chairman JOHNSON OF CONNECTICUT. It is difficult in the estimating area because there are only four States actually that have the right to do this. So, nobody can develop a product that could go nationwide.

Mr. EMANUEL. Okay. Thank you.

Chairman JOHNSON OF CONNECTICUT. Thank you. Mr. Pomeroy is not a Member of the Subcommittee, but he has an high interest I know these areas, and I am going to invite him to question.

Mr. HOLTZ-EAKIN. Could I speak on this issue about the partnerships and make two points,. One big picture point which is I hope the spirit of the opening remarks was conveyed that there is a total cost to the demand or these services that would be incurred by the economy and the financing issue is about figuring out who bears them. So, savings in one piece, be they Medicaid—it may not necessarily mean that the overall bill is lower. That was my point.

Chairman JOHNSON OF CONNECTICUT. Right. Okay.

Mr. HOLTZ-EAKIN. Try to say more clearly. Number two, on the partnerships, the key leading to big savings is to get large increases in new purchasers, and it was our judgment that the particular proposal we looked at would have incremental new purchasers that were not large, but instead we would really have just a big shift of the base, and that we the source of the cost estimate.

And I am happy to get us together and work through the details on it.

Mr. EMANUEL. Can I—you mind if I? Or you want to move on? Chairman JOHNSON OF CONNECTICUT. Well, can you make it brief? I did interrupt you so.

Mr. EMANUEL. No. I'll make it—

Chairman JOHNSON OF CONNECTICUT. Sorry.

Mr. HOLTZ-EAKIN. If that is the basis and the premises and the tipping point is you are looking for scale, and you don't have the scale, and so, therefore, it is going to cost Medicaid more money and until we do this on the scale to get an economy of scale and the efficiencies out of it. Basically, with four States and so forth, it is going to cost Medicaid more money and it has to be a program that is expanded nationwide or bigger.

Mr. EMANUEL. So, we can certainly work with you and give you a feel for how that looks.

Chairman JOHNSON OF CONNECTICUT. Well, let us leave this question open, because I think if you talk to some of the States where they have used it, we might get a different answer.

Mr. Pomeroy.

Mr. POMEROY. Well, Madam Chair, thank you so much for letting me see in this hearing. I got some data from the States themselves directly on the point. California issued 72,683; enforced 61,273, in claim 735, exhausted 86. Exhausted and assessed Medicaid 24. To me that's a very, very positive ratio. It is similarly with like to the other four States. Connecticut issued 36,613; exhausted 21. Indiana issued 32,800; exhausted 16 I think there is—these are the data report by the States themselves. I think unlike a lot of long-term care insurance issues, we have data here—10 years of records from the States themselves and I am convinced that it is very positive; that people are laying private third party protection is protecting their assets and they are not following into Medicaid eligibility. I also think for those that say, well, that is just for those very affluent households that never would have hit Medicaid eligibility, the dollar for dollar coverage model is one that can be priced for—as limited a time as one year. It is much affordable, and it protects assets dollar for dollar of third-party coverage. I think we have an experiment here that is working. We have got—I think with the States of California, Connecticut, Indiana, and New York. We have a body that we can really look at so it is not just conjecture or philosophy. We actually have numbers we can draw conclusions from. Dr. Holtz-Eakin, is that your brief?

Mr. HOLTZ-EAKIN. It is certainly the case that that tells you performance in the presence of the partnership program. The question from the point of view of cost effectiveness is what would performance had been in the absence. That is the unknowable and in those circumstances. In other States, it is the reverse. You don't have the program, you ask what it would like in the presence of it. The intricacy of doing the cost estimates on these and evaluating the President's budget and other things is, in fact, comparing both. And so you never get to see both. You have one that we get to see in your case, and we ask what it would have looked like for Medicaid in the absence of the partnership program. This strikes me as of the same character as the questions that Mr. Emanuel

and Congresswoman Johnson had. I would be happy to sit and work with all of you.

Mr. POMEROY. And the Chairwoman as been very gracious in giving me time here to make a point. I would just ask you looking at what we've coming at us in terms of increased long-term care expenses, and the need, the desperate need, to try and get more private pay dollars into this mix. Is long-term care an insurable risk?

Mr. HOLTZ-EAKIN. The question I think—the answer of course, is yes from the broad point of view of the economy as a whole. You can spread the risks of those expenses. The question is whether the private market in isolation can they handle that? The next step would be are there particular regulatory or other government policies that we'll need to supplement a private market to make it work, or is it something that simply will not function in the absence of the government being the entity that spreads the risk. I think it is about that, and I don't think there is definitive answer, and I think this is the source of the interesting. The partnership program, which is the interaction between Medicaid and private long-term care insurance. It is the source of the interest more generally in the small scale, the current long-term care market.

Mr. POMEROY. I'll allow you it is an insurable risk, and that viewed not on the micro—not on the macro, but on the micro for an individual household that doesn't want to face just spend down to get Medicaid eligibility it can be viable risk protection tool. Now, admittedly, we need to advance this topic, but I don't think that when an individual household has the kind of cost exposure that long-term care brings them, we can afford to be just dismissive of this as something that can never work. Indeed, we've got now plenty of market data that I think suggests this can be a valuable protection to families and you can have sufficient consumer protection, so they are getting something meaningful for their premium dollar. I yield back, Madam Chair.

Chairman JOHNSON OF CONNECTICUT. Thank you very much, Mr. Pomeroy. We will get together and discuss this at greater length after this panel and in the course of these deliberations. But we have all recognized and we all recognize in our daily life that the performance of a market depends in part on the evaluation of value. And as you pointed out and several others would point out in their testimony, many people don't evaluate the current policies as offering very much value. But these partnership policies offer a different value. And they have provided particularly to modest income families a cheaper product that guarantees them the right to pass some inheritance on to their children and these are not big savers who have any other inheritance.

So, it is worth looking at the motivation, at the structure of the product, and, therefore at the nature of the savings or cost to the system. So, we look forward to working with you on that. Thank you very much, Dr. Holtz-Eakin. We appreciate your being here today. And now we will call the next panel forward altogether. And we will start with Dr. Gerety. I numerated your—the institutions that you represent as I had my introductory remarks, but as you sit down, Dr. Gerety is the Professor of Medicine, Geriatrics and Extended Care, the University of Texas in San Antonio, and rep-

represents the Geriatric Society. Buck Stinson is with Genworth Financial. Mike Meiners is from George Mason University, and Dr. Gehm represents the Lutheran Homes from Michigan. And we have been joined—by Dr. Feder has been before us before and we welcome you back. And we have been joined by our Committee Member, Mr. Camp, whose plane just arrived from Michigan, and I would like to recognize him.

Mr. CAMP. Thank you. I just wanted to welcome Mr. Gehm from Michigan and not from my district, but from an area near my district, and I wanted to thank him for all the good work that Lutheran homes does and to welcome him to the Committee and just to mention I look forward to your testimony.

Chairman JOHNSON OF CONNECTICUT. Thank you, Gary. Dr. Gerety, you probably are familiar you have 5 minutes. The yellow light will remind as you are coming to the end and red light will indicate when the 5 minutes is up, and your entire statement will be included in the record. If you have trouble seeing it and you all sort of get the picture from the rest. They'll be nodding. Thank you for being with us.

**STATEMENT OF MEGHAN GERETY, PROFESSOR OF MEDICINE,
GERIATRICS AND EXTENDED CARE, UNIVERSITY OF TEXAS,
HEALTH SCIENCE CENTER AT SAN ANTONIO, SAN ANTONIO,
TEXAS**

Dr. GERETY. Members of the Subcommittee. You have already introduced me and my title, so I won't repeat that. But I will tell you that I am a geriatrician, and that geriatricians are primary care oriented physicians who do at least 1 year of additional training after initial specialty certification. We specialize in the care of older persons and are experts in the delivery of care across all settings, but particularly in long-term care settings. Today as you are discussing long-term care, I think it is important that we recognize that long-term care cannot be defined as a list of settings or a defined set of services. And it is also not possible to accurately predict a person's long-term care choices based simply on a knowledge of his or her diseases or functioning. In addition to these factors, one has to have a comprehensive picture of an older person, both their social resources, psychological states and their personal preferences. Too often today, our system creates a gap between medical services and the essential non-medical services that are part of long-term care. In long-term care, these services are inextricably intertwined and are most effective when delivered together.

Today our long-term care system is a fragmented patchwork of payers, providers, settings and formal and informal care. And too often this results in extra costs and poor outcomes, and I would like to illustrate this for you with an example, which is something that I see virtually on a daily basis in my practice. An 88-year-old woman who lives at home. She falls. She breaks her hip. She is admitted to the acute care hospital, has a hip repair, and following that she is transferred to a skilled nursing facility where Medicare will pay for the first 21 days of her benefit without a significant co-pay on her part. At the conclusion of her therapy unfortunately, she hasn't gained sufficient independence to be able to return home. Now, she could go home with extensive—with some sup-

portive services in the home, but Medicare's home health benefit only pays for an average of 42 days of care, and most of those visits are not skilled but rather unskilled. So, she does qualify for Medicaid and remains in the nursing home. Several months later, she develops a urinary tract infection requiring IV fluids and IV antibiotics. Medicaid won't pay for that in the nursing home, but Medicare will in the hospitals. So, she returns there to the hospital with all of its associated risks and potential complications.

This is a sort of payment driven kind of chaotic care that is played out thousands of times every day in this country. When integrated properly, however, long-term care services can serve many purposes, completing care from hospitals, smoothing transitions between care settings, providing relief to care givers and indeed potentially preventing hospitalizations and emergency room services. That structure today, however, this long-term care system has a long way to go to fill its potential. And I believe as we face my aging—I am one of the baby boomers—we have got to modernize the system to meet our needs. I also believe that long-term care today is undergoing a transformation that acute care underwent a couple decades ago. Payment systems are modernizing to become resource-based rather than charge-based. But as acute care was then, long-term care still is now largely institutionally based. And providers and consumers now understand that what we once thought was safe to provide within only in institutional walls can be as safely potentially more economically and more comfortably provided at home. But long-term care's financing and eligibility has not caught up with this. It has not adopted the change in public's preferences or to the expanded array of long-term care services, settings, and technology. We believe that public policy must adopt a shift in its paradigm that acknowledges these changes, updating and reforming the long-term care system of today. We also believe that system inequities can be addressed by a series of fixes that should be carefully studied and considered.

First, public and private financing systems should develop coherent methods to allocate resources across institutional and non-institutional programs. In doing so, we believe services should be targeted to high-risk populations and titrated according to need, potential benefit, and consumer preference. Second, while Medicaid provides permanently only a safety net, we must find a more comprehensive way to meet long-term care needs. As you know, a woman age 65 today can expect to live about 20 more years; five of those or more will be spent with some disability and she has about 40 percent chance of spending some time in a nursing home. Now private long-term care insurance vehicles are increasing in number, but they are not very accessible to people with modest means. And premiums as unpredictable over the long term, causing some people to drop coverage at an age when they most need it. I myself have not purchased long-term care insurance, because I find the policy options not as valuable as I might think and because it is difficult, in fact, to calculate the risks and benefits that I would receive from those policies. Third, prescription of long-term care should be preceded by a comprehensive assessment prior to long-term care services.

Too often today, care is not—is delivered based on eligibility, not on a thoughtful care plan that elicits preferences, assesses need and establishes goals. And although long-term care comprises many disciplines, typically these disciplines are not integrated into a team that provides compassionate competent care. And as we move toward—am I in the red? Okay. I'm sorry. I would just say that I believe that this Committee and the House itself faces many challenges in trying to address long-term care: the challenge of trying to marry public and private financing, the challenge to make insurance for long-term care sensible and accessible and affordable, and the challenge of creating a workforce that is going to be able to provide care for these people. So, I thank you for the opportunity to participate today, and will close my remarks.

[The prepared statement of Dr. Gerety follows:]

Statement of Meghan Gerety, M.D., Professor of Medicine, Geriatrics and Extended Care, University of Texas, Health Science Center at San Antonio, San Antonio, Texas

Chairman Johnson, Congressman Stark and Members of the Subcommittee. Thank you for inviting me to testify today on a critical issue—long term care.

I am Dr. Meghan Gerety, a Board certified geriatrician and Professor of Medicine at the University of Texas Health Sciences Center at San Antonio and Associate Chief of Staff and Service Line Manager for Geriatrics and Extended Care at the South Texas Veterans Health Care System. I have had a geriatric practice for twenty years and have practiced and overseen health care in virtually every form of long term care. I have experience in surveying nursing homes, serving as a nursing home and home care medical director and have provided care to many persons in assisted living facilities.

I currently serve as President of the American Geriatrics Society. I appreciate the opportunity to participate in today's hearing on behalf of the American Geriatrics Society (AGS), an organization of over 7,000 geriatricians and other health care professionals dedicated to the care of older adults.

Geriatricians are physicians who specialize in caring for older persons in all settings of care. Geriatric medicine promotes preventive care and care management that helps patients maintain functional independence in performing daily activities and improves their overall quality of life. When maintenance of function is not possible, geriatricians seek to optimize quality of life in the context of limited functioning. With an interdisciplinary approach to medicine, geriatricians typically work with a coordinated team of other providers, caring for the most complex and frail of the elderly population.

Many geriatricians spend part or all of their time in long term care settings, including a broad range of medical, social, personal care and supportive services provided to persons with limitations in basic and instrumental activities of daily living (ADLs), such as bathing, dressing, or eating. It is important to recognize that we cannot define long term care as a list of settings or as a set of defined services. Equally important to understand, it is not possible to accurately predict a person's long term care choices by knowing his or her diseases, functional status, or cognitive abilities. Instead, one must have a comprehensive picture not only of these factors but also social resources (the scope and depth of the caregiving network), psychological states, and personal preferences. At the present time, our current, fragmented long term care system too often creates an artificial gap between the medical components of long term care and the equally as important non-medical components. In a long term care population, medical needs and supportive care are inextricably intertwined.

Today I will focus on the following areas:

- Long term care: The past and present
- Long term care policy: How we allocate resources
- Comprehensive assessment: A method to assess needs
- Attaining an adequate long term care workforce
- Long term care: Costly but often inefficient
- Modernization: Using successful intervention studies to shape long-term care
- The Baby Boomers and the future

Long term care—The Past and Present

When employed properly, long term care services can serve many purposes. Long term care can complete essential medical care begun in acute care hospitals, smooth the transitions between hospital and nursing home or nursing home to home, fill unmet need for basic or instrumental activities of daily living, defer the need for institutional care, provide relief to caregivers, and prevent unnecessary hospitalizations and emergency room visits. As it is structured in our nation, however, long term care has yet to fulfill its potential. As we face the demographic imperative of the aging baby boomers (a group to which I proudly belong) it is imperative that we organize long term care to fulfill its potential over the next 40 years after which most of us will be gone and need will decline.

Our current long term care system is not well designed to provide ongoing support of chronically ill, functionally impaired persons. A woman reaching age 65 can now expect almost twenty additional years of life, but over five of those years are likely to be spent with some degree of disability, and she has a 40 percent chance of spending some time in a nursing home. Interestingly, despite an increase in the number of aged persons, nursing home use has remained relatively static during the last decade, a fact which may in part be explained by older persons preferences for other long term care settings such as assisted living and in part by slight declines in disability rates in old age.

Today, unpaid family caregivers provide most long term care informally, but many persons must rely on formal or paid care as a supplement or a sole source of care. Unfortunately, our nation's system of long term care is neither integrated nor comprehensive, but rather a fragmented patchwork of payers, providers and settings, government and private programs, and formal (paid) and informal (unpaid) caregivers. This mix of programs provides varying services and often has confusing and differing eligibility criteria, enrollment processes, access points and financing systems. Access to long term care varies significantly from state to state and from payer to payer. Today, we face the challenge of modernizing care to include proven methods, accommodate consumer expectations, incorporate new technologies, and maximizing the partnership between private and public sources of funding.

This is best explained through a common patient example. An 88 year-old woman lives in her home, falls and breaks her hip. She is sent to the hospital where Medicare covers her care. Following her surgery, she is sent to a nursing home for rehabilitation, also covered by Medicare. However, when her therapy is completed she is less independent and therefore cannot return to her home. She qualifies for Medicaid coverage in the nursing facility, but NOT for enhanced services that would allow her to return safely home. After several months at the nursing home, she develops a urinary tract infection and needs antibiotics and IV therapy. Unfortunately, Medicaid will not cover this service in the nursing home, but Medicare will cover it in the hospital. The woman is transferred back to the hospital. This chaotic, payment-driven approach to care is played out thousands of times each day throughout the country. It does not serve the patient well.

Long term care today is undergoing a transformation similar to that experienced by acute care over the last two decades. As acute care was, long term care today is still largely provided in institutional settings with only a few states spending more on home—and community-based care than on nursing homes. Many long term care payment systems have become resource-based rather than charge-based, forcing providers to carefully evaluate the mix, intensity and duration of services that can be offered, resulting in marked variations in service availability and quality across the nation.

At the same time, providers and consumers have come to understand that services once thought to be safe only within institutional walls can be safely, more economically, and more comfortably provided in home—and community-based settings. Consumers of care, their families and caregivers are no longer satisfied accepting the settings and services that some agency or authority prescribes. Instead, they expect services that fill the needs they perceive and services that are more easily consumer-directed or modified. Long term care financing and eligibility systems have not yet adapted to changes in the public's attitudes or to the expanded array of long term care settings, services and technologies. In many ways, while long term care delivery has evolved, our public policy and financing have remained static. Public policy must adopt a paradigm shift that acknowledges these changes; updating and reforming the long term care system of today.

Long term care Policy: How we allocate resources

At the present time, publicly and privately funded long term care systems do not have a coherent method of allocating resources across programs or targeting services according to an individual's need or potential benefit. Instead, any person who satis-

fies eligibility criteria is entitled to receive a service package that often is not matched to need or titrated to potential benefit. Despite their recognition of the importance of institutional and home- and community-based long term care services, there is no consensus among private or public payers about the role of these services, the population to which they should be targeted, or the scope and duration of services that should be provided. Long term care services are popular with consumers and have been codified in statute and regulation as entitlements to eligible persons who have severe functional impairments, skilled needs, or who are at risk for institutionalization. The status quo has become ingrained and made changes in eligibility for, targeting of, or defined limitations of scope or amount of long term care difficult to propose or evaluate.

One interesting approach to allocation of long term care resources, as proposed by William Weissert in a recent *Journal of Aging and Health* article, would be to characterize the eligible long term care population with respect to different types of risk, e.g., risk of hospitalization, functional decline and/or institutionalization. Each of these risk profiles may benefit from different intensities and mixes of services. For instance, those at risk of hospitalization may require more nursing than unskilled care. The plan of care might include a focus on patient/caregiver education and illness management. In contrast, moderately frail persons at risk for functional decline may benefit from rehabilitation-oriented interventions that restore function and lower risk for decline or institutionalization. Persons at the highest risk for institutionalization (those with more functional disabilities who require heavier care) may be able to defer institutionalization if more home care provides sufficient unskilled services to meet functional needs.

First, under this system, the government would establish clear financing for services for persons with long term care needs. Once eligibility for services has been established, a systematic method could be used to 'titrate' services on the basis of risk of adverse outcomes, effectiveness of the in-home services of mitigating the risk, and the value (or cost) of the outcome to be avoided. Long term care providers could be provided with an individual patient's profile of estimated risks of death, functional decline, hospitalization and nursing home admission. A projected budget could be developed based on each person's risk of each of the outcomes and a plan of care developed within that budget. For instance, persons at high risk of institutionalization (the most costly outcome) would have a higher monthly budget for care than persons at low risk. A person with high risk of all of the adverse outcomes: hospitalization, institutionalization, functional decline and death would have the highest budget.

Our current long term care system would make such a system difficult to propose or to evaluate. Most significantly, the current system utilizes a cliff approach whereby Medicaid covers the majority of long term-care services for persons in nursing homes. Those who do not meet the eligibility criteria for spend down or the limited Medicare benefits do not receive government-financed long term care. Medicaid is not a satisfactory solution. It's a critical safety net, but we need to find a more comprehensive and even way to meet the long term care needs so the burden doesn't fall to the states. We must change this approach through the development of a meaningful long term care benefit for all that need it. The reallocation of resources discussed above could help defray some of the costs of such a benefit.

Comprehensive assessment—a method to assess needs

The AGS believes that a comprehensive assessment by qualified providers of geriatric care should precede the prescription of long term care. Often long term care services are allocated according to eligibility, rather than being based on a care plan derived from a comprehensive assessment that evaluates needs, elicits preferences, and establishes goals. For any person, it is very difficult to create a package of long term care services that addresses both medically necessary care for illnesses and supportive care for the functional deficits that are the consequence of disease. The package should also address personal preferences for care design.

The ability to perform assessment is limited by the different eligibility criteria and different methods of resource allocation employed by the States and the federal government. Medicare provides short-term nursing home care for persons recovering from acute illness and injury and provides medically necessary skilled home health care services to homebound Medicare beneficiaries. Personal care and homemaker services are restricted to situations in which they are incident to the skilled care needs and in cases where they facilitate treatment or to maintain health. So, Medicare home care largely focuses on medical needs and does not support the functional needs that are present in many persons requiring long-term care. States provide nursing home care for very low income persons who meet minimum functional criteria. Access to Medicaid funded alternatives to nursing home care, such as in-home

personal care or chore services, adult day health care or care in assisted living settings is highly variable from State to State. Hence a person who requires both skilled care and personal care must rely on a patchwork of programs that are not integrated, not based on identified needs or treatment goals. Too often, the program fragmentation deters appropriate assessment to promote the highest level of quality care and patient choice.

Long term care—An adequate workforce

We are faced with growing workforce shortages in all long term care settings. The AGS highly values direct caregivers in our nation's nursing homes, home care agencies and other long term care settings. Not only must they have the requisite knowledge and skills, but also their attitudes while delivering hands-on care can influence the success of care and affect quality of life for vulnerable elders. Compassionate, competent care must be our goal.

National policy and action will be required to create and maintain a workforce qualified to deliver skilled, competent compassionate geriatric care. There is already a shortage of physicians, nurses, social workers, and personal care providers who are trained in geriatric care. Unless action is taken to meet future need, drastic shortages will occur over the next decade. Our current long term care financing system is not designed to support a workforce sufficient in numbers, skills, stability, and commitment to geriatric care. To increase recruitment into geriatric disciplines, trainees must envision a bright future in geriatric care, have role models who enjoy their work and feel satisfied with their lifestyle. Given the current low recruitment rates, measures to "jump-start" recruitment into the geriatrics disciplines are justified and are urgently needed. The measures should include loan-repayment for geriatric trainees and support for advanced fellowships to train geriatricians in research, administrative, and educational skills.

Long term care is costly but often ineffective

About 10 million people in the U.S. need long term care, with about two-thirds of this population comprised of the elderly. Most of these individuals live in the home and community, but as their needs progress they may require long term nursing home care. According to the Centers for Medicare and Medicaid Services (CMS), national health expenditures for nursing home and home care were approximately \$139 billion dollars in 2002. Of that cost, approximately 55% is funded by the Federal and State Governments, 32% comes from out of pocket payments by consumers and 11% from private insurance. Although long term care insurance vehicles are increasing in number, a relatively small number of individuals have purchased such insurance.

Long term care insurance is not yet a viable option for many Americans. Private options tend to be less appropriate for those with modest means. Tax incentives for private long term care insurance primarily benefit the higher income. Additionally, premiums are often unpredictable over the long term. Long term care insurance premiums often increase dramatically as individuals age, meaning that people drop their policies just when they need them most. In fact, as a baby boomer and a geriatrician I have neglected to purchase a long term care policy because it is of limited value.

Despite these large expenditures described above, our fragmented system is inefficient, costly and lead to poor outcomes. Lack of coordination among settings and providers of care is a serious problem. Often there is inadequate transmission of information among providers, inadequate assessment of patient needs, poor care during transitions, and both under- and over-medication and health care utilization. Vulnerable persons often find themselves in long term care programs that use a 'one size fits all' approach where services are not matched to their needs or available in a timely fashion when need arises. The absence of flexibility in long term care programs poses a barrier to 'just in time care' which has the potential to prevent hospitalization or emergency room care.

The current system lacks proper incentives for promoting alternative delivery systems. For instance, many consumers have indicated a preference for care in the home and community. But, our current system of financing has a strong institutional bias. While the majority of persons with long term care needs (83 percent) live in the community, 78 percent of their help is from unpaid sources such as family and friends. Government financing as well as long term care insurance favors institutional settings. Congress should promote alternative delivery systems, such as early intervention and care management in nursing homes and the community, as well as greater use of home and community based care when appropriate.

The long term care system needs modernization and we urge Congress to thoughtfully consider these issues before enacting sweeping change in long term care pro-

grams. Improvement in the long term care delivery systems requires innovation and investment in development and testing of new models of care. We urge Congress to fund evaluation of new models of long term care and use the results to modernize the system.

Modernization: Using successful intervention studies to shape long term care

To achieve improvements in functioning and achieve reductions in avoidable health care utilization, long term care programs must have the flexibility to pattern themselves after proven interventions. The most effective models of care incorporate coordinated interdisciplinary team care. Although most nursing homes and home and community-based services are delivered under a plan of care approved by a physician, there is no real integration of health care professionals and personal care providers into a functioning interdisciplinary team that coordinates medical, social, rehabilitative, and other services. Case management models that use either nursing or social work personnel that are not members of integrated teams do not appear to either avoid costs or promote function. In the last decade, numerous examples of models of care that are characterized by integrated interdisciplinary teams have emerged. Policy makers in a position to influence the direction of home and community based services may wish to incorporate lessons learned from these trials.

One model of care is based on comprehensive geriatric assessment. In this model an integrated interdisciplinary team assesses the patient and, in consultation with the patient and caregiver, develops a plan of care. Part or all of the assessment may be conducted at home and home visits may be a part of the intervention.

A different and successful model of care targets short-term home care services not toward meeting needs for ADL support or skilled care, but rather to the mitigation of specific risks or conditions. An interdisciplinary assessment followed by a twelve-week intervention to reduce risk of falls was highly successful in reducing fall risk by almost one-third. A highly focused short-term rehabilitation intervention in the home has been shown to significantly reduce the risk of functional decline in persons who are only moderately frail and have not yet developed significant ADL disability. These interventions suggest that highly focused, intensive, short-term, home-based care can be successful in addressing common geriatric conditions and preventing functional decline, often in persons who would not meet either skilled need or disability criteria for home and community based long term care. Despite these positive outcomes, today's long term care system is not structured to permit such uses of home care or rehabilitation services.

Long term care and Baby Boomers—The Future

Long term care needs will explode in the next few decades as baby boomers like me age. Baby boomers are less likely to be satisfied with a narrow range of long term care programs or to be forced into one size fits all programs like traditional nursing home or home care. We are informed consumers and expect to be able to pick and choose among services to select those that we feel may best meet our needs. Indeed the long term care marketplace is evolving quickly and providing an large array of available services: assisted living, retirement communities, personal assistants, shopping and transportation services, personal care homes among others. Baby boomers have increasing sophistication about program characteristics such as quality indicators, and are willing to embrace new technologies such as telehealth.

The challenge to today's policy makers will be how to most effectively marry public and private funding for long term care. How can we encourage the purchase of long term care insurance? What is the optimum cost-sharing methodology that will permit access to necessary care, encourage participation of families and caregivers in care, and discourage over-utilization? What public policies will support the development and maintenance of a workforce of providers highly skilled in geriatric care? What set of regulations and policies will give long term care providers the flexibility to target resources according to need and to potential benefit? What is the appropriate mix of provider directed and consumer directed care? All of these questions will need careful deliberation by public and private entities as we move to modernize the system.

The American Geriatrics Society would like to work with the Subcommittee to resolve the issues these issues. We thank you for including us in today's important hearing.

Chairman JOHNSON OF CONNECTICUT. Thank you very much, Dr. Gerety. Mr. Stinson.

STATEMENT OF BUCK STINSON, PRESIDENT OF LONG TERM CARE DIVISION, GOVERNMENT RELATIONS, GENWORTH FINANCIAL

Mr. STINSON. Thank you, Mrs. Johnson. Distinguished Members of the Committee, thank you for inviting Genworth Financial to testify at today's hearing. We believe that long-term care is an often overlooked, yet critically important Federal policy issue and are pleased that you have decided to have an open discussion about our Nation's long-term care needs. I am the President of Genworth Financial's Long Term Care Insurance Division. Genworth Financial is a Richmond, Virginia based company which provides life, health, retirement, and mortgage insurance products to more than 15 million customers in 22 countries. We are the largest and most experienced long-term care insurance provider in the country, with more than 30 years experience and more than \$500 million in claims being paid every year.

We will submit more extensive information in our written testimony to the Committee, but for now I think it would be most helpful if I touch on a couple of the populations that we have learned over the years and what we think it means to long-term care marketplace. As a private long-term care insurance company, we take our job very seriously. We believe that we provide policies that protect people from potentially catastrophic consequences and allow them access to quality care environments. The expected growth in the number of people needing long-term care is staggering. Based on Genworth's unique 30 years of long-term insurance claims history, 60 percent of those reaching age 65 use long-term care at some point in their lives. There are more than 6.2 million Americans that own long-term care insurance today. Since 1996, the average age of purchase of long-term care insurance has radically dropped 10 years, from age 69 to age 59. This customer is married and likely to be college educated. Where our customer used to be post-retirement, today's customers are baby boomers who purchased the product as part of a larger financial plan.

The long-term care insurance market has evolved from nursing home only to one that offers flexible care options and numerous consumer protections. For example, of the top long-term care insurance salaries, coverage now includes flexible plans covering nursing homes, assisted living facilities, home health care, hospice care, and respite care; strict adherence to consumer protections in line with HIPA and the National Association of Insurance Commissioners (NAIC); benefits including case management services, home care, or chore services; coverage of some medical equipment; survivor benefits and care giver training. Due to consumer interest in limited pay policies, some companies offer these types of policies as well in different variations. For example, single pay, 10 pay, or pay to 65. Benefits through policies are triggered when the policyholder has cognitive impairment, as an example suffering from Alzheimer's or they need assistance in performing two or more activities of daily living, such as bathing or dressing. Plans are guaranteed renewable, meaning that the insurer cannot change the terms of the policy coverage as long as the policy holder continues to pay the premium.

Rates cannot be raised without approval from the State Departments of Insurance. Coverage also includes a 30-day free look period, and some companies offer a return of premium feature that allows the refunding of premiums paid if the policy ever dies before a certain age. We believe that over the time the long-term care insurance market will continue to expand as a result of aging demographics, increasing health care and nursing care cost, growing awareness of the limitations of government programs, and increasing public awareness of the benefits of private long-term care insurance. However, more must be done. We believe that a public education effort must be a critical component of the expanding awareness of the true cost and likelihood of long-term care needs. Many non-buyers mistakenly believe that their health insurance or Medicare provides coverage for long-term care. Generally speaking long-term care is very expensive. Depleting the perspective according to a 2004 Genworth Study on the cost of care, the average nursing in the United States cost \$65,200 per year. Yet only 7 percent of seniors have said enough money to cover even 1 year of nursing home care.

Assisted living facilities cost on average \$28,800 per year. There is no magic wind that will solve the long-term financing problems that are looming for millions of Americans. In the end, many different approaches will have to be applied if we are to solve the problem. We believe it is important for private industry to be a part of the solution. Two partial solutions that we urge the Subcommittee to explore are tax incentives for long-term care insurance and public education. A great example of an effective awareness campaign is the recent Department of Health and Human Services (HHS) and Center for Medicare and Medicaid Services (CMS) "Own Your Future" program, which was launched earlier this year and in five pilot States—Virginia, Nevada, Arkansas, Idaho, and New Jersey. We believe this type of program—this is the type of program that should be expanded nationwide. Madam Chairwoman, we want you to know that we applaud your efforts to bring attention to this issue from these hearings today, to the legislation that you have proposed to enact an above the line tax deduction for long-term care insurance premiums.

As the market leader, we fully support tax incentives for the purchase of long-term care insurance, and we offer your support to help you achieve this goal. Just last month, we hosted a forum on Capitol Hill to present focus group findings on long-term care policy to many of your staff. The research confirmed what many of us in the industry have long suspected that many Americans do not understand that they have a huge potential long-term care financing burden hanging over their heads. We would be happy to present it to you and your staff members, as well as discuss other ways we can develop research and find answers to the long-term care policy problems. Let me close by telling you that we are committed to being a partner, a resource, and an asset to this Committee on both sides of the aisle. We are eager to work with you and your staff to share our abundant data and to conduct new research as needed. We know that long-term care insurance is not the solution for everyone; however, we believe it has to be a part of the broader solution that leads to a better long-term care strat-

egy for our country. Thank you for the opportunity to be here today.

[The prepared statement of Mr. Stinson follows:]

**Statement of Buck Stinson, President of Long Term Care Division,
Government Relations, Genworth Financial**

Genworth Financial is a Richmond, Virginia based company, which provides life, health, retirement and mortgage insurance products to more than 15 million customers in 22 countries. Our long-term care business is the largest and most experienced provider in the country, with more than a million customers and over \$500 million in claims being paid every year.

We believe that long-term care is an often overlooked, yet critically important federal policy issue and are pleased that you have decided to have an open discussion about our nation's long-term care needs. As a private long-term care insurance company, we take our job very seriously. We provide policies that protect families from potentially catastrophic consequences and allow them access to quality care environments.

Current Trends in Caring for Our Aging Population

Americans are living longer with the oldest of the 77 million baby boomers reaching retirement age in 2008. The most significant growth will be among those 85 and older, a segment that will more than triple in size to 5.2 percent of the population by 2050. This surge in our elderly population will create an acute demand for long-term care (LTC) services.

Long-Term Care Differs

Long-term care is different than what most of Americans think of as health care, and it isn't usually covered by health insurance policies, HMO plans or Medicare supplemental policies. Both Medicare and most health insurance policies are designed to cover expenses resulting from ordinary doctor care or hospital stays.

The Congressional Budget Office estimates that total expenditures for long-term care services for the elderly in 2004—excluding the value of donated care—will total \$135 billion. Of that, nearly a third is paid out of pocket.

Long-term care needs are typically triggered by the need for assistance with activities of daily living, including bathing, eating or dressing, as well as cognitive impairment resulting from illness including dementia and Alzheimer's disease. Long-term care can range from basic help with chores and activities in your own home, assistance with activities of daily living in an assisted living facility or highly skilled care in a nursing facility. The possibility of needing long-term care due to an illness or physical disability is something most people don't like to think about. But as we age, and because Americans are living longer, the likelihood that we will need some kind of assistance is very real.

The expected growth in the number of people needing long-term care is staggering. Sixty percent of those reaching the age of 65 are expected to need long-term care at some point in their lives[1] According to the AARP, seven million people over the age of 65 needed long-term care in 2001 and by 2020, the number is expected to increase to 12 million.

Caregiver Changes

Traditionally, long-term care needs are taken care of within the family, with nearly 70 percent of elderly individuals receiving volunteer help from their personal network. Over the next several decades, that number is expected to drastically decline due to several factors. With the size of the American family getting smaller, there are fewer adult children to take care of elderly parents—and these children live farther away from their parents than they did a generation ago. In addition, there are more women—the traditional caregivers—in the workforce, and studies have shown that care giving at home suffers proportionately with hours of employment[2]

Long-Term Care Payment

Beyond their families, Americans have several options when it comes to receiving and paying for long-term care, but few are prepared for the financial reality or the impact on their assets.

We often underestimate the costs of long-term care. With nursing home care averaging \$65,200 (daily rate of \$179) per year, savings and assets may be quickly diminished. According to the 2004 Genworth Cost of Care Survey, the problem is even more acute in urban areas, where nursing home care costs are 20 percent higher than in rural or suburban areas. In some states, such as New York, California and

Minnesota, the cost of urban area care was more than 40 percent greater than in non-urban areas of those states. The survey queried more than 6,000 providers in 88 separate regions, including nursing homes, assisted living facilities and home care providers. These numbers become especially daunting when we consider that ten percent of those entering nursing homes will stay there for five or more years.³

Average Costs of Long Term Care in the United States:

Nursing Homes	\$179.00 per day
Assisted Living Facilities	\$79.00 per day
Certified Home Care	\$20.08 per hour

Source: 2004 Genworth Cost of Care Survey for Nursing Homes, Assisted Living Facilities and Home Care Providers

Most Seniors Unprepared

Most seniors are not financially prepared to pay for these long-term needs. According to a study done by the Bureau of Census, only seven percent of American seniors have enough saved to cover even one year of nursing home care.⁴

Most Americans are also not wealthy enough to fully fund their long-term care needs through private savings. Many rely on public programs provided at taxpayer expense by the state and federal government. However, the majority of Americans are unaware of the fact that Medicare is not intended to cover the majority of long-term care expenses, and Medicaid coverage for long-term care only becomes available if and when an individual depletes most of their savings and assets or that Medicaid can recoup long-term care expenses after a covered individual's death by foreclosing on that individual's house. State Medicaid programs force seniors to "spend down" their assets, essentially spending all of their savings and assets before they will cover expenses such as nursing home care. In fact, according to the Department of Health and Human Services, this accounts for more than half of the nursing home residents, who "have become poor enough" to qualify for Medicaid coverage.

Nearly one-third of all long-term care bills are paid by individuals and families out-of-pocket. As a result, 70 percent of single people and 50 percent of married couples who require long-term care become destitute.⁵

Even those seniors who believe they have saved enough may still be in trouble. The one thing that none of us can predict is the length or extent of any impairment that may befall us.

Long-Term Care Insurance Helps Americans Plan for Long-Term Care Needs

Long-term care insurance allows people to pay certain, smaller payments now in order to ensure that they can afford the long-term care coverage they likely will need later in life, instead of taking the financial risk of losing their life savings in order to become eligible for government programs.

In addition to "sharing the risk" with others to mitigate the costs, long-term care insurance often allows policyholders more choices and greater quality of care.

According to LIMRA International, there are 6.2 million Americans who own long-term care insurance today. Despite those positive numbers, there remains a general lack of understanding with respect to LTC insurance that leaves many people baffled, discouraged and, in the end, unprepared to meet their own needs.

With more than 30 years of experience, Genworth has also been at the forefront of identifying emerging trends and working with health and advocacy experts to develop better forms of coverage and protections. Most significantly, Genworth has determined that nearly 50 percent of all the company's claims paid over time have been for care provided to patients with Alzheimer's and other forms of dementia. With four and a half million Americans currently diagnosed with Alzheimer's, and the number projected to grow to 14 million in coming decades, this is an important chronic illness to plan for early on in life.

¹ Employee Benefit News, *A Federal Case for Long Term Care*, 2/02/03.

² *The Tradeoff Between Hours of Paid Employment and Time Assistance to the Elderly*, Urban Institute, February 2000.

³ U.S. Department of Health and Human Services.

Policy Coverage and Offerings

Planning for future long-term needs by securing a long-term care insurance policy is one way Americans can help ensure that they retain their independence and quality of life as they age. Industry trends indicate that the baby boom generation is gaining an appreciation for long term care insurance as evidenced by more Americans planning for their long-term needs earlier. The average age of people buying long-term care insurance has shifted dramatically from post-retirement to pre-retirement. Since 1996, the average age of individuals purchasing long-term care insurance has dropped from 69 to 59. One explanation of this trend can be attributed to the baby boomers planning ahead, as they see how their parents' needs for long-term care are addressed.

Of the top 13 companies providing long-term care insurance, there have been more than \$8 billion in claims paid through 2002. The 13 largest companies offer policies to individuals ranging in ages from 18 to 99, provide a \$50-\$600 per day benefit, guarantee renewability and offer many different options for coverage and inflation protection.

In addition to "sharing the risk" with others to mitigate the costs, long-term care insurance often allows policyholders more choices and greater quality of care. For instance, the market has evolved from nursing home-only to one that offers flexible care options and numerous consumer protections.

Most policies allow customers to choose between in-home care, assisted living facilities and nursing homes, encouraging the individual and their families to customize his or her care needs. In addition, policies offer the services of a local care coordinator that meets with a policyholder at the time of claim to help craft a plan of care and identify local care providers. There is a chart in the appendix that illustrates the typical coverage offered by the top long-term care insurance sellers.

The most recent study of industry-wide data and trends was conducted by America's Health Insurance Plans (AHIP) in 2002.

At that time AHIP found that:

- Approximately 80 percent of all long-term care insurance policies were sold through the individual market. Ninety-four percent of long-term care insurers sold in this market.
- In contrast, as of December 31, 2002, 28 percent of the 2002 long-term care insurance carriers sold policies in either the employer-sponsored or life insurance markets. This is in comparison with only 14 percent in 1988. The employer-sponsored and life insurance markets also represented 21 percent of all long-term care policies sold as of 2002, up from less than 3 percent in 1988.
- This study validates the persistency of long-term care insurance coverage. Findings from this study show significantly lower than expected lapse rates.
- Long-term care insurance carriers paid more than \$8 billion in benefits to their claimants through 2002.
- More than 280,000 new long-term care insurance policyholders, representing almost one-third of all policies sold in 2002, purchased their coverage through their employer. A significant portion of this growth can be attributed to the launching of the Federal Long-Term Care Insurance Program. This program made long-term care insurance available to federal government employees and annuitants and their qualified dependents and relatives.

As in previous years, the long-term care insurance market was concentrated among a relatively small number of sellers. Thirteen companies represented approximately 80 percent of all individual policies sold in 2002. AHIP also conducted an in-depth look at the top sellers' latest policies and found that these insurers offer policies with a wide range of benefit options and design flexibility at moderately priced premiums. Its key findings were:

- All companies offer plans covering nursing home, assisted living facility, home health care, hospice care, respite care, and alternate care services.
- Other common benefits include case management services, homemaker or chore services, restoration of benefits, reimbursement of bed reservations in long-term care facilities, coverage of some medical equipments, survivorship benefits, and caregiver training.
- Spousal discounts are more prevalent and offer significant reductions in premiums. The discount ranges from 10 to 40 percent.
- There appears to be consumer interest in limited pay policies and some companies are beginning to offer these types of policies in different variations, such as single pay, 10-pay, and pay until 65 options.
- Criteria used for benefit eligibility is deficiency in performing activities of daily living (ADLs) and cognitive impairment.

- All plans are guaranteed renewable, have a 30-day “free look” period, cover Alzheimer’s disease, have a waiver of premium provision, and offer unlimited or lifetime nursing home maximum periods.
- All companies use a six-month or less preexisting condition limitation.
- Age limits for purchasing continue to expand. Companies offer individual policies to people as young as 18 and as old as 99.
- All plans offer the National Association of Insurance Commissioners (NAIC) Long-Term Care 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; shortened benefit period is the most common type offered.

Future Outlook

Over time, the long-term care insurance market will continue to expand as the result of aging demographics, increasing healthcare and nursing care costs, growing awareness of the limitation of government programs and the increasing public awareness of the benefits of private long-term care insurance.

However, more must be done. There is no magic wand that will solve the long-term care financing problems that are looming for millions of Americans. In the end, many different approaches will have to be applied if we are to solve the problem.

While Congress has done a great deal to encourage private retirement planning, long-term care planning has been largely unaddressed. We believe it is important for private industry to be part of the solution, both in terms of educational awareness and legislative policymaking.

There are several policies that could make a great impact on both American’s long-term care needs and the federal budget. Financial incentives, most notably in the form of some level of tax deductibility, would most likely produce the greatest stimulus for more Americans to better plan for their future health needs. Public education and greater cooperation between the public and private sectors could also make a very significant contribution to easing the pressures that are currently building.

Genworth recognizes, as part of its corporate mission, an obligation to raise the public’s awareness of the impending long-term care challenges. The company is also fully committed to working in partnership with policymakers and consumer advocates to better serve the needs of the nation’s aging population.

Just last month, we hosted a forum on Capitol Hill to present focus group findings by noted researchers Bill McInturff of Public Opinion Strategies and Geoff Garin of Peter D. Hart Research on long-term care policy to many of your staff.

The research confirmed what many of us in the industry have long suspected—that many Americans do not understand that they have a huge potential long-term care financing burden hanging over their heads.

We would be happy to present it to you or your staff members, as well as discuss other ways that we can develop research that finds answers to our long-term care policy problems.

A great example of an effective awareness campaign is the recent HHS and CMS “Own Your Future” program which was launched early this year in five pilot states (VA, NV, AR, ID and NJ) We believe this should be expanded nationwide.

In closing, we want to assure Members of the Committee, as well as staff, that we are committed to being a partner, a resource and an asset on both sides of the aisle. We are eager to work with you to share our abundant data and to conduct new research as needed. We do not have all of the answers, but we hope to be part of the solution that leads to a better long-term care strategy for our country.

Thank you for the opportunity to provide this testimony to the Committee.

Appendix

Source: American Health Insurance Plans; Long-Term Care Insurance in 2002

Chairman JOHNSON OF CONNECTICUT. Thank you very much, Mr. Stinson. Doctor Meiners?

STATEMENT OF MARK R. MEINERS, PH.D., PROFESSOR AND DIRECTOR, CENTER FOR HEALTH POLICY, RESEARCH AND ETHICS, GEORGE MASON UNIVERSITY, ARLINGTON, VIRGINIA

Mr. MEINERS. Thank you for inviting me to speak on a topic that has been new and dear to me for many years. In my testimony today, I want to focus on two of the programs I have been working on—the Partnership for Long-Term Care and the Medicare-Medicaid Integration Program. Each of these programs provide excellent case studies of the creativity and perseverance States have demonstrated in carrying out their long-term care responsibilities in the face of often times great barriers. It is the barriers with which we need your help. States are hungry for workable models to deal with their long-term care responsibilities. There is general recognition of the need to improve the health care delivery system for those with chronic care needs. A commonly accepted premise is that to make progress, we must improve the integration and coordination of acute and long-term care. To do this, health plans and providers must experiment with systems of care and financing. But I want to start with the financing option that is known as the Partnership for Long-Term Care because, as many of you know, form tends to follow finance in health care.

The Partnership for Long-Term Care is a state-based program developed with the support of the Robert Wood Johnson Foundation. The program is designed to stimulate long-term care insurance market by helping to balance the difficult competing pressures between product value and price. Four States—California, Connecticut, Indiana, and New York—are currently operating the public-private partnership which provides consumer special protection against depletion of their assets in the financing of long-term care. The Partnership long-term care insurance policies work in the following way: By buying a Partnership Policy, a person qualifies for Medicaid benefits under special Medicaid rules. When a Partnership Policy is exhausted, the policyholder is permitted to retain assets equal to the amount his or her insurance has paid out. There are some nuances to this that allow for total assets model. We can talk about that another time. The person is then eligible for coverage under Medicaid without having to be impoverished. Insurers participating in the Partnership must meet the program certification standards. These standards ensure the participating long-term care policies are of a high quality. Among the standards required in each State are inflation protection, minimum benefit amounts, and agent training. Participating insurers are also required to provide the State with information on purchasers of certified products and on the utilization of benefits.

The program is fiscally conservative, helps middle income people avoid impoverishment, serves as an alternative to Medicaid estate planning, promotes better quality insurance products which promote consumer protection efforts, enhances public awareness regarding long-term care needs and options, and helps maintain public support for the Medicaid program. About \$43 million in asset protection has been earned to date, but the vast majority of that protection will never actually be needed because in most cases the insurance covers the needs of beneficiaries until they die. This is

one of the unique strengths of the Partnership. It provides a meaningful incentive to prepare for the risk of long-term care with insurance, while costing relatively little. Indeed, early estimates and recent experiences suggest that the program can save Medicaid costs. At least some of you Committee Members are quite familiar with the Partnership Program having had a hand in grandfathering the current States, giving them the right to operate the program and it is part of the 1993 Omnibus Budget Reconciliation Act. The same legislation, however, put restrictions on wider State replication of this idea, which has proved to be a major barrier to broadening the success of the program. Without the repeal of the OBRA '93 restrictions on partnership style asset protection, it has not been possible to stimulate the multi-State interest necessary to justify the commitment of resources by insurers and their agents to support these alternative marketing strategies.

We respectfully ask you all to work with your colleagues on the Ways and Means Committee to remove the OBRA restrictions on the Partnership Program. In addition to financing innovations like the Partnership, there is a profound need for new systems of care that integrate the financing, delivery, and administration of primary, acute, sub acute, and long-term care. The current Medicaid crisis along with the new Medicare prescription drug benefit and the increased recognition of the high cost and unique care needs of many special needs populations, including those eligible for both Medicare and Medicaid, the dually eligible, has prompted renewed interest in the integration of Medicare and Medicaid managed care. Effective care management for such a population can best be accomplished when health plans have the ability to coordinate the service delivery and financing the entire continuum of health and long-term care services. The current financing delivery system contains many obstacles to the development of such integrated care models. The Medicare-Medicaid Integration Program, with the support of the Robert Wood Johnson Foundation, has been working with States to help end the fragmentation of financing, case management and delivery, and service delivery that currently exists with our two main public financing programs.

The ultimate goal of these efforts is to help evolve an effective way for all populations in need of or at risk for the full continuum of acute and long-term care services to get care more efficiently and effectively. The Partnership for Long-Term Care is a strategy that can help broaden the market for long-term insurance. But financing is only part of the problem to be solved. There needs to be systems of care that integrate acute and long-term care so that the limited resources available are spent wisely on behalf of the consumer. Together, Medicare and Medicaid have an enormous impact on our health care delivery system as well as on the private insurance market. We must begin to recognize the critical interrelationship between these two programs and approach Medicare-Medicaid modernization efforts in tandem. Systems of care that integrate Medicare and Medicaid for dual eligibles are beginning to show us how to deal with the complex clinical, operational, and financial problems that will increasingly confront us as our population ages. These State-based efforts should be supported as good investments in our future. Thank you.

[The prepared statement of Mr. Meiners follows:]

Statement of Mark R. Meiners, Ph.D., Professor and Director, Center for Health Policy, Research and Ethics, George Mason University, Arlington, Virginia

Chairman and members of the Subcommittee, my name is Mark Meiners. I am a professor at George Mason University where I direct the Center for Health Policy, Research, and Ethics. I specialize in the economics of aging and health as it relates to public policy. For over 30 years I have worked with the Federal government, state governments, the Robert Wood Johnson Foundation and many others to develop and direct state programs designed to improve our Nations' long-term care financing and delivery systems. In my testimony today I want to focus on two of the programs I am working on—the Partnership for Long-Term Care and the Medicare-Medicaid Integration Program. Each of these programs provide excellent case studies of the creativity and perseverance states have demonstrated in carrying out their long-term care responsibilities in the face of great barriers. It is the barriers with which we need your help.

The Medicaid Crisis and State Initiatives in Long-Term Care

It is not surprising that states have been the focal point in reform of long-term care. Much of long-term care is related to daily living needs rather than health care needs. This tends to make the approach to care more the concern of individuals and their communities. Perhaps even more important, financing and administration of long-term care under the Medicaid program has been an increasing burden for states. Their desire to find alternatives to nursing home care has provided most of the experience with program innovation.

States are hungry for workable models to help deal with their long-term care responsibilities. There is general recognition of the need to improve the health care delivery system for those with chronic care needs. A commonly accepted premise is that to make progress we must improve the integration and coordination of acute and long-term care. To do this, providers must experiment with new systems of care and financing.

The Partnership for Long-Term Care

The Partnership for Long-Term Care is a state-based program developed with the support of the Robert Wood Johnson Foundation. The Partnership program is designed to stimulate the long-term care insurance market by helping to balance the difficult competing pressures between product value and price. Four states (California, Connecticut, Indiana, and New York) are currently operating this public-private partnership which provides consumers special protection against depletion of their assets in the financing of long term care.

The Partnership long term care insurance policies work in the following way. By buying a Partnership policy, a person qualifies for Medicaid benefits under special Medicaid rules. Once a non-Partnership policy runs out, an individual must spend virtually all of their savings before they qualify for Medicaid. In contrast, when a Partnership policy is exhausted, the policyholder is permitted to retain assets equal to the amount his or her insurance paid out (IN and NY have allowed some policy holders to keep all remaining assets). The person is then eligible for coverage under Medicaid without having to be impoverished.

Insurers participating in the Partnerships must meet the program certification standards. These standards ensure that participating long-term care policies are of high quality. Among the standards required in each state are inflation protection, minimum benefit amounts, and agent training. Participating insurers are also required to provide the state with information on purchasers of certified products and on the utilization of benefits.

The Partnership states selected the strategy of linking the purchase of long-term care insurance to Medicaid eligibility after considering numerous alternatives. The program is fiscally conservative, helps middle income people avoid impoverishment, serves as an alternative to Medicaid estate planning, promotes better quality insurance products which promote consumer protection efforts, enhances public awareness regarding long term care needs and options, and helps maintain public support for the Medicaid program.

Each of the four Partnership states maintains a web page full of useful information that, among other things, tracks the experience of their program for consumers, agents, and policy makers. For example, approximately 238 thousand applications have been taken in the four states since the start of the program. The average age of purchasers is in the range of 58–63 and women comprise 55–60 percent of the

purchasers. For more information see: www.umd.edu/aging and go to the Partnership for Long-Term Care. Links for each of the Partnership States can be made from this web page.

About \$43 Million of asset protection has been earned to date but the vast majority of that protection will never be actually be needed because in most cases the insurance covers the needs of the beneficiary until they die. That is one of the unique strengths of the Partnership; it provides a meaningful incentive to prepare for the risk of long-term care with insurance while costing relatively little. Indeed early estimates and recent experience suggest that the program can save Medicaid costs. During the planning phase of the program (1991) we used the Brookings-ICF Long-Term Care Financing Simulation Model and identified potential savings gradually increasing so that by the final estimation period of 2016–2020 there was a 7 percentage point decline in Medicaid's share of the long-term care bill. More recently, the Partnership states that are using the dollar-for-dollar model have developed their own estimation strategy which shows their cumulative Medicaid savings to date as being in the range of \$8–10 million. While it is always difficult to estimate with certainty the behavior change that would come from a National Partnership model it seems clear that the current Partnership States' experience are going in the direction of the savings that were originally anticipated from the earlier simulations.

The Partnership Balancing Act

Partnership policy sales indicate steadily growing interest in public-private long-term care insurance policies. However, the numbers also reveal that the public is still wary about the need for such policies and needs positive reinforcement to consider such an investment in their future. There are good reasons for this that involve the differences in perspectives that have fueled the status quo.

In the early stages of program development, arguments against the Partnership were raised primarily by social insurance advocates who viewed the program as an incremental step which would erode support for more ambitious reform. As the Partnership was implemented, insurers voiced their own dissatisfaction with certain aspects of the program design because it deviated from some of the standard approaches used to market this coverage and required extra attention beyond that for non-partnership products. Not satisfying everyone exactly to their liking is, after all, what we believe to be necessary for a workable public-private partnership.

Most of the arguments for and against the Partnership share common issues viewed from different perspectives. Central to the strategy is the fact that Medicaid is the primary public payer for long-term care that states are the key decision makers regarding Medicaid rules and insurance regulation, and that the states need to be at least budget neutral in their efforts to provide a positive incentive to the insurance market.

OBRA '93 Language A Major Barrier to Replication

At least some of your committee members are quite familiar with the Partnership program having had a hand in grandfathering the current Partnership States the right to operate their programs as part of the 1993 Omnibus Reconciliation Act. That same legislation, however, put restrictions on wider state replication of this idea which has proved to be a major barrier to broadening the success of this program.

At the time when the Partnership programs were initiated, two countervailing forces clashed. First, state interest in the Partnership grew well beyond the four states funded by the Robert Wood Johnson Foundation. In fact, 12 states passed enabling legislation to create programs modeled on the RWJF program. Second, the Omnibus Reconciliation Act of 1993 (OBRA '93), enacted the same year as the RWJF Partnership was implemented, contained language with both indirect and direct impact on the expansion of Partnership programs. Indirectly, the Act closed several loopholes in the Medicaid eligibility process, thereby providing further incentives for persons to purchase private insurance for long-term care. The Act also makes specific mention of Partnership programs. The statute contains a "grandfather" clause which recognizes as approved the four initial states, plus a future program in Iowa and a modified program in Massachusetts (protecting only the home from estate recovery). These states were allowed to operate their partnerships as planned since the Health Care Financing Administration had approved their state plan amendments before May 14, 1993.

While states obtaining a state plan amendment after that date are allowed to proceed with Partnership programs, they are also required to recover assets from the estates of all persons receiving services under Medicaid. The result of this language is that the asset protection component of the Partnership is in effect only while the

insured is alive. After the policyholder dies, states must recover what Medicaid spent from the estate, including protected assets. At the very least this becomes a very complicated and convoluted message for consumers. It also removes one of the major incentives people have to plan for their long-term care needs. The effect has been to significantly stifle the growing interest in replicating the Partnership in other states. Promising efforts in Colorado, Illinois, Iowa, Maryland, Michigan, and Washington, to name a few, were sidetracked by the impression that Congress did not support this program.

Next Steps

Without the repeal of the OBRA '93 restrictions on Partnership style asset protection, it has not been possible to stimulate the multi-state interest necessary to justify the commitment of resources by insurers and their agents to support these alternative marketing strategies. But there is growing recognition that States need flexibility in dealing with the pressures on the Medicaid system and that private long-term care insurance is a needed alternative to public financing. The National Governor's Association has for some time now been calling for elimination of federal barriers to public-private insurance partnerships like those in the RWJF states and the expansion of authority to all states to implement such programs.

When the OBRA '93 restrictions are repealed, the current Partnership States suggest the following core benefit and administrative features be considered for a National Long-Term Care Insurance Partnership Program. The idea is that a Partnership Rider be created that could be attached to a federally tax-qualified long term care insurance policy. The purpose of the proposed features is outlined in brackets.

Rider Benefit Standards:

1. Compound inflation protection at 5% annually for both the daily and maximum benefit for all ages. [To protect both the consumer and the state's Medicaid program.]
2. Maximum lifetime benefit options must include 1 or 2 year plans (according to state law/regulations). [Opens the market to the middle income consumer who is most at risk of having to go through Medicaid spend-down. Protects the state's Medicaid program.] Maximum lifetime benefit paid out in a pool of money.
3. Minimum daily benefit—calculation to be determined later. [To protect both the consumer and the state's Medicaid program.]
4. Tax-qualified plan that includes an assessment and plan of care developed by a licensed health care practitioner who is independent of the insurance company. "Independent" = not on the staff of the insurance company. [To provide some level of standardization and to protect the consumer.]
5. Reduced benefit offer, in place of lapsing, at original issue age and taking into account accrual of inflation protection over time. [To protect both the consumer and the state's Medicaid program.]
6. Asset protection—start with the dollar for dollar model. [Currently in existence are three models—dollar for dollar, total asset protection and a combination of both dollar for dollar and total asset protection. Starting with the dollar for dollar model would be the easiest for states to implement with a budget neutral stance for Medicaid.]
7. Coordination of benefits. [Protects the state's Medicaid program.]

Administrative/Regulatory Standards:

1. Existing partnership programs would be allowed to remain as they are.
2. Companies wanting to participate would sign a National Participation Agreement. One agreement would suffice for all states. An Officer of the company would sign the agreement. It would state the following:
 - a. Partnership Riders may not be attached to home care only policies.
 - b. Partnership Riders may be attached to tax-qualified policies that calculate premiums based on issue age. No attained age premiums. [Protects the consumer and the state's Medicaid program.]
 - c. A Partnership Rider must be offered with all eligible tax-qualified policies, with premium for the Rider being equal to the policy with a 5% compounded inflation protection feature.
 - d. The company agrees to abide by the reporting requirements (some type of uniform system—could be the Uniform Data Set already in existence). Reporting requirements are for the purpose of tracking participation and tracking asset protection. The companies would submit data to a central repository on a regular basis. States would have access to

- the data. (Funding of the repository to be determined later.) [Protects the consumer and the state's Medicaid program.]
- e. The company agrees to abide by the reporting requirements even if they later decide to stop issuing Partnership riders.
 - f. The company agrees to be audited by a State (in-person) after the first Partnership policyholder has gone into benefit status. An audit performed by one state will be accepted by all other states. However, any state may perform an audit of that state's policyholders' records via mail or electronic means. The purpose of the audit is to ensure accurate tracking of asset protection. [Protects the consumer and the state's Medicaid program.]
 - g. The company agrees to provide quarterly asset protection reports to policyholders who are in benefit status; and providing service summary reports to policyholders who have exhausted policy benefits, lapsed their policies, or upon the policyholders' requests. A copy of such reports will be sent to the State. [Protects the consumer and the state's Medicaid program.]
 - h. The company agrees to obtain from, and provide a copy to, the applicant consent to release information to the State as well as a disclosure form (content to be determined later) that provides information about asset protection and Medicaid. [Protects the insurer, the state's Medicaid program, and the consumer.]
 - i. The company agrees to accept applications for policies with Partnership Riders from, and pay commissions to, agents who show completion of a five-hour continuing education course on the Partnership program. [Protects the consumer.]

Medicare/Medicaid Integration

I have started my testimony with the Partnership program because I believe that overturning the OBRA '93 restrictions is a relatively easy to accomplish next step that can lead to even more creative efforts that are needed to help reform Medicare and Medicaid. Further, form follows finance and, in the absence of appropriate financing mechanisms and incentives, delivery reform will be nearly impossible to accomplish. In addition to financing innovations like the Partnership, there is a profound need for new systems of care that integrate the financing, delivery and administration of primary, acute, sub acute, and long-term care services. The current Medicaid crisis along with the new Medicare prescription drug benefit and the increased recognition of the high cost and unique care needs of many special needs populations, including those eligible for both programs (the dually eligible), has prompted renewed interest in the integration of Medicare and Medicaid managed care.

There are more than six million individuals in this country who are eligible for both Medicare and Medicaid. The dually eligible represent a costly subset of the Medicare population. More than \$200 billion is likely to be spent on duals in 2005—roughly the same amount spent on either population alone, despite the relatively small case load in each program. While only about one-sixth of Medicare beneficiaries were dually eligible in 2001, they accounted for over a quarter of total Medicare expenditures. With Medicaid where duals comprise a little over a sixth of the population, the costs even more disproportionate, with the duals accounting for about a third of all Medicaid costs. Total spending across all payers for duals was more than double the amount for Medicare-only beneficiaries in 2001.

Many in this group have complex medical care needs due to multiple chronic conditions. Twice as many duals are in poor or fair health as non-duals, they have more chronic conditions than Medicare-only enrollees and 75% have functional limitations. Comorbid medical conditions and disabilities require the use of multiple care providers and care management services to coordinate care among multiple providers to ensure appropriate care, optimize health outcomes and prevent adverse health events. Consider, for example, that Medicare beneficiaries with 5 or more chronic conditions, on average, sees 14 different physicians annually, has 40 office visits and fills 50 prescription drugs.

Effective care management for such a population can best be accomplished when health plans have the ability to coordinate the service delivery and financing of the entire continuum of health and long-term care services. The current financing and delivery system contains many obstacles to the development of such an integrated system. Of major concern to the development of managed care programs is the fragmentation of financing and responsibility for patient care. Medicare and Medicaid currently maintain wholly separate contracting, reimbursement and quality standards for managed care organizations, in spite of overlapping populations. If man-

aged care providers are to be effective in accessing the most appropriate and cost effective care for their patients they must have the flexibility to provide whatever combination of care and services is the most clinically effective and economically efficient.

Getting Medicare and Medicaid policy to work together can be quite difficult. Unnecessary hospitalizations of those in nursing homes are encouraged by low Medicaid reimbursements, bed hold day payments, and DRG related payment incentives for short stay hospital admissions. Medicare physician payments are biased toward hospital care instead of care in the office, home, or nursing home. More emergency room visits, medical transportation, and readmissions result. Too little home and community care is available to serve as an alternative to nursing home care. Improved managed care models are again being looked to as a way to handle these problems. Integrated care programs represent an opportunity for better care outcomes and greater cost-efficiencies by improving the attention to detail that is often missing for people when there is no systematic effort to coordinate care.

The model of nursing home care originally demonstrated by Evercare is a case in point of improved care management and outcomes through integrated care. Evercare provides care management, aggressive primary care services and early identification and treatment of acute illness to long-term nursing home residents. While beneficiaries with four or more chronic conditions are 99 times more likely to be hospitalized for an ambulatory care sensitive condition that could have been prevented with appropriate ambulatory care, Evercare has reduced hospital use among nursing home residents by 45%, including preventable hospitalizations. Reductions in hospitalization result in significant cost-savings to both the acute and long-term care systems when one considers risks associated with hospitalization for seniors—infections, depression, falls, irreversible functional decline that may require life-long supportive services, loss of bone mass and other forms of decline that can lead to life-long decline in health status and increased acute and long-term care costs.

The PACE model is probably the best known example of successful integration of acute and long-term care under managed care arrangements. Full integration is made possible by a pooling of Medicare and Medicaid resources; over 95% of PACE members are dually eligible. Now that PACE has been made a permanent option within Medicare there is growing interest in making this model of care more appealing to private pay populations who need similar care. The challenge will be to get middle class seniors to substitute private insurance or financing for long-term insurance for Medicaid dollars and to make a commitment to the prescribed delivery system. One approach that might work is to offer this care approach as a preferred provider arrangement under long-term care insurance contracts. Other options for expanding alternative financing, contracting and care arrangements warrant examination to determine the potential for PACE alternatives to serve large numbers of Medicare beneficiaries.

The Medicare/Medicaid Integration Program, with the support of the Robert Wood Johnson Foundation, has been working with states to help end the fragmentation of financing, case management, and service delivery that currently exists with our two main public financing programs. The ultimate goal of these efforts is to help evolve an effective way for all populations in need of or at risk for the full continuum of acute and long-term care services to get their care more efficiently and effectively.

Arizona, Florida, Massachusetts, Minnesota, Texas, New York, and Wisconsin are among the states that have made considerable progress in integrated care program development with the help of the Center for Medicare and Medicaid Services (CMS). Other states (CA, GA, NJ, MD, WA) have been working at it and are interested in doing more. Though the initial focus is on public pay clients the delivery system development lessons are equally relevant to long-term care insurance links that might be made with Medicare managed care products as the private market alternative for those not eligible for Medicaid. The growth of Medicare managed care products designed to serve special needs populations will eventually stimulate the development of products in the private sector that could well benefit from the type of incentives offered by the Partnership program as a way to encourage the purchase of comprehensive shorter-term coverage that is appealing and affordable to middle and modest income purchasers. Indeed the group most at risk for spend-down to impoverishment if they need long-term care could benefit greatly by being in a system of care that managed chronic illness well. That way unnecessary accidents, behavior, and transition mistakes associated with the client's special needs could be better avoided and help keep people from needing Medicaid all together.

Currently the conflicting Medicare and Medicaid financing and administrative rules continue to result in significant duplication, fragmentation, and costs. The new Medicare Special Needs Program (SNP) statute and regulations could be a way to

begin to mainstream the types of care system improvements that have begun to be tested in the various state integrated care demonstrations. The current SNP regulations do not as yet provide states and health plans the authority to integrate financing, care delivery and administration that has been achieved under the current dual demo waivers. It is important to allow Medicare demonstrations seeking designation as SNPs to convert to SNP demonstrations with the authority to retain previously approved waivers so that they can continue to refine and enhance the models developed under demonstration authority. Consideration should also be given to allow states to waive Federal Medicaid rules where they conflict with Federal Medicare rules and to add requirements for long-term care benefits that are not addressed in Federal regulations.

States should also be allowed to integrate Medicare and Medicaid administration and expand eligibility through state plan amendments. This could allow for creative upstream program development for pre-duals that could be linked with Partnership type asset protection incentives in exchange for voluntary participation in managed care plan programs involving care coordination and/or chronic care management strategies.

Conclusions

Medicare and Medicaid often share in the delivery of health and social services to high-cost chronically ill elderly and disabled individuals. But Medicare does not cover long-term care so private insurance enters the picture as a way to help people prepare for this risk and avoid having to depend on Medicaid. The Partnership for Long-Term Care is a strategy that can help broaden the market for long-term care insurance. But financing is only part of the problem to be solved. There needs to be systems of care that integrate acute and long-term care so the limited resources available are spent wisely on behalf of the consumer. Together, Medicare and Medicaid have an enormous impact on our health care delivery system as well as on the private sector insurance market. The incremental development of these two programs has created many distortions and inefficiencies in providing care to individuals who qualify for both programs, as well as in the delivery system as a whole. We must begin to recognize the critical inter-relationship between these two programs and approach Medicare and Medicaid modernization efforts in tandem. Only through a unified approach to care for the dually eligible, can we optimize health care outcomes and contain the cost of care for the highest-cost subgroup in the health care system. Systems of care that integrate Medicare and Medicaid for dual eligibles are beginning to show us how to deal with the myriad of complex clinical, operational, and financing problems that will increasingly confront us as our population ages. These state based efforts should be supported as good investments in our future.

Chairman JOHNSON OF CONNECTICUT. Thank you very much. Mr. Gehm.

STATEMENT OF DAVID GEHM, PRESIDENT AND CHIEF EXECUTIVE OFFICER, LUTHERAN HOMES OF MICHIGAN, FRANKMUTH, MICHIGAN

Mr. GEHM. Thank you. Madam Chairman and Members of the Subcommittee, I am pleased to have the opportunity to testify today on behalf of Lutheran Homes of Michigan and the American Association of Homes and Services for the Aging, of which we are a member. Lutheran Homes of Michigan is a non-profit Christian agency providing a full range of services to God's oldest children. Our facilities provide round-the-clock Medicare-certified skilled nursing care, certified home care, senior housing, hospice, and private-duty services to hundreds of Michigan seniors and their families of all faiths. Lutheran Homes' history tracks the trends in long-term care over the last several decades and the ways in which our field has in some ways come back to the future. Over the last 114 years, Lutheran Homes has evolved from a housing provider for impoverished elderly to adding services as needed. Post enact-

ment of Medicare and Medicaid in the sixties, we became predominantly a nursing home provider and now we are back to the future as we evolve back to housing, with services leading the way. In that context, I want to mention the need to finance supportive and health-related services in affordable housing settings. Public payments for nursing home care bundle housing costs together with the cost of health care and supportive services. For short stay skilled nursing patients and some very frail longer stay residents, this arrangement has proven to be a cost-effective way of ensuring that they receive the level of care they require.

However, we are seeing the unbundling of the services can make much more sense for people who don't need the entire package of services that nursing homes are required and bound to provide. But if housing and supportive services are unbundled, they must both be available and affordable to people if people are to have a realistic alternative to nursing home care. The full Ways and Means Committee has jurisdiction over the Nation's largest affordable housing program, the low-income housing tax credit. I would hope that this Committee can spearhead discussions with other congressional Committees that oversee housing and supportive services to overcome some of the obstacles to coordinating affordable housing with services that enable people to age with dignity in place. In the future, we believe that housing plus services can help many people avoid or postpone entry into nursing homes. I want to emphasize that although Medicaid and Medicare to a lesser extent are an important source of funding for long-term care, our community also plays a large role in financing the services our clients and residents receive.

Lutheran Homes and providers like us across the Nation create life enriching opportunities for our elders by leveraging the social capital in our communities. Last year alone, Lutheran Homes logged over 19,000 hours of volunteer time in support of our services. We also received donated funds nearing \$1 million to help offset unfunded needs and create additional services seniors need. Future policy should find a way to strengthen this public and private partnership. Because Medicaid is primarily a health care program, long-term care developed an excessively medical and institutional bias that is difficult to overcome. And the lack of realistic financing alternatives at least for the current generation of seniors has made Medicaid a de facto long-term care insurance program for middle class individuals, although it is important to keep in mind that families still provide the preponderance of long-term care on an informal and unpaid basis.

The increasing trend of asset divestitures to qualify prematurely for Medicaid coverage of nursing home costs has negative consequences for the Medicaid program, for long-term care providers, and for consumers, both those who access Medicaid and those who use their own resources to pay for their care. People are often surprised by the price of long-term care, which reflects constantly rising costs for staff and other elements of top notch services. In most States, Medicaid reimbursement does not keep up and private room rates become higher than they otherwise would have to be in order for a facility to break even. The burden of cost inadequately covered by Medicaid now falls unequally on the narrow segment of

nursing home residents who pay their own way because they end up paying more than they otherwise would have to, drawing down their savings more rapidly. The question isn't is long-term care properly funded? But rather what is it we want the program to buy? If the intended outcome is the bare survival of residents, then Medicaid probably is adequate. However, if the intent is to have nursing home residents and elders in the community thrive according to the spirit of the nursing home standards in OBRA 87, we have a long way to go.

The future of long-term care when innovatively and successfully created will be led by a government, provider, consumer partnership that leverages emerging care technologies and fully embraces the consumer-focused culture change movement that is now underway. To be successful, we will need regulations rethought for this new world, and we will need innovative funding design which aligns with what seniors and their care givers want. In closing, I just want to mention a project that Lutheran Homes has initiated, which we are calling Operation Enduring Thanks. In early June, we plan to bring approximately 30 of our World War II veteran residents here to Washington to see the new World War II Memorial on the Mall. Congressman Camp is a member of our honorary steering Committee for this project, and we greatly appreciate his generosity in helping us help these older veterans achieve this recognition. Once again, I appreciate the opportunity to discuss these issues with you today, and I look forward to working with you on the future of aging services. Thank you.

[The prepared statement of Mr. Gehm follows:]

**Statement of David M. Gehm, President and Chief Executive Officer,
Lutheran Homes of Michigan, Frankemuth, Michigan**

Madame Chairwoman and members of the subcommittee, I am pleased to have the opportunity to testify today on behalf of Lutheran Homes of Michigan and the American Association of Homes and Services for the Aging (AAHSA), of which we are a member. Lutheran Homes of Michigan is a non-profit Christian agency providing a full range of services to God's older children. Our facilities provide round-the-clock Medicare-certified skilled nursing care, certified home care, senior housing, hospice, and private-duty services to hundreds of Michigan seniors of all faiths. In addition to basic housing, nutrition, and medical care, Lutheran Homes provides a number of life-added programs whose cost is completely covered by private fundraising. Sixty percent of our residents are dually eligible for Medicare and Medicaid.

Our history tracks the trends in long-term care over the last several decades and the ways in which our field in some ways is turning back to the future. Lutheran Homes began 114 years ago primarily to give low-income seniors an affordable place to live, adding whatever services were necessary. Over the next several decades, we developed a long history of finding ways to meet seniors' varied needs. With the establishment of the Medicare and Medicaid programs in the 1960s, we became primarily nursing home oriented. While that so-called medical model and the government programs that finance it continue to fill a critical need, we are finding that consumers strongly prefer to receive services in the places they call home. We therefore are diversifying our services once more to approximate the kind of care we originally provided, with affordable housing as the focal point for the delivery of supportive services. In fact, within the next fifteen years we see ourselves moving away from providing skilled nursing facility care except for short-term rehabilitation and some levels of dementia.

In that context, I want to mention the need to finance supportive and health-related services in affordable housing settings. Public payments for nursing home care bundle housing costs together with the costs of health care and supportive services. For short stay skilled nursing patients and some very frail longer stay residents with more extensive care needs, this arrangement has proven to be a cost-effective way of ensuring that they receive the level of care they require.

However, we are seeing that unbundling the services can make much more sense for people who don't need the entire package of services that nursing homes provide. But if housing and supportive services are unbundled, they must both be available and affordable if people are to have a realistic alternative to nursing home care.

The full Ways and Means Committee has jurisdiction over the nation's largest affordable housing program, the low-income housing tax credit. I would hope that this committee can spearhead discussions with other congressional committees that oversee housing and supportive services programs to overcome some of the obstacles to coordinating affordable housing with services that enable people to age in place. In the future, we hope that housing plus services can help many people avoid or postpone entry into a nursing home.

I want to emphasize that although Medicaid, and Medicare to a lesser extent, are an important source of funding for long-term care, our community also plays a large role in financing the services our clients and residents receive. We do not discharge residents who become indigent, and private fundraising in the community pays for approximately half of the cost of their care. Our Annual Fund assists many seniors who are in desperate need of help with their health care expenses. Last year we fund-raised nearly \$1 million, of which about half was used for direct program support, with the rest placed into long term capital replacement or other special accounts.

In addition to financial support, our communities contribute greatly to the quality of life for our residents through many hours of volunteer time. Volunteers help our residents with activities, religious services, telephone companionship, transportation, meal deliveries, and errands, as well as assisting our staff with clerical and office work. In 2004, we logged 19,000 volunteer hours, people giving of their time and talent to enrich the quality of life for our residents.

We need to build on the existing private contributions to long-term care in order to develop a more rational and balanced long-term care system. Up to now, heavy reliance on the Medicaid program as the primary source of financing for long-term care has had some unintended consequences. Because Medicaid is primarily a health care program, long term care developed an excessively medical and institutional bias that is difficult to overcome. And the lack of realistic financing alternatives, at least for the current generation of seniors, has made Medicaid a de facto long term care insurance program for middle class individuals, although it is important to keep in mind that families still provide the preponderance of long-term care on an informal, unpaid basis.

The increasing trend of asset divestitures to qualify prematurely for Medicaid coverage of nursing home costs has negative consequences for the Medicaid program, for long-term care providers, and for consumers, both those who access Medicaid and those who use their own resources to pay for their care. People often are surprised by the price of long-term care, which reflects constantly-rising costs for staff and other elements of top-notch services. In most states, Medicaid reimbursement does not keep up, and private-pay rates become higher than they otherwise would have to be in order for a facility to break even. The burden of costs inadequately covered by Medicaid now falls unequally on the narrow segment of nursing home residents who pay their own way, because they end up paying more than they otherwise would have to, drawing down their own savings more rapidly. A letter I recently received from the family member of a privately-paying resident expressed his outrage over the inherent unfairness built into the current system. At the same time, consumers who access Medicaid coverage must devote all of their income except for a small personal needs allowance to their nursing home care, removing from them any financial independence.

We must find equitable and effective ways to better share the essential costs of long-term care between public and private sources. Any one of us at some point could find ourselves in need of these services.

The question isn't "is long term care properly funded?", but rather "what is it we want the program to buy?" If the intended outcome is the bare survival of residents, then Medicaid probably is adequate. However, if the intent is to have nursing home residents and those in the community thrive, according to the spirit of the nursing home standards in the Omnibus Budget Reconciliation Act of 1987, we have a long way to go.

We increasingly are looking to technology to maximize our quality and cost-efficiency of care. Traditionally, ours has been a "high touch" field, but we now are using new technology to track our home care staff, hoping to become as sophisticated at scheduling them as Federal Express is at tracking packages. AAHSA's Center on Aging Services Technology is working with researchers, Intel and other technology companies, and providers to find ways in which technological developments

could be applied to the field of aging services in order to help elders remain independent and to provide services more effectively.

Another important trend in our field is culture change, shifting away from hierarchical staffing to a team approach to care and emphasizing consumer direction of the services we provide. The federal nursing home standards that were put into place under OBRA '87 generally have improved the quality of care provided in our nation's nursing homes. We feel that the culture change movement, emphasizing consumer direction and autonomy, is well within the spirit of OBRA and other federal and state nursing home quality initiatives. At the national level, officials at CMS have indicated that OBRA should not be a barrier to putting the "home" into nursing home care, but implementing culture change still requires step-by-step negotiations with state survey agencies because of highly prescriptive regulations. Lutheran Homes has embarked on a complete transformation of our nursing departments, but we are still short of our ideal goals. We need a new spirit of cooperation among providers and government agencies so that we can partner in carrying out innovative approaches to long-term care.

In closing, I just want to mention a project in which Lutheran Homes is now involved, which we are calling Operation Enduring Thanks. We plan to bring approximately thirty of our World War II veteran residents here to Washington to see the new World War II Monument on the Mall. Congressman Camp is a member of the Honorary Steering Committee for this project, and we greatly appreciate his generosity in helping our older veterans achieve this recognition.

Once again, I appreciate the opportunity to discuss these issues with you today, and I look forward to working with you on the future of aging services.

Chairman JOHNSON OF CONNECTICUT. Thank you very much, and before I recognize Dr. Feder, let me excuse myself for the questioning portion. I am going to stay and listen, but I am going to let the gavel transfer as testimony concludes. But I do want to thank you all for your thoughtful comments and for the continuity that I see flowing between them as to great importance of integrating care to greater quality and greater flexibility, and to make the changes in payment system and thinking and regulatory law and so on that that kind of holistic approach requires. I have read your testimony, Dr. Feder, and I am sorry that I won't be here to listen to the questions, but I do look forward to the full report that you are working on. I recognize you and turn the gavel over to my colleague from Louisiana, Mr. McCrery.

**STATEMENT OF JUDY FEDER, PH.D., PROFESSOR AND DEAN,
GEORGETOWN PUBLIC POLICY INSTITUTE**

Ms. FEDER. Thank you, Madam Chair. I appreciate being part of such an informative panel, and I appreciate speaking before you all, Mr. Stark, Members of the Committee on long-term financing. As Mrs. Johnson said, a lot of the information that I am relying on today and is in my statement for the record comes from a Robert Wood Johnson funded project that we call the Georgetown Long-Term Care Financing Project. I hope the information can be useful to you, and you can find it at www.LTC.Georgetown.edu. So, please take advantage of it. I want to concentrate now on three points: on long-term care financing as a problem not just for the future, but now, and not just for the budget, but more importantly for people in need of long-term care and their families; on the inability of private long-term care insurance regardless of its potential value and growth in use to address that problem adequately; and on the critical role of increased public, especially Federal fi-

nancing, to assure affordable access to long-term care, both now and in the future.

First, long-term financing as a problem now, not just as well as in the future. Among the roughly eight million people outside of nursing homes who are estimated to need long-term care, one in five report receiving insufficient care, with a great likelihood of falling, soiling themselves, or being unable to bathe or to eat as a result. The burden of long-term care is borne overwhelmingly by individuals and the families of those in need, in both caregiving and dollars, rather than spread through a public or private insurance. This is true despite the fact that the need for long-term care poses an unpredictable catastrophic risk, best handled by insurance. Almost 40 percent of the population estimate to be in need of long-term care today is under the age of 65, a population that clearly faces an unpredictable risk. And among the population about to retire today, the need for long-term care is also unpredictable, with tremendous variation in the likelihood of long-term care use. Close to half of today's retirees are estimated to die ultimately having needed either no long-term care or a year or less, while at the other extreme, one in five are estimated to need more than 5 years of care.

Insurance is increasingly recognized as the way we ought to handle long-term care financing. But private insurance can only do some of the job. Indeed, promotion of private insurance as a fundamental solution or even as a priority ignores its significant limitations. Private long-term care insurance is not available to people who already have long-term care needs. Though available, it is not designed to meet the needs of younger people who are also at risk of needing long-term care; is not affordable to the substantial segment of older persons now and in the future with low and modest incomes; limits benefits in dollar terms in order to keep premiums affordable, but therefore leaves policy holders with insufficient protection when they most need care; and lacks the premium stability and benefit adequacy that can assure purchasers who pay premiums year after year that it will protect them against catastrophe.

We need only look at the experience in health insurance to recognize that reliance on the individual market plagued by risk selection, high market and cost benefit exclusions, and other problems for long-term care will be grossly inadequate to assure adequate protection to most people. Current public policy also falls short of assuring insurance protection. Medicare focuses primarily on skilled care, not long-term care. Medicaid is the Nation's long-term care safety net. It is invaluable but it provides care—it does not provide what we think of as insurance in that it does not protect people against financial catastrophe. Rather, it protects them only after catastrophe strikes. Some have labeled the impoverishment of Medicaid as a fallacy, claiming that many people on Medicaid could pay for themselves. And some have claimed that having Medicaid available is a substantial deterrent to the purchase of long-term care insurance. As CBO Director Holtz-Eakin indicated a few moments ago, there is little evidence available to support either claim.

Despite Medicaid's essential role, however, its protection has significant limitations. It provides too little care in the home where

people would prefer to receive it; its eligibility and benefits vary substantially from State to State; and its services are too vulnerable to the fiscal pressures that States face. And as we have heard from CBO, if the problem is bad today, it is only likely to get worse in the future. What is needed for a different future is a public policy action. Developing better policy requires an assessment options to assure access to affordable long-term care and to distribute financing equitably between individuals who need long-term care and their families on the one hand, and the rest of Federal and State taxpayers on the other.

Consideration of budget implications is a part of that assessment, but allowing budgetary constraints to drive that process distorts the Nation's policy choices. Last April's CBO report did precisely that, though I was pleased to hear Dr. Holtz-Eakin present a far more balanced approach today. To assert that, as CBO does, cutting back already inadequate Medicaid and Medicare protection would save Federal dollars is not surprising if you are focusing only on reducing Federal costs. But as CBO states, such a policy would increase burdens on family and reduce access to care. Similarly, CBO notes that promoting long-term care insurance whether through partnerships or other mechanisms is unlikely to reduce costs or even substantially expand coverage. What is needed is the expansion of Federal dollars to support a more adequate approach across the Nation. We know that such an approach must need not eliminate personal responsibility, as many European nations are working to more fairly distribute burdens—

Mr. MCCRERY. [Presiding.] Dr. Feder, if you could wrap up.

Ms. FEDER. And in conclusion, to more fairly distribute burdens across individuals and taxpayers, we can do the same, and it ought to be our highest priority.

[The prepared statement of Ms. Feder follow:]

Statement of Judy Feder, Ph.D., Professor and Dean, Georgetown Public Policy Institute

Chairman Johnson, Mr. Stark, and members of the Committee, I'm pleased to have the opportunity to testify before you today on long-term care. My testimony will reflect more than twenty-five years of research experience in long-term care, at Georgetown University and, before that, the Urban Institute. Based on that research, my policy conclusions are the following:

- Today, 10 million people of all ages are estimated to need long-term care, close to 40 percent of whom are under the age of 65. Among the roughly 8 million who are at home or in the community, one in five report getting insufficient care, frequently resulting in significant consequences—falling, soiling oneself, or inability to bathe or eat.
- The need for long-term care is unpredictable and, when extensive service is required, financially catastrophic—best dealt with through insurance, rather than personal savings. But the nation lacks a policy that assures people of all ages access to quality long-term care when they need it, without risk of impoverishment.
- Private insurance for long-term care is expanding and will play a growing role in long-term care financing. However, even with improved standards and special “partnerships” with Medicaid, it does nothing for those currently in need, is not promoted as a means to serve the under-65 population and, in the future will be affordable and valuable for only a portion of the older population—most likely, the better off.
- Medicaid is the nation's only safety net for those who require extensive long-term care. Rather than serving primarily as a deterrent to the purchase of private insurance, it serves overwhelmingly to assure access to care for those least able to afford that insurance. But its invaluable services become available only

when and if people become impoverished; its protections vary substantially across states; and, in most states, it fails to assure access to quality care, especially in people's homes.

- A growing elderly population will mean greater demand on an already significantly stressed Medicaid program, squeezing out states' ability to meet other needs and, at the same time, likely reducing equity and adequacy across states.
- Policy "solutions" that focus only on limiting public obligations for long-term care financing do our nation a disservice. Although individuals and families will always bear significant care-giving and financial responsibility, equitably meeting long-term care needs of people of all ages and incomes—throughout the nation—inevitably requires new federal policy and a significant investment of federal funds.

The following will lay out inadequacies in current long-term care financing; the implications of growth in the elderly population for future inadequacies; and the importance of federal policy to sustain and improve long-term care protection. Unless otherwise noted, I am drawing on research from the Georgetown Long-Term Care Financing Project, funded by the Robert Wood Johnson Foundation, and available at our web site: ltc.georgetown.edu. The opinions I present are, of course, only my own.

People who need extensive assistance with basic tasks of living (like bathing, dressing and eating) face the risk of catastrophic costs and inadequate care. Today, almost 10 million people of all ages need long-term care. Only 1.6 million are in nursing homes. Most people needing long-term, especially younger people, live in the community. Among people not in nursing homes, fully three quarters rely solely on family and friends to provide the assistance they require. The range of needs is considerable—with some people requiring only occasional assistance and others needing a great deal. Intensive family care-giving comes at considerable cost—in employment, health status and quality of life—and may fail to meet care needs. Nationally, one in five people with long-term care needs who are not in nursing homes report "unmet" need, frequently resulting in significant consequences—falling, soiling oneself, or inability to bathe or eat. The cost of paid care exceeds most families' ability to pay. In 2002, the average annual cost of nursing home care exceeded \$50,000 and 4 hours per day of home care over a year were estimated to cost \$26,000. Clearly, the need for extensive paid long-term care constitutes a catastrophic expense.

The likelihood of needing long-term care is also unpredictable. Although the likelihood increases with age, close to 40 percent of people with long-term care needs are under the age of 65. And the need for care among the elderly varies considerably. Over a lifetime, projections of people currently retiring indicate that about 30 percent are likely to die without ever needing long-term care; fewer than 17 percent are likely to need one year of care or less, and about 20 percent are likely to need care for more than five years.

Because long-term care needs are unpredictable and may be financially catastrophic, insurance is the most appropriate financing strategy. Reliance on savings alone is inefficient and ineffective. People will either save too much or too little to cover expenses. However few people have adequate private or public long-term care insurance. Although sales of private long-term care insurance are growing (the number of policies ever sold more than tripled over the 1990s), only about 6 million people are estimated to currently hold any type of private long-term care insurance. Growing numbers of older people, especially of the segment with significant resources, will create the potential for substantial expansion of that market. But private long-term care insurance policies remain a limited means to spread long-term care risk. Private long-term care insurance

- Is not available to people who already have long-term care needs;
- Is not designed to meet the needs of younger people who are also at risk of needing long-term care;
- Is not affordable to the substantial segment of older persons, now and in the future, with low and modest incomes;
- Limits benefits in dollar terms in order to keep premiums affordable, but therefore leaves policyholders with insufficient protection when they most need care; and
- Lacks the premium stability and benefit adequacy that can assure purchasers who pay premiums year after year that it will protect them against catastrophe.

We need only look at experience in health insurance to recognize that reliance on the individual market—plagued by risk selection, high marketing costs, benefit exclusions, and other problems—for long-term care will be grossly inadequate to assure adequate protection to most people.

Current public policy also falls far short of assuring insurance protection. Medicare, which provides health insurance to many who need long-term care, covers very little long-term care. Its financing for nursing home care and home care is closely tied to the need for acute care and is available for personal care only if skilled services—like nursing and rehabilitation therapy—are also required.

It is Medicaid that provides the nation's long-term care safety net. Most nursing home users who qualify for Medicaid satisfy Medicaid's income and asset eligibility requirements on admission. But 16 percent of elderly nursing home users begin their nursing home stays using their own resources and then become eligible for Medicaid as their assets are exhausted. Because the costs of long-term care are so high relative to most people's income and resources, the opportunity to "spend down" to eligibility—spending virtually all income and assets in order to qualify—is essential to assure access to care. Some have labeled impoverishment a "fallacy", arguing that the bulk of Medicaid resources go to finance nursing home care for people who could afford to pay for themselves, but who "transfer" their resources in order to qualify for Medicaid benefits. Such exaggeration relies on anecdote, not evidence. Indeed, the evidence shows that few of the elderly have the income or wealth that would warrant such transfer; that people in poor health are more likely to conserve than to exhaust assets; that, for the elderly population as a whole, transfers that occur are typically modest (less than \$2000); and that transfers that are associated with establishing eligibility are not significant contributors to Medicaid costs.

Further, there is little evidence to support the argument that Medicaid's availability is a substantial deterrent to the purchase of long-term care insurance (CBO, "Financing Long-Term Care for the Elderly," April 2004). This argument is based far more on theoretical assumptions than on empirical analysis of people's actual behavior. Indeed, analysis of actual purchases of private long-term care insurance found no impact on purchase decisions among older workers and found the slight impact on purchasers over age 70 too small to explain the very low proportion of elderly holding policies (Frank A. Sloan and Edward C. Norton. 1997. "Adverse Selection, Bequests, Crowding Out and Private Demand for Insurance: Evidence from the Long-Term Care Insurance Market, *Journal of risk and Uncertainty* 15, no.3: 201–219).

Despite Medicaid's essential role, however, its protections differ considerably from what we think of as "insurance". Medicaid does not protect people against financial catastrophe; it finances services only after catastrophe strikes. Further, Medicaid's services fall far short of meeting the needs and preferences of people who need care. Medicaid's benefits focus overwhelmingly on nursing home care—an important service for some, but not the home care services preferred by people of all ages. In the last decade, Medicaid home care spending has increased from 14% to 29% of Medicaid's total long-term care spending. But nursing homes still absorb the lion's share of Medicaid's support for long-term care.

Medicaid protection also varies considerably from state to state. As a federal-state matching program, Medicaid gives states the primary role in defining the scope of eligibility and benefits. A recent Urban Institute analysis emphasized the resulting variation across states in service availability as a source of both inequity and inadequacy in our financing system. In an examination of 1998 spending in 13 states, long-term care dollars per aged, blind, or disabled enrollee in the highest spending states (New York and Minnesota) were about 4 times greater than in the lowest (Alabama, Mississippi)—a differential even greater than that found for Medicaid's health insurance spending for low income people.

Both our own research and that conducted by the Government Accountability Office tells us that differences in state policies have enormous consequences for people who need long-term care. Studies comparing access for individuals with very similar needs in different communities show that people served in one community get little or no service in another. Georgetown research finds that the same person found financially eligible or sufficiently impaired to receive Medicaid services in one state might not be eligible for Medicaid in another—and, if found eligible, might receive a very different mix or frequency of service. And a comparison of use of paid services in 6 states finds almost twice the incidence of unmet need (56%) in the state with the smallest share of people likely to receive paid services as in the state with the largest (31%).

This variation—as well as ups and downs in the availability of benefits over time—undoubtedly reflects variation in states' willingness and ability to finance costly long-term care services. The recent recession demonstrated the impact on states of changes in their economies and the vulnerability of Medicaid recipients to states' reactions. In 2001, Medicaid accounted for 15 % of state spending, with long-term care responsible for 35% of the total. Virtually all states were cutting their Medicaid spending as budget pressures struck, endangering access either for low in-

come people needing health insurance, older or disabled people needing long-term care, or both.

In sum, under current policy, neither public nor private insurance protects people against the risk of long-term care. Despite Medicaid's important role as a safety net, the overall result for people who need care is catastrophic expenses, limited access to service, and care needs going unmet.

Given inequities and inadequacies in our current approach for long-term care, it is no wonder that we are concerned about the future, when a far larger proportion of the nation's population will be over age 65 than are today. Experts disagree on whether disability rates among older people in the future will be the same as or lower than they are today. But even if the proportion of older people with disabilities declines, the larger number of older people will likely mean a larger number of older people will need long-term care in the future than need it today. The population aged 85 and older, who are most likely to have long-term care needs, is likely to double by 2030 and quadruple by 2050.

States will vary in the aging of their populations—with resulting differences in the demand for long-term care and the ability of their working-aged population to support it. To identify future demands on Medicaid, a Georgetown study examined census data on the ratio of elderly people to working-age adults between 2002 and 2025. Nationally, this ratio changes from about one to five (one person over age 65 for every 5.2 people of working age) in 2002 to one to three—an increase of about 66 percent. But the changes differ across states, with some states well below the national average (e.g. California, Connecticut, D.C., Massachusetts) and others, far above. In many states, the ratio increases by more than three quarters and in a few (e.g. Colorado, Utah, and Oregon), it more than doubles. All states will be challenged to meet increased long-term care needs.

States are already struggling with Medicaid's fiscal demands, which challenge their ability to meet equally pressing needs in education and other areas. And state revenue capacity varies considerably. If current policies persist, pressure to make difficult tradeoffs will only get stronger. In the future, states with bigger increases in the elderly-to-worker ratio will face the greatest pressure. And, since many of the states with above average changes currently spend relatively little per worker on Medicaid long-term care, there is a strong likelihood that in the future, long-term care financing will be even less equitable and less adequate across the nation than it is today.

What's needed for a different future is public policy action. Developing better policy requires an assessment of options to assure access to affordable quality long-term care and to distribute financing equitably between individuals who need long-term care and their families, on the one hand, and the rest of federal and state taxpayers, on the other. Consideration of federal budgetary implications is an important part of the assessment process. But allowing budgetary constraints to drive that process distorts the nation's policy choices. Last April's CBO report on long-term care financing did precisely that. Explicitly focusing on the achievement of only one policy goal—alleviation of "pressure" on the federal budget—the report treated as legitimate only policy options with the potential to reduce federal spending, without regard to the consequences for people in need.

From this perspective, the report's first set of policy options—cutting back already inadequate Medicaid and Medicare protection—is not surprising. But its implications are nevertheless horrifying. CBO straightforwardly states that such action could reduce the number of people dependent on public programs—a fairly obvious conclusion. But it presents no evidence that people inappropriately rely on Medicaid today; and no evidence that savings or private long-term care insurance would provide adequate protection if Medicaid were made more restrictive for the future. Indeed CBO explicitly recognizes that this approach implies greater burdens on family and friends, greater difficulty in obtaining care, and greater bad debt for long-term care providers. If the policy goal is—as it should be—to improve care and distribute costs equitably, such cutbacks seem unconscionable, not desirable.

The CBO report's second set of options to alleviate fiscal pressure aim to "improve the functioning of the market for private long-term care insurance"—a strategy that is less likely than public cutbacks to reduce access but still unlikely to significantly improve either access or equity. Standardizing long-term care insurance policies might facilitate consumers' ability to make choices in the marketplace and improve the adequacy of private long-term care insurance. But, as CBO notes, standards that improve policies would likely increase insurance premiums. The result might be better protection for those who can afford private insurance—a worthy goal, but it is highly unlikely to be an increase in the numbers of people willing or able to buy insurance.

CBO's consideration of so-called "partnerships for long-term care"—which would allow benefits paid by private insurance to offset (or protect) assets for Medicaid users who purchase approved private long-term care insurance policies—also reveals this strategy's limitations. These partnerships have been advocated as a means to save Medicaid money by preventing "spend-down" and asset transfers. The hope is that allowing the purchase of asset protection, along with insurance, will encourage modest income people to purchase private long-term care insurance. Experience with these policies in four states has produced only limited purchases, primarily among higher income people, and has affected too few people for too short a period to assess its impact on Medicaid spending (Alexis Ahlstrom, Emily Clements, Anne Tumlinson and Jeanne Lambrew, "The Long-Term Care Partnership Program: Issues and Options", Pew Charitable Trusts' Retirement Security Project, George Washington University and The Brookings Institution, December 2004). The partnership has contributed to improved standards for long-term care insurance policies and more partnership policies are being sold to more modest income people as the standards that apply to them are also applied to the broader market. However, as CBO notes, if these policies simply substitute for policies individuals would otherwise have purchased or increase the likelihood of using long-term care services, they may eventually increase rather than decrease Medicaid expenditures. From the budgetary perspective, advocacy of reliance on Medicaid to essentially subsidize private long-term care insurance alongside promotion of budget legislation to curtail federal Medicaid contributions seems both disingenuous and risky. Further, from the broader equity perspective, targeting private long-term care insurance to modest income people seems questionable. The purchase of a limited long-term care insurance policy could easily absorb close to 10 percent of median income for a couple aged 60—a substantial expenditure for a cohort acknowledged as woefully unprepared to meet the basic income needs of retirement.

Even more questionable are proposed tax preferences for private long-term care insurance. CBO does not analyze these proposals, perhaps because they would clearly increase rather than decrease public expenditures. Nevertheless, they are consistently on the policy agenda, despite the likelihood that they will be poorly targeted to improve insurance protection. Experience with health insurance tells us that such credits are likely to primarily benefit those who would have purchased long-term care insurance even in the absence of credits—substituting public for private dollars—and, as currently proposed, are not even designed to reach the substantial portion of older and younger Americans with low and modest incomes.

Indeed, the whole focus on reducing public spending and promoting private insurance ignores the public responsibility to address for all Americans what should be our fundamental policy choice: do we want to live in a society in which we assure affordable access to long-term care for people who need it or in a society in which we leave people in need to manage as best they can on their own?

There is little question that to address both current and future long-term care needs requires not a decreased but an increased commitment of public resources—and, to be adequate and effective in all states—federal resources. Expanded public financing for long-term care could take a variety of forms and by no means need eliminate private contributions. One option, modeled on Social Security, would be to provide everyone access to a "basic" or "limited" long-term care benefit, supplemented by private insurance purchases for the better-off and enhanced public protection for the low income population. Another option would be establishment of a public "floor" of asset protection—a national program assuring everyone access to affordable quality long-term care—at home as well as in the nursing home—without having to give up all their life savings as Medicaid requires today. The asset floor could be set to allow people who worked hard all their lives to keep their homes and modest assets, while allowing the better off to purchase private long-term care insurance to protect greater assets. Either public/private combination could not only better protect people in need; it could also provide substantial relief to states to focus on health insurance, education and other pressing needs—relief that governors have explicitly requested by calling on the federal government to bear the costs of Medicare/Medicaid "dual eligibles". Because Medicaid serves the neediest population and, in the current budgetary environment is at risk, my highest priority for expenditure of the next federal dollar would be responding to this call (along with supporting more home care and better quality care) with more federal dollars to Medicaid.

Some will undoubtedly characterize proposals like these as "unaffordable", given the fiscal demands of Medicare and Social Security and the current federal budget deficit. But that deficit reflects policy choices. I would far rather see expenditure of the next federal dollar devoted to enhanced Medicaid long-term care financing than to tax credits for long-term care or tax cuts in general. Indeed, the estate tax is es-

pecially appropriate for long-term care financing: taxing everyone's estate at certain levels, to provide reasonable estate protection for those unlucky enough to need long-term care.

As we look to the future, examination of the choices being made by other nations of the world is instructive. Analysis by the Organization for Economic Cooperation and Development (OECD) of long-term care policy in 19 OECD countries (presented at the June 2004 research meeting of AcademyHealth) found that the number of countries with universal public protection for long-term care (Germany, Japan and others) is growing. Public protection, they report, does not imply the absence of private obligations (cost sharing and out-of-pocket spending), nor does it imply unlimited service or exploding costs. Rather, in general, it reflects a "fairer" balance between public and private financing—relating personal contributions to ability to pay and targeting benefits to the population in greatest need. Many of these nations have substantially larger proportions of elderly than the U.S. does today and therefore can be instructive to us as we adjust to an aging society.

Clearly, we will face choices in that adjustment. If we are to be the caring society I believe we wish ourselves to be, we too will move in the direction of greater risk-sharing and equity by adopting the national policy and committing the federal resources which that will require.

Mr. MCCRERY. Thank you. Mr. Stinson, Dr. Feder outlined a number of reasons that private long-term care insurance is not working and won't work in her opinion. Would you like to respond to the reasons that she gave or in the alternative give me your reasons why long-term care insurance is not being purchased in large numbers these days?

Mr. STINSON. I would be happy to respond. Correct maybe just a couple of points or give my perspective on the a couple of the things that Ms. Feder presented and then give an answer perhaps to why more people haven't bought long-term care insurance. She indicated in her findings that the product is not designed for younger people. And I will take exception to that. I have dozens and dozens of claimants under age 50. In fact, my youngest claimant is 36 years old. The product to those families is extremely important. It is going to pay for costs of care for those families for many, many years, and the policies today are designed with extreme flexibility in terms of where you can receive care. So, I believe the products are built for a younger population. In fact, in my testimony, I indicated that the average age is now down in the high fifties, and it is dropping rapidly. So, it is a financial planning product for the baby boomers.

The dialog before this panel got up was why aren't more people owning long-term care insurance. About 8 percent of adult Americans own long-term care insurance today. Over 65, that number is about 15 percent of Americans over age 65 own the product. That is not incredibly unique. Life insurance ownership is about 30 percent. long-term care insurance has only been around in its form today for about 10 to 15 years. So, the fact that 15 percent of adult Americans over age 65 own the product is actually a pretty good thing. I mention the statistic six million people. Why isn't the number 30 percent? I think the single biggest issue that we have in front of us is the reluctance of the American people to embrace an idea that they are going to lose their independence. People don't want to think about it. People don't want to talk about it. That forces a lack of awareness of three important things: the lack of awareness or the likelihood of needing care; the lack of awareness

of the cost of long-term care; and a lack of awareness around what the funding options are. I think our single biggest issue facing the penetration of this particular product is the lack of awareness in the public today of long-term care issues.

Mr. MCCRERY. How do you change that?

Mr. STINSON. I think a couple of things. The tax incentive that has been proposed I think does two things. It certainly will help on the cost, on the affordability side of purchasing long-term care insurance. As I mentioned, long-term care insurance is not a product for everyone. I think the most important thing that an above the line tax deduction would provide or a discussion around the Partnership is the fact that it would bring this topic to every kitchen table in America today. Everyone has just completed filing their tax returns. If that particular item was on every single tax return in America, people would be asking their financial planners, asking their advisors, or looking to one another and say what is long-term care insurance? Should I be taking some action? And I think the Partnership Programs are another great way in terms of getting the concept out and with an objective oversight from government, from the States, and a plan that works in public and private partnership is a great way and an inexpensive way to address the issue.

Mr. MCCRERY. Why is it not a product for everyone?

Mr. STINSON. In terms of affordability, if you look at lower income families, I think, the average premium for this product is \$1,500 to \$2,000. For those that are just getting by and putting food on the table, living paycheck to paycheck, I do not believe this particular product or many financial products is the right solution for that individual family.

So, that is an area of the population I don't believe this product is designed for and we recognize that. And that is the purpose of our Medicaid system.

Mr. MCCRERY. Ms. Stark.

Mr. STARK. Thank you. Thank you, all of the witnesses for participating. Mr. Stinson, can you tell us what your persistency is on your long-term care policies?

Mr. STINSON. Yes. Our—to flip it around and say lapse rate, voluntary lapse rate. The number of people that just stop paying premiums.

Mr. STARK. Before they die or before they—

Mr. STINSON. Right.

Mr. STARK. Mature.

Mr. STINSON. Excluding mortality, is about one and a half percent. Most of our customers hang on to this policy until they pass.

Mr. STARK. Okay. And can you give us a loss ratio?

Mr. STINSON. That is a more complicated answer.

Mr. STARK. All right.

Mr. STINSON. It is difficult to frame a specific percent for you, sir.

Mr. STARK. Why?

Mr. STINSON. I would have to understand the context of the question. I know about half of my customers are going to file a claim.

Mr. STARK. No. Of the premiums you take in, how much do you pay out in benefits? That's what I have always thought of as loss ratio, but—

Mr. STINSON. I can get you—I don't have the number right off the top of my head, sir.

Mr. STARK. Well, I don't. Well, whatever you can give us. The last year you can think of what were your in force premiums for your long-term care?

Mr. STINSON. In force premium is about a billion six. We pay out about \$500 million in claims every year.

Mr. STARK. So, your loss for insured is about a third. Right? Thirty percent?

Mr. STINSON. In that definition.

Mr. STARK. Very good.

Mr. STINSON. And I know that about 50 percent of the people that own the policies today will file a claim at some point.

Mr. STARK. Well, I don't have any other questions, Mr. Chairman.

Mr. MCCRERY. Mr. Lewis?

Mr. LEWIS OF GEORGIA. Thank you very much, Mr. Chairman. Let me thank each of you for being here today, and thank you for your testimony. Dr. Feder, it is good to see you again. I haven't seen you in a long time. Thank you. Mr. Gehm, your written testimony stated that Medicaid reimbursement does not keep up with the cost of care in nursing homes. Can you tell me how the repeal of the Borne Amendment in 1997 has affected your bottom line? Has the quality of care diminished as a result or lower payment as anticipated? Would you say that some of the quality problems in nursing homes that are being reported in recent years are the result of the repeal?

Mr. GEHM. I can tell you that in our experience through the early '90, even into some of the mid '90s with Borne intact, Medicaid funding was more consistent with our expense profile for caring for folks. As a result of the repeal of Borne, what we have seen at least in Michigan, and I think this is similar across the country, is that the increases in Medicaid initially did not keep up with what the inflation of the expenses were and more lately we have seen, of course, some rollbacks in Medicaid. As a result, our bottom line has been impacted significantly. Provider taxes came onto the scene, and so it would take some analysis to get you some direct numbers at least in the case of Lutheran Homes and that could be done. I would be happy to do that.

Mr. LEWIS OF GEORGIA. I would love to seeing maybe other Members of the Committee would like—

Mr. GEHM. I would be happy to do that. But I think the overall theme for us right now is certainly the trend with respect to Medicaid is that the differential between cost of care and coverage under Medicaid is a widening gap for us. Your broader question about whether it has impacted quality issues in nursing homes. On the one hand, I can't help but think that it hasn't. On the other hand, I know that the provider community has become very innovative within the regulations and very proactive in trying to create new futures and new models of care, and I think quality continues to grow and we have seen it in the quality indicators that are

tracked and monitored. And so we are happy with the direction that it is going. But certainly funding will always impact quality, certainly to a certain extent.

Mr. LEWIS OF GEORGIA. Thank you very much, Mr. Gehm. Dr. Feder, I would like to ask you and this may be a question that my friend, Mr. Pomeroy, may be interested in. I understand that the National Association of Insurance Commissioners is currently promoting formation of an interstate compact that will circumvent State laws and allow same insurance products, including long-term care insurance, to be monitored and essentially regulated by non-governmental effort. Are you familiar with this proposal? What are your thoughts on that?

Ms. FEDER. Mr. Lewis, I am relying on the work done by my colleague, Nila Kaufman, at Georgetown who has in looking at the policy has indicated a number of concerns as have many who have looked at it. The concerns being that rather than strengthening the standards that apply to the policies affected that it creates an opportunity for some insurance to be sold that escapes State standards that are more restrictive and more effective. So, rather than strengthening consumer protections, the concern is that it would weaken them.

Mr. LEWIS OF GEORGIA. Other members of the panel have any reaction? Thank you, Dr. Feder. Thank you, Mr. Chairman.

Mr. MCCRERY. Yes, sir, Mr. Lewis. Mr. Pomeroy?

Mr. POMEROY. Thank you, Mr. Chairman. First of all, let me congratulate—first express my appreciation for being allowed to ask questions, not being a Member of the Health Subcommittee. But I want to acknowledge that I think this has been an excellent panel. And it has been my pleasure to work with a couple of panels for a long time—Dr. Feder, and even longer Mark Meiners. We have been trying to figure this one out for 20 years. And it is really good to see you again. The first question I direct to Mr. Stinson and it relates to the loss ratio questions that Mr. Stark—I am a little rusty from my old insurance regulatory days. But I believe the loss ratio includes claims reserving in the loss side of the equation. So, if it was—it is not simply a matter of claims paid out in a given year versus premium in a given year on the loss side, those premiums held in reserves to pay future losses are also counted as loss; isn't it for a loss ratio?

Mr. STINSON. Hence, my reluctance to just jump at an answer to the question. Just an incurred loss ratio of the claims that I am actually paying was the 30 percent number there, the \$500 million, divided by the billion six, when, in fact, the insurance companies do have to put up substantial reserves to pay for claims in the future.

Mr. POMEROY. And as the policy book ages, your claims go up?

Mr. STINSON. Absolutely. Absolutely.

Mr. POMEROY. Do you know your target loss ratio for getting policy form and rates approval in a given State?

Mr. STINSON. Not in a particular State.

Mr. POMEROY. My notion is it is 60 percent or better.

Mr. STINSON. Right. Sixty to seventy percent is a range.

Mr. POMEROY. Right.

Mr. STINSON. Yes.

Mr. POMEROY. The real debate of long-term care insurance is should we try and figure out some private protections for people or is it all basically a waste of time awaiting some significant Federal relief with a comprehensive program. I have run into this from my youngest days as insurance commissioner trying to work on improving what was offered by way of this coverage. My approach was kind of agnostic on the question. I think that until we pass something—that is a big Federal program to address the concern in this area—people have legitimate risk exposure and then therefore a legitimate need to try and get something in place that deals with it. Dr. Feder, do you acknowledge that can be a legitimate role in the meantime here.

Ms. FEDER. Absolutely, Mr. Pomeroy. And I know how hard you have worked to achieve that. And I think that the policies, as we have heard from Mr. Stinson and also Mark Meiners and the Partnership, the policies have improved dramatically over the years as the policies have evolved. But when we look at a focus of public policy, I have a number of concerns.

Mr. POMEROY. My question is—I am surprised to hear the debate almost, there was a wonderful little trip down memory lane, because it sounded a lot like 1985 all over again. I am just looking at this budget, which is in tatters, and has been horrifically handled by Congress in my belief. But I don't see any shred of a possibility of some significant new comprehensive Federal program to deal with this long-term risk, especially when you consider the aging of the population.

Ms. FEDER. But, Mr. Pomeroy, what we do know in this budget is that we are seeing proposed cuts in the Medicaid program that we rely on for long-term care.

Mr. POMEROY. I think that is very ill advised.

Ms. FEDER. That the partnerships, we heard a CBO estimate that it might increase costs and that we—therefore, I find it a matter of concern to rely on a program that is being squeezed on the one hand to provide some subsidy on the others.

Mr. POMEROY. Has Georgetown, your study been able to look at the partnerships and try and draw your own conclusions about whether it is a net cost or saving?

Ms. FEDER. We have not done that. What we will be doing as part of the larger project is looking at the partnerships alongside other initiatives that could be taken to see what their consequences are in terms of costs and—

Mr. POMEROY. Before my time entirely. Thank you very much, and it is I really good to see you again.

Ms. FEDER. Could I just say one more thing on the trouble? No. I won't then.

Mr. POMEROY. Well, I want to get Mark in here before my time runs out.

Ms. FEDER. All right.

Mr. POMEROY. I am at the Chairman's leave. So, do you have an evaluation in terms of whether this is a net cost or a net minus or largely a wash but in the meantime people are getting substantial private coverage and protecting some assets, which should be considered on the plus side I imagine.

Mr. MEINERS. Well, back—it seems like 20 years ago, when we were starting the program. We did simulations with them and the state of the art modeling technique of using the Brookings ICF model that Judy is now using a version of. And we had estimated that as the program unfolded by year, it was done in five-year intervals, 2016 to 2020, the rollback should be a 7 percent in each point drop in Medicaid costs as a proportion of the expenditures. Now, more recently—

Mr. POMEROY. Well, I am just going to ask if you could take that model and then juxtapose into it the early, experiences that we have had in the pilot States.

Mr. MEINERS. Because we get asked this question all the time, the States have really developed their own model based on some responses they have gotten from surveys as well as the experience of purchasers as much as you mentioned. There is a fairly good tracking that has been done now. And the States—the three dollar for dollar States—California, Indiana, and Connecticut—have estimated at this point a savings of \$8 million to \$10 million in an aggregate basis.

Mr. POMEROY. And—

Mr. MEINERS. They are showing savings from their perspective of putting these numbers on the table and—

Mr. POMEROY. Actuarially, many—depending on the period of time of protection purchased, but people—and with the disability sufficient so that they actually become institutionalized many will before becoming Medicaid eligible—before they have exhausted their coverage die, and is that seems to be—as I look at the data, it looks like this is fitting an actuarial expectation and that getting them that extra private coverage is indeed allaying the inevitable Medicaid hit. Even if it is essentially a wash on Medicaid, it is getting them additional private pay so they are having asset protection in a very meaningful way that is of value to creating the estate.

Mr. MEINERS. What we are seeing is that most of the asset protection incentive that is earned is not used because the insurance is the first thing that pays and most people will die, in using up the insurance to take care of their long-term care needs. So, relatively little of the Medicaid asset protection is ever used. And the flip side of the way you get the benefit of it is the strategy is really designed to bring people in the market who are resistant. We worry about the size of the market. There is a lot of denial out there. There is a lot of worry about costs versus quality, and frankly the people who need it most are the ones who are asking those questions the hardest. And the Partnerships are really designed and I think can be effective in getting to that middle modest income group that really need this kind of protection because it is geared toward providing a more limited yet significant useful type of care, level of care.

Mr. POMEROY. My time is exhausted, but I really appreciate this information.

Mr. MEINERS. Good to see you.

Mr. POMEROY. If you have stuff to bring to my attention at the office I would really enjoy learning a lot more from your perspective. Thank you, Mr. Chairman.

Mr. MCCRERY. Before I ask Doctor, there was a couple more questions about the Partnership, I want to give Mr. Stark a follow up.

Mr. STARK. I just wanted to ask unanimous consent to insert the CBO estimates in the record, which show a \$45 million cost on the Partnerships and I think that should be part of the hearing's records.

Mr. MCCRERY. Without objection.

Mr. STARK. And I will discuss the question of reserves on loss ratios with my colleague privately.

Mr. MCCRERY. Dr. Meiners, I want you to talk a little bit more about the partnership concept, especially as it relates to Medicaid estate planning. Dr. Feder says in her testimony that there is not really a lot of evidence out there that that is going on, that it is all anecdotal. I have several books here that we got from the library that are all about Medicaid estate planning. So, somebody thinks it is going on. There is a Web site from the University of Minnesota that says Medicaid estate planning involves legal and financial approaches to satisfying financial eligibility requirements for Medicaid. More specifically, an individual's assets are sheltered with the intention of voluntarily becoming impoverished to meet Medicaid eligibility criteria. So, there is something going on out there, and my question to you, Dr. Meiners, is if this is going on, do you think the partnership concept is a way to minimize that?

Mr. MEINERS. Okay, yes. Let me take a pick on the issue. First of all, I think we can debate back and forth how much of it is going on. I think when it happens, unfortunately it happens because people haven't been able to prepare for this risk. And the reason they are unprepared for the risk is because they really haven't had good options, particularly those people that are most at risk of easily spending down. So, when the problem hits and they haven't prepared, they are going to look for ways to shelter their limited assets and that is, viewed as this divestiture notion. And most people, if you were facing them as a social worker, someone like that, you would probably help them do it because, their backs are to the wall and they don't really have a whole lot. So, what we are trying to come up with is an alternative that really is appealing to people so that when—they can avoid that situation. I think several things can happen then. The issue of going after people's divestiture behavior is something that is very hard. We have seen it being politically hard. So, the only way you can really do it is if you have a reasonable alternative, like the partnership, that really helps people plan for this risk and get that out there far enough in advance so that you have sort of the carrot and the stick. Otherwise, it becomes very hard to do that.

I think, bottom line, in terms of what you do about asset transfers, we have debated this on and off and on and off, and it is kind of like if there are a lot of asset transfers going on, then it is something that we ought to do something more about. And if there is

not a lot of assets transferring going on, then what does it matter if we do something about it? So, either way, doing something about it is to sort of send the message, that this really isn't what ought to happen, is important. But I, frankly, feel like you really need something like the partnership or other ways to help people prepare for this risk so that the information can be out that there is something positive that can be done about it. One of the reasons that we struggle with this is because we don't really have good answers, so we don't raise the problem, and sort of—CMS, for example, has done their educational campaign, but it has been very slow in unfolding and fairly limited. And I think in part it is because there is a hesitancy to acknowledge that we have any answers. I think the partnership is an answer that we can work on that actually can help to strengthen the Medicaid program and give people incentives to provide for themselves at the same time. And then the asset transfer issue can be dealt with more effectively.

Mr. MCCRERY. Thank you. Before I give any of the other panel members a chance to make a last comment before we adjourn, I just want to point out that while we haven't made a bubble on deductibility public policy for long-term care insurance, we have allowed the use of health savings accounts balances for paying premiums which, of course, are pre-tax dollars. So, there is that vehicle out there now that is available for paying premiums for long-term care insurance. Does any other panel member want to make a comment before we adjourn.

Ms. FEDER. I would.

Mr. MCCRERY. Dr. Feder?

Ms. FEDER. Just I wanted to say, going back to Mr. Pomeroy's questions about frustration in trying to do something, one area of concern to me is that we will be cutting Medicaid while talking about these other areas that would rely on it. But even of greater concern if we take new initiatives is if we are going to actually commit to spending new public dollars, it seems to me that they must go first to those who are in greatest need, which means targeted down the income scale. And that is why I am most concerned about policies that would continue to, that have done or would continue to offer tax incentives for the purchase of private long-term care insurance, or targeted to the higher-income population. It seems to me that many of us can afford to buy these products already if we so choose. And spending these—you are quite right—hard-do-come-by tax dollars on the population most able to take care of themselves seems to me a very unwise policy choice.

Mr. POMEROY. Mr. Chairman, if I might ask a follow-up question.

Mr. MCCRERY. Sure.

Mr. POMEROY. Well, what if it is like this. We have enough dollars to either help a broader number, if we leverage some private dollars into the mix, even though that means gearing it at middle income as opposed to the most needy income, versus helping a smaller number that have no assets at all and so have to be 100 percent public funded. These are the terrible policy choices a bad budget environment leaves us with, but I think that it shouldn't be dismissed out of hand, helping the broadest number that you can.

Ms. FEDER. Well, actually, I think that it is not that we are helping people even today, with people who have no assets, people who are going on Medicaid, the evidence is overwhelming, or people with modest income and assets who contribute all those assets and income to the costs of their care. So, we are relying on private and public resources now. It is just a public-private partnership, if you will, that is tremendously unfair to the individuals unlucky enough to fall into that trap. I have heard some people refer to it as the last estate tax left, is on individuals who are so unlucky as to need long-term care and exhaust their resources. So, we can enhance Medicaid's ability to protect people who have long-term care needs and still rely, still be relying on profit resources but do a far better job of mixing public and private resources, even if we don't go all the way to a social insurance program, as Mr. Stark—

Mr. POMEROY. My notion is, just in response—the discussion will be continued, I suppose, in philosophical ways for a long time. If, for example, you took the Federal dollars and tried to bring up spend-down levels so we have a higher level for eligibility for Medicaid; or, on the other hand, you tried to preserve, the payment for Medicaid services that are under great stress now. Either way. You basically do not expand substantially the portion of the population that you are helping. And if you, on the other hand, with a partnership approach, can incent additional people buying this third-party coverage, which is getting additional private payment into the mix, conceivably you are leverage dollars that allow you to help a larger number of people.

Ms. FEDER. It is just not clear to me that the partnership is actually serving as the incentive that you would like it to be. People can buy limited-dollar policies now. They do run the risk of having to ultimately spend down to Medicaid, so I do get that they are getting the additional asset protection. But as we hear, most of them are dying before they exhaust the one- and two-year benefit period. So, they buy that now.

What is troubling to me as a public policy is targeting our attention on modest-income people. I looked at the data. It says for a 60-year-old, you are asking somebody for a limited-dollar policy to spend—I have to double-check my notes, but I think it was 10 percent of income, roughly, median income for 60-year-olds, on a policy. That doesn't feel to me like we are helping them so much. They haven't even got sufficient resources for retirement. So, I would rather we worked harder on making the safety net decent.

Mr. POMEROY. I certainly understand your point.

Ms. FEDER. Thank you.

Mr. MCCRERY. Let's go—this is your last chance. Mr. Gehm?

Mr. GEHM. Thank you. I would like to offer maybe an alternative kind of perspective with respect to long-term care insurance and its kind of market penetration, such as it is, and these kinds of things. I am not sure that, from where I sit on kind of the long-term care continuum, from the provider side, both within, certainly, my organization, colleagues I speak with in Michigan and across the country, I have really come to the conclusion that the lack of buy-in to long-term care insurance isn't necessarily a rejection of that product, but mostly a rejection of what you are insuring against, and that is the notion that it is buying you traditional

nursing home care rather than what it really can do for us with respect to buying services that link to housing. So, I think we might have some success if we begin to think a little differently about what it is we are trying to get long-term care insurance to really do. And when it allows folks to link services with housing, which the programs do allow, I think we will have some success. The problem is people think they are insuring against nursing home risk. They don't want to deal with it. And I agree with my colleague down the panel here, who suggested that there is this kind of I-don't-want-to-deal-with-my-own-aging bias with respect to that. And if we can offer the market choices in terms of care venues and housing with services and other things as part of what we talk about when we talk about long-term care, I believe that we will have more success in creating the right incentives in the market for folks to go ahead and insure against that risk.

Mr. MCCRERY. Thank you.

Dr. Meiners?

Mr. MEINERS. I appreciate the opportunity to mention one more thing, and that is as we try to think creatively, I really was trying to orient us to thinking about these systems of care, the integration of Medicare and Medicaid, because when you pull those dollars, you really have the chance to actually take Medicare dollars the only way you really can and turn it into more of an ability to pay for things like the In-Home Supportive Services program that was mentioned earlier, a personal care program, long-term care programs. So, I think those are a model of where you can pool dollars and the States are creating systems of care that are unique in doing more than is normally out there in the process, coming up with better ways of caring for people. I think, with that structure in place, you could use something like the partnership incentive to perhaps encourage people who are pre-duals, who haven't yet ended up on Medicaid, and get them in some of those systems of care with care management, care coordination, and perhaps have them get the kind of coordination that helps them avoid ever needing to spend down or at least delaying that spend-down process, where they would ever need to end up on Medicaid. Now, that is something, if you let States work with those pre-duals and some incentive systems, States really get a lot out of that because this person never really becomes a full dual-eligible, never really becomes Medicaid-eligible, because they are getting better care up front. I think there are a lot of creative things we can do there in this situation we are in, which is not unlike the situation we were in when I first started looking at long-term care insurance more than 20 years ago. We need that kind of creativity. And I think there are ideas that we can pursue in that regard, and the partnership and those integrated care systems can both be part of it.

Mr. MCCRERY. Mr. Stinson?

Mr. STINSON. Thank you, yes. Just in response to the question around does the partnership program help sell insurance. We believe it does. Statistically, we sell more partnership programs in those States that have the partnership program than non-partnership policies. A significant proportion of the policies we sell in California, Connecticut, Indiana, New York are partnership policies because we believe consumers see the value of the private and public

partnership and the value of that program. So, we believe it does help insurance and would offer broader coverage for consumers. Again, the long-term care insurance industry does not believe that the long-term care insurance product is the only solution. We believe that it should be part of the solution. We believe that the way to get greater penetration is a program of greater education and awareness. I think broader consideration of the partnership program is a very just cause, and considering above-the-line tax deductions, other forms of tax incentives will help people consider this product and own more of it.

Mr. MCCRERY. Dr. Gerety, you get the last word.

Dr. GERETY. I would just urge the Subcommittee to think, along with all these issues about financing and the structure of care, to not forget that you need a workforce to deliver that care. And right now we are already in a situation where we have a real shortage of qualified professionals who can deliver geriatric care—doctors, nurses, social workers, therapists, personal care providers. And so as we are trying to prepare for all this need, I think the Nation has to face the fact that without public policy action, you simply will not have trained people to be able to provide high-quality care. And I think any program that you undertake to reform long-term care has to address these work-force issues, or we will be stuck with still-poor-quality care even in a system that might have financing available.

Mr. MCCRERY. At the risk of engendering more discussion, which I will cut off immediately, any ideas you have on how we could improve that climate, we would welcome. Because we have been struggling with it for some time. Thank you all very much for a very interesting discussion of the topic. And we thank you very much for coming to our humble chamber and sharing your ideas with us..

[Whereupon, at 6:18 p.m., the hearing was adjourned.]

[Submissions for the record follow.]

Statement of Alane Dent, American Council of Life Insurers (ACLI)

The American Council of Life Insurers (ACLI) is a Washington D.C.-based national trade association representing more than 350 member companies that offer life insurance, annuities, pensions, long-term care insurance, disability income insurance and other retirement and financial protection products. ACLI member companies have 81 percent of the long-term care insurance in force in the United States.

We are delighted that this Subcommittee is addressing an important issue facing this nation—long-term care—through the hearing process and possibly through legislation. Subcommittee Chairwoman Nancy Johnson has been and continues to be a thoughtful leader on this issue by introducing legislation that would encourage individuals to plan ahead and adequately provide for their future long-term care costs by purchasing long-term care insurance. A number of Members of this Committee have sponsored this legislation, and we are pleased to discuss with the Subcommittee the role that private long-term care insurance plays in ensuring the retirement security of millions of middle-income families.

To elevate the issue of long-term care today and over the next decade ACLI co-sponsored the 2005 White House Conference on Aging's Mini-Conference on Long-Term Care. At this conference participants representing long-term care stakeholders within both the public and private sectors came together to actively address the serious issues associated with long-term care and worked to formulate public policy recommendations to the upcoming White House Conference on Aging that will be held later this year. The Mini-Conference on Long-Term Care participants urged Congress to enact laws which would encourage private arrangements by individuals and their families for LTC services, such as tax incentives for the purchase of long-term care insurance or other private options for financing long-term care.

One of the greatest risks to asset loss in retirement is unanticipated long-term care expenses. ACLI has found that nearly half of all Americans will need long-term care at some point in their lives. A 65-year-old woman has a 50-percent chance of needing nursing-home care in her lifetime; a 65-year-old man has a 30 percent likelihood of needing such care. One in five over age 50 is at risk of needing it in the next twelve months. The annual cost of a nursing home stay averages \$55,000 and is projected to reach \$241,000 by 2030. Two visits a day by a home health aide to help with bathing, dressing, and household chores can cost \$2,500 a month. If skilled help, such as physical therapy, is needed the expense is greater. These costs can quickly erode a hard-earned retirement nest egg.

Today, your Subcommittee is focusing on the current financing for long-term care services; private long term care insurance options include the Long Term Care Partnership programs; and the challenges ahead in financing needed services for an aging population. We want to stress that both current and future long-term care financing needs can best be met through the broader use of long-term care insurance.

Current Financing for Long-Term Care Services

• Long-Term Care Insurance

The long-term care insurance market is vibrant and innovative. ACLI recently surveyed the long-term care insurance market, with the assistance of America's Health Insurance Plans (AHIP) and found that the individual market in terms of premiums is approximately 12.5 times larger than the group market in terms of premiums—\$6,502 million compared to \$510 million, and 3.5 times larger in terms of policies versus certificates—4 million policies compared to 1.1 million certificates.

The individual market grew at 7.5% from 2003 to 2004 (in terms of premiums). The group market grew at 25%. The strong growth in both markets represents the value of the product and the continued effects of the Federal Long-Term Care Insurance Program that made long-term care insurance available to federal government employees, annuitants and their qualified dependents and relatives. This program stands as an example to all employers to offer similar programs to encourage their employees to prepare for their future retirement needs. The average age of purchasers of long-term care insurance continues to decrease as individuals increasingly understand it as a tool to retirement income security. In 2004, long-term care insurance carriers paid more than \$2.1 billion, or a 20 percent increase from 2003, in long-term care insurance benefits.

long-term care insurance continues to evolve to give policyholders more choices and greater quality of care. For instance, the market has evolved from nursing home-only to one that offers flexible care options and numerous consumer protections. Most policies allow customers to choose between in-home care, assisted living facilities and nursing homes, encouraging the individual and their families to customize his or her care needs. In addition, policies offer the services of a local care coordinator that meets with a policyholder at the time of claim to help craft a plan of care and identify local care providers. Other common benefits include:

- case management services;
- homemaker or chore services;
- restoration of benefits;
- reimbursement of bed reservations in long-term care facilities;
- coverage of some medical equipments survivorship benefits;
- caregiver training; spousal discounts; and
- limited pay policies.

All plans are guaranteed renewable, have a 30-day "free look" period, offer an inflation protection, cover Alzheimer's disease, have a waiver of premium provision, and offer unlimited or lifetime nursing home maximum periods.

• Incentives to Encourage Individuals to Buy Long-Term Care Insurance

An integral solution to meeting long-term care expenses will be the reintroduction and passage of H.R. 2096, the "Long-Term Care and Retirement Security Act of 2003" that the Chairwoman introduced in the 108th Congress. The measure provided individuals with an above-the-line federal income tax deduction for the premiums they pay to purchase long-term care insurance. The long-term care policies subject to the deduction are covered by broad consumer protections. In addition, the measure would permit long-term care insurance policies to be offered under employer-sponsored cafeteria plans and flexible spending accounts. Finally the bill includes a tax credit to individuals with long-term care needs or their caregivers of up to \$3000.

This important tax incentive will go a long way toward encouraging the purchase of long-term care insurance by middle-income Americans. Moreover, providing this

important tax incentive means that Americans who take advantage of long-term care protection will not be a burden on the Medicaid system and will not have to spend-down their retirement assets to pay for long-term care before becoming eligible for Medicaid. Instead, they will have the choice of a variety of services if they are unable to perform a specific number of activities of daily living or are cognitively impaired. Today's long-term care insurance 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 modification. These options can enable people who are chronically ill to live in the community and to retain their independence.

While the financial benefits to individual policyholders are obvious, the benefits to government—and future taxpayers—of wider purchase of private long-term care insurance are substantial. By the year 2030, Medicaid's nursing home expenditures could reach \$134 billion a year—up 360 percent over 2000 levels. ACLI's research indicates that by paying policyholders' nursing home costs—and by keeping policyholders out of nursing homes by paying for home—and community-based services, private long-term care insurance could reduce Medicaid's institutional care expenditures by \$40 billion a year, or about 30 percent.

In addition, the ACLI study found that wider purchase of long-term care insurance could increase general tax revenues by \$8 billion per year, because of the number of family caregivers who would remain at work. Today, 31 percent of caregivers quit work to care for an older person; nearly two-thirds have to cut back their work schedules; more than a quarter take leaves of absence, and 10 percent turn down promotions because of their care giving responsibilities. It costs the typical working caregiver about \$109 per day in lost wages and health benefits to provide full-time care at home—which is almost as much as the cost of nursing home care.

- **Long-Term Care Partnerships**

Increasingly, states are tackling the costs of long-term care and are exploring ways to partner with the private insurance industry to alleviate the growing burden. One such way is through the *Partnerships for Long-Term Care*, a pilot program developed by the Robert Wood Johnson Foundation in conjunction with state governments and the support of the private insurance industry.

The Partnerships allow consumers to purchase a long-term care policy whose benefits must be fully utilized prior to qualifying for Medicaid. When that coverage is exhausted, individuals may apply for Medicaid, as they would have without the private insurance. Because they utilized their insurance coverage under the Partnership, they can protect the level of assets as defined in their policy.

Partnerships have taken the form of two models. The dollar-for-dollar model allows people to buy a policy that protects a specified amount of assets. The total asset model provides protection for 100 percent of assets once they exhaust their private insurance coverage.

The Partnership program is currently operational in four states: California, Connecticut, Indiana and New York. More than 180,000 long-term care insurance policies have been purchased in those states, and it is estimated that through these Partnerships, approximately \$30 million of assets have been protected. The Partnership benefits consumers, Medicaid and private insurers.

Few Partnership policyholders have accessed Medicaid to date. Of the more than 180,000 policies that have been purchased since 1992, fewer than 100 individuals have exhausted those benefits and applied to and or accessed Medicaid.

In 1993, shortly after the Partnership pilots began, Congress suspended expansion of the Partnership to any additional states. The pilots were stopped due to concerns that a publicly funded program such as Medicaid would endorse private insurance programs. Others were concerned that the Partnership might increase Medicaid spending. However, as Medicaid costs increase, Congressional representatives from non-Partnership states have become interested in implementing Partnership programs. During the 108th Congress, legislation was introduced in both the House and the Senate that would repeal that prohibition. In addition, 16 states have passed legislation that would implement a Partnership once the 1993 restrictions are withdrawn or waived. The long-term care insurance industry is interested in expanding the Partnership beyond the four pilot states and is actively engaged in a public policy dialogue that is intended to utilize the lesson learned those four Programs.

ACLI believes that some type of simplified uniform approach to the LTC Partnership Program that includes eligibility for benefits for any approved tax-qualified LTC policy; state reciprocity; dollar for dollar asset protection; uniform, simplified annual reporting to a single repository; and consumer protection can play an im-

portant role in encouraging the purchase of LTC insurance and help provide important savings to Medicaid.

Future Financing for Long-Term Care

Private long-term care insurance will be the key to future financing for long-term care. The insurance industry continues to educate Americans that a financially secure retirement includes a plan to cover future long-term care expenses. To help educate consumers on how to select and purchase a long-term care insurance policy, ACLI maintains educational brochures and information on its website, and upon request, which encourages consumers, when considering a major purchase of long-term care insurance, to:

- (1) look for insurance companies that are reputable, consumer oriented, financially sound and licensed in their particular state,
- (2) obtain the name, address and telephone number of the agent and insurance company,
- (3) take time when making a purchase, ask for and read the outline of coverage of several policies,
- (4) understand what the policy covers and ask questions to be clear about what the policy is not intended to cover,
- (5) understand when the policy becomes effective, what triggers benefits and if it is tax deductible at the state and/or federal level,
- (6) answer questions on medical history and health truthfully on the application, and,
- (7) contact the State Insurance Department or the State Health Insurance Assistance Program with questions on long-term care insurance and the insurance company with specific questions about the policy.

The federal government and the states have also recognized the need to educate individuals in the workplace to plan to cover their future long-term care needs. The federal government, by Act of Congress, has taken the lead and set the example for other employers by offering federal employees and their families the protection of long-term care insurance. Through this program, federal employees are able to protect their retirement savings from a long-term care event and will have the choice of providing care for themselves or a family member in the home, through assisted living or in a nursing home.

Last year, the Department of Health and Human Services began a federal project to increase awareness among retirees and near-retirees about the need to plan ahead for potential long-term care needs. Governors of five pilot states are conducting long-term care awareness campaigns over a two- to three-month period, starting in January 2005. The campaign includes press conferences, mailings to 50- to 70-year-olds in each state, advertising and follow-up mailings. Results will be evaluated and improved before expansion to other states. The five states include Virginia, Idaho, New Jersey, Nevada and Arkansas.

About half the states have programs through state personnel offices that afford state employees/retirees the opportunity to purchase individual long-term care insurance policies. Twenty-one states provide tax incentives for purchasing long-term care insurance. Most state tax deductions share some features with federal rules—allowing all or part of premiums and expenditures to be deducted. Two states provide a tax deduction or credit for employers offering group LTC insurance policies. As more than 77 million baby boomers approach retirement, the rapidly aging workforce together with more employees caring for elderly parents heighten the importance of long-term care planning as a workplace issue.

In conclusion, we believe that protection and coverage for long-term care is critical to the economic security and peace of mind of all American families. Private long-term care insurance is an important part of the solution for tomorrow's uncertain future. As Americans enter 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. We also believe that the costs to Medicaid—and therefore to tomorrow's taxpayers—will be extraordinary as the baby boom generation ages into retirement, unless middle-income workers are encouraged to purchase private insurance now to provide for their own eventual long-term care needs. ACLI believes it is essential that Americans be given an above-the line deduction for this product that is so vital for their retirement security.

Again, the ACLI looks forward to working with this Subcommittee to help Americans protect themselves against the risk of long-term care needs.

Statement of Laura Howard, Americans for Long Term Security (ALTCS)

Chairman Johnson;

Americans for Long Term Care Security, a bi-partisan, 35-member organization commends you on scheduling today's hearing examining long term care. It is consistent with your strong leadership on this issue for most of the past decade.

ALTCS strongly believes that as Congress prepares to examine broad issues and possible legislation related to retirement security, long term care must be included. We believe your Long Term Care and Retirement Security Act from the past several Congresses and when introduced in the 109th Congress will be the most comprehensive long term care bill before Congress.

We must not just recognize but respond to the growing challenge that long term care poses to individuals, families and the nation. Long term care costs now exceed costs for medical devices and prescription drugs combined. Medicaid, which will get much attention at this hearing, now exceeds education as the largest expenditure in state budgets. Nursing home expenses under Medicaid have risen by more than 100 percent between 1990 and 2000.

Meanwhile, we confront the aging of the baby boomers in our nation. Long term care remains the greatest unfounded liability for this generation.

We need greater incentives through the tax code to encourage more Americans who are able to purchase long term care insurance. Your legislation has proposed a phased-in, above-the-line deduction for qualified long term care insurance premiums. This is good policy that can encourage more Americans to purchase this product which is evolving in a positive way to address more of what people might face with respect to long term care.

Any discussion of long term care must also address another growing challenge—family caregiving. Estimates point to more than 20 million American families who are confronted with caregiving responsibilities of one kind or another. They need relief from the costs associated with caregiving. These are direct and daily costs and other costs such as reduced earnings. Your bill recognizes this need by calling for up to a \$3,000 tax credit for family caregivers.

We also applaud your legislation's call for coverage of long term care in employer cafeteria plans and FSAs. This too will be important to achieve balanced long term care reform.

As the hearing will raise today, by approaching long term care reform as both a public and private sector responsibility it might be achieved.

ALTCS also strongly believes that we must intensify our public education efforts around long term care. It remains a fact that too many Americans still believe that Medicare covers long term care. There remains a huge disconnect between what people need to know and what they do know about long term care to help them make responsible decisions. ALTCS salutes the work being done by the 2005 White House Conference on Aging on this aspect of work on long term care. Their mini-conference on long term care is being held today as well and it should produce one or more resolutions for later consideration and adoption by the delegates.

ALTCS believes that beyond robust public education, improving long term care will also require a strong and trained workforce and the sharing of financial risks involved in providing care.

ALTCS looks forward to our continued work with you, Chairman Johnson, this Subcommittee, and later the full Congress on behalf of achieving passage of meaningful long term care legislation. We must make the necessary investments today in terms of tax incentives and reforms to Medicaid. Important savings can and eventually will be achieved to Medicaid and Medicare through this investment. Medicare and Medicaid both are celebrating their 40th anniversaries. It also means we are 40 years older as a society in terms of addressing the needs of our aging population. Today's challenges are tomorrow's crises if we fail to act.

Statement of Hal Daub, American Health Care Association

As President and CEO of the American Health Care Association (AHCA), the nation's largest association of long term care providers, and as a former member of the Ways and Means Committee myself, I would like to thank Rep. Nancy Johnson for holding this hearing—and for her long time advocacy of not just improving long term care, but also for exploring and proposing new ways to finance our seniors' growing care costs

I would also like to thank every Member of the Health Subcommittee for their consistent, diligent attention to the healthcare needs of America's most vulnerable population of seniors and persons with disabilities.

A thoughtful discussion regarding long term care's chronic solvency crisis—and the extent to which the expansion of long term care insurance and partnerships can improve the financial stability and quality of Medicare and Medicaid services—is timely and necessary.

As we are all aware, the Administration's proposed FY 2006 budget reduces Medicare long term care funding by \$25 billion and Medicaid by an unprecedented \$60 billion over a ten-year period. These double whammy budgetary reductions will undoubtedly create short-term instability, thereby putting in jeopardy the financial foundation required to maintain and sustain the care quality improvements we have all worked so hard together to achieve.

I'd like to remind members of this Subcommittee that former HHS Secretary Tommy Thompson and CMS Administrator Mark McClellan stood with our profession last December to announce not just that nursing home care quality in America is improving in a quantifiable manner through the Nursing Home Quality Initiative (NHQI)—but that there is indeed a direct correlation between stable funding sources and levels of care quality.

At the time the Secretary expressed "hope" that continued stability of long term care funding will lead to further quality improvements.

In light of the improvements in nursing home care we have achieved with the Administration through the NHQI, the cumulative long term care funding cuts are ill considered, and not only place seniors' care quality at risk, but sends the long term care sector backwards.

Even the Medicare Payment Advisory Commission (MedPAC), which is historically critical of the skilled nursing facility (SNF) sector, declined to support the short-sighted budgetary savings of reduced Medicare reimbursements. Rather, the commission suggested preservation—but reallocation—of the add-ons.

The bottom line is that these proposed budgetary reductions will cut into quality care and reduce our ability to properly prepare for the demographic challenges facing America.

Since passage of the 1997 Balanced Budget Act (BBA)—which resulted in approximately 15 percent of long term care providers seeking bankruptcy protection—skilled nursing providers have been on a dangerous and unnecessary economic roller coaster ride of Medicare cuts followed by temporarily-restored funding.

The President's proposed budget places a critical sector of our nation's health care delivery system back on the roller coaster in a manner that will negatively impact not only our current and future ability to maintain and sustain quality gains for the residents we serve, but also capital investment into our sector.

This hearing today coincides with the White House Conference on Aging Long Term Care Mini-Conference—which today is hosting leading stakeholder organizations, including AHCA, as we work towards developing a comprehensive policy road-map to ensure our nation's future long term care needs can be achieved.

The policy recommendations developed at the mini-conference will serve as the basis for the long term care policy discussions at the full 2005 White House Conference on Aging, to be held later this year.

Among those speaking during the two day forum are Harvard Law School Professor Arthur Miller who moderated the discussion, CMS Administrator Mark McClellan, and Dorcas Hardy, the former Administrator of the Social Security Administration, and Chairman of the White House Conference on Aging Policy Committee.

For the record, Madame Chairman, I would like to submit AHCA's statement delivered today at the Conference, as it coincides with the very themes and issues being discussed today:

"The demographics are startling. With 77 million baby boomers rapidly approaching an age when many will require long term care services, it is imperative that we establish policies now to equip us to provide the highest quality care in the most appropriate setting for the patients and residents of tomorrow.

"This demographic wave will present new and unexpected challenges for providing and funding healthcare services in homes, communities, nursing facilities or other residential care settings. This forum of our nation's premier long term care experts and thought leaders will most certainly help provide policy makers a framework for taking the right steps now to meet the changing needs of an aging population."

We know for certain the impending wave of aging baby boomers and advances in health care and medicine will allow many, many more Americans to live longer—and these simultaneous developments require fresh, realistic approaches towards long term care financing.

As America will soon confront its greatest unfunded liability—the public cost of future retirees’ long term care needs—Congress needs to investigate a variety of new approaches that utilize the tax code to more effectively meet these costs.

In that regard, AHCA and NCAL have always been strong proponents of your proposal, Madame Chairman—the “above-the-line” tax deduction also supported by President Bush, Rep. Earl Pomeroy (D–ND) and by Senators Charles Grassley (R–IA), among others.

A deduction of this nature could dramatically increase the number of people who purchase long term care insurance by reducing its costs. Increasing the size of the pool will also drive down premium costs, making the insurance model progressively more appealing.

We also strongly support the Long Term Care Insurance Partnership Program Act—legislation introduced by Senators Craig and Bayh in the last Session of Congress, which expands the ability of citizens to purchase state-approved long term care insurance policies—so they can take control of how and where their own long term care needs are met.

Should the need for care exhaust the benefit of the policy, the Partnership program provides asset protection, allowing individuals to qualify for Medicaid, without “spending down” their entire savings.

The many benefits to this legislation are significant:

- It would conserve scarce Medicaid resources due to the fact long term care expenses will be increasingly met by the private sector;
- It would promote greater self-reliance and individual responsibility as Americans meet their own care needs as opposed to relying exclusively upon government funding;
- It would allow seniors to bequeath at least a portion of their assets to loved ones; and
- It would encourage the expansion of the long term care insurance market which will have a positive impact of helping to make policies more affordable.

In particular, Madame Chairman, expansion of the long term care insurance market is especially important: for patients, expanding the market will bring about increased long term care funding stability and the concomitant benefit of higher quality care; for states and for taxpayers, the inherent benefit is reduced financial and budgetary pressure on Medicaid-financed long term care.

As we thank you here today for bravely addressing the so-called “elephant in the room”—the need to create longer term solutions for long term care financing—we also encourage the exploration of other private activities, such as reverse mortgages, tightening asset transfer requirements, and enacting new tax laws to incentivize the purchase by individuals of long term care insurance. But these alone will not create a comprehensive solution for long term care financing, and so, we look forward to working with you, Madame Chairman, your committee, Congress and the Administration to seek out and create new and innovative resolutions to this impending crisis.

With the impending cuts proposed for both Medicaid and Medicare in the FY 2006 budget, these are much-needed initiatives meriting fast-track consideration and enactment.

With the funding instability produced by initial budget cuts, funding restorations, eligibility and benefit changes, more cuts and the general cycle of uncertainty that best characterizes federal long term care funding over the past decade—regardless of who controls Congress and the White House—our profession is acutely aware of the linkage between Medicaid and Medicare funding instability and our ability to maximize patients’ care quality.

It is alarming that that 85 percent of Americans believe their long term care needs will be met by Medicare, Medicaid or their existing health insurance. This fact underscores the need for government to help educate and inform its citizens to understand how to prepare for their retirement and its financing.

When individuals understand the risks they face, the costs of care, and the options before them, we as a nation should be confident the vast majority of Americans will choose to act responsibly and plan for their future needs and the needs of their families.

This fundamental premise reflects American values: Americans want to control their destiny, and every individual must—and should—take some level of responsibility for their future, and that of their family. If armed with the facts and the means, people will do what is right to protect their health, their family, and their economic interests.

With the proper planning and level of commitment this matter deserves, Congress can begin laying the groundwork for a long term care financing system that has the capacity to meet the care needs of millions of future retirees.

Madame Chairman, there is no stronger supporter of Medicaid reform than AHCA, and we have very publicly and consistently called on Congress and the states to maintain its financial viability with appropriate levels of investment.

Demographic realities require a change in policy and a transformation in thinking.

We must fundamentally shift the role of government—from government simply paying for services—to government helping individuals save for their own long term care needs.

Thank you for the opportunity to submit our testimony today, and we look forward to working productively and cooperatively with this Committee, with this Congress and with this Administration to do what America has always done when presented with a challenge of this scope: engage in honest debate, create a workable plan, earn the support and trust of the nation's citizens, and pursue a course that is in the best interest of every American.

**Statement of Suellen Galbraith, American Network of Community Options
(ANCOR), Alexandria, Virginia**

The American Network of Community Options (ANCOR) is the national organization of more than 850 private providers of supports and services to more than 380,000 individuals with mental retardation and other disabilities throughout the nation. For nearly 40 years, ANCOR has represented at the national level private providers who offer community living and employment supports and services to people with significant disabilities. Throughout its history, ANCOR has been a staunch advocate for *quality* long-term supports to people with disabilities in their communities. ANCOR appreciates this opportunity to provide written testimony to the Ways and Means Subcommittee on Health.

First, ANCOR extends appreciation to Chairwoman Nancy Johnson for convening this hearing and for the subcommittee's attention on this important national issue. ANCOR will provide brief comments in the following five areas:

1. **Diversity of Individuals in Need of Long-Term Care**
2. **Intersection of Multiple Federal Financial and Medical Services**
3. **Workforce Crisis Affecting Delivery of Long-Term Care**
4. **Need for Multiple Public and Private Options**
5. **Sustained National Dialogue**

ANCOR believes that how our nation frames public policy is in large measure due to the questions asked and/or problems identified which in turn determine how we arrive at answers and solutions contained in the public policy. To aid the Subcommittee in its work, ANCOR suggests that their work include addressing the following questions:

1. Who needs long-term care? (i.e., breadth and scope of populations, individual characteristics; differences and similarities)
2. Who pays for long-term care? (i.e., intersection of public and private health and financial mechanisms, private income and savings, Social Security cash benefits, state and federal programs)
3. Who delivers long-term care? (i.e., state and local governments, family and friends as caregivers, institutional and community-based agencies, paid staff)
4. What public programs assist in providing long-term care? (i.e., housing, transportation, social services)
5. What private means are currently available to help finance and deliver long-term care?
6. What public and private options need to be created to ensure availability of long-term care for those who need it?
7. What constitute quality supports and how can we ensure quality through our payment systems?
8. How will future demographic changes and system redesign strategies affect each of these areas?

Diversity: Long-Term Care: Not Just For Retirees, But a Lifetime Need

Today, nearly 10 million Americans need long-term services and supports to assist in their daily living. And yet, any one of us at anytime can find him/herself in need of long-term supports and services. For some individuals, for example—a person born with mental retardation, cerebral palsy, or autism—these are lifetime needs. For others, the onset of a severe disability may come as a teenager when an automobile accident results in a brain injury; in mid-life as a result of a job injury and altering employment options; or as an elder with Alzheimer’s disease.

For some, the need for long-term services and supports is due to a physical disability that affects their ability to perform activities of daily living (ADLs) such as eating, dressing, toileting, and walking. For others, a cognitive disability affects their ability to perform typical instrumental activities of daily living (IADLs) such as meal preparation, medication management, and financial and home management. In some cases, the disability may an individual’s affect cognitive, mental and physical abilities.

The number of elderly persons is projected to increase dramatically, both as a percentage of the population and in absolute numbers, due in part to the aging of the 77 million baby boomers and to increased life expectancy. The entry of baby boomers into the long-term supports and services system will place additional burden on an already strained system. In addition, long-term services are vital to individuals with disabilities under the age of 65—especially in light of the fact that they may require supports over a lifetime. With the aging of parents who currently provide long-term supports to their adult children with mental retardation, nearly 700,000 parents who are caretakers now will soon be in need of their own long-term supports. long-term services and supports are not only an issue for older Americans, but also for children and working-age adults with disabilities as well, and any examination of long-term supports must account for all populations.

While this Subcommittee is very aware of the fact that the need for “long-term care” is not solely an issue for the elderly or aging, frequently policymakers address the financing and delivery of supports and services as if it were unique to the elderly. This singular focus limits the options in the range and type of supports and services offered to individuals. There is a wide range in the ages of those in need of long-term supports and services and that there is a wide range in the nature of those supports and services.

Acknowledgment of these diversities are important in looking at both the financing and structure of long-term supports and services. What a 79 year old female with Alzheimer’s with no family needs is entirely different than what a 42 year old man with mental retardation who can work part-time needs. The desires and needs of a person in their 60s and 70s is very different for someone in their 20s or 40s. For example, personal assistance to get to work is not a desire of someone in their 70s.

ANCOR urges the Subcommittee to keep the following factors in mind:

- 1. Individuals who need long-term supports are a diverse group.**
- 2. long-term supports may be time limited or needed over the lifetime of an individual.**
- 3. Supports should be provided on an individual basis and are likely to change over the life-time of an individual.**

Intersection of Multiple Financing and Delivery Systems

For the 10 million people who need long-term supports and services now and for the millions of family members who are their caregivers and the millions of paid direct support professionals who deliver these supports and services, one thing is very clear: There is no national long-term care policy and there is no cohesive or uniform long-term care system. In fact, most individuals and families who arrive at the need for long-term supports and services face a fragmented delivery system. Hundreds of thousands of individuals each year must face the roller coaster of determining whether they meet eligibility to qualify for supports and if there will be money available in any given year for their essential supports.

The system we now depend upon is best described as a patchwork of programs that vary from state to state and community to community. Each program has its own standards for eligibility and provides different services. This assortment of services is inefficient, inequitable and often ineffective. The lack of a cohesive national policy to assure access to long-supports has left most people with disabilities with an unrecognizable and splintered system of support for their long-term care needs.

long-term care is an essential component of family financial security. The longer we continue to disregard the financial impact of long-term disabilities on individuals

and on society, the wider the gap in our nation's economic security becomes. The current system for enhancing economic security is principally derived from earnings, Social Security, Medicare, employer provided pensions and savings, none of which addresses our long-term care needs. No one is immune from the risk of having a family member in need of long-term care, not to mention the possibility that they will need assistance themselves. About 45 percent of the long-term care population is under the age of 65. Yet, although the need for health insurance to cover a patient's medical expenses in case of catastrophic illness is widely accepted, few people are insured against the costs of providing long-term support services. This lack of insurance coverage jeopardizes the financial security of families and diminishes the economic security of the country. It also places a greater burden on the nation's primary long-term care financing program—Medicaid.

And, yet, the public and many policymakers mistakenly assume that long-term supports are needed only by the elderly and that Medicare provides payment for such services to the elderly. Aside from the new prescription drug coverage added to Medicare and limited after-hospital care, this federal program provides little in the way of long-term supports to the nation's elderly and disabled populations.

Medicaid successfully provides long term care to individuals with disabilities and seniors, accounting for 43% of total long-term care spending. It also finances premiums, co-payments, and long-term supports for those who are also Medicare eligible. However, most of Medicaid's long-term services are considered *optional* services under current Medicaid law. Yet, for those who need these essential services to get out of bed and to eat, go to school, go to work, and contribute to their community, they are by no means *optional*. More than half of all Medicaid long-term care spending goes toward institutional services.

Currently, there are few if any long-term insurance products that will cover the comprehensive services needed by non-elderly individuals with severe disabilities. Once born with a disability, long-term insurance is not an option.

By default, the Medicaid program has become the nation's only publicly financed source of long-term supports and services. However, Medicaid was never intended to be the nation's primary financing source of long-term supports and services. The state and federal governments' reliance on Medicaid as the sole source of long-term supports and services not only forces individuals to spend-down their assets and resources to become eligible for the essential services, but places the burden for our nation's long-term supports on one single program—Medicaid—thereby jeopardizing its financing and its structure and rendering a need for radical changes with claims of *unsustainable growth*.

Because long-term care financing was never integrated into our national retirement and disability security system, an unstable and convoluted patchwork system of financing has emerged. Federal programs do not co-ordinate with or even complement private long-term care insurance. States provide long-term care as a public assistance program that helps seniors only after they have reached the poverty level while it condemns people with disabilities to a life of permanent impoverishment. Unless they have purchased long-term care insurance or have significant savings, the average family must try to piece together limited Medicare coverage, public services, and personal resources, until they spend down to Medicaid eligibility. Clearly, the complexity of the health care financing system requires a multi-faceted solution. Public and private resources must be mobilized and coordinated into a flexible array of programs that can be adapted to provide appropriate levels of care at a reasonable cost.

What is lost in examinations of long-term supports and services is the intersection of Social Security retirement and disability programs, Medicare, Medicaid, private insurance, housing, transportation, and other federal and state assistance programs.

Public and Private Options

long-term care is an essential component of family financial security. The longer we continue to disregard the financial impact of long-term disabilities on individuals and on society, the wider the gap in our nation's economic security becomes. The current system for enhancing economic security is principally derived from earnings, Social Security, Medicare, employer provided pensions and savings, none of which addresses our long-term care needs. No one is immune from the risk of having a family member in need of long-term care, not to mention the possibility that they will need assistance themselves. About 45 percent of the long-term care population is under the age of 65. Yet, although the need for health insurance to cover a patient's medical expenses in case of catastrophic illness is widely accepted, few people are insured against the costs of providing long-term support services. This lack of insurance coverage jeopardizes the financial security of families and diminishes the

economic security of the country. It also places a greater burden on the nation's primary long-term care financing program—Medicaid.

Medicaid has become the single largest public payer of long-term care services. Moreover, although most people prefer to live at home, Medicaid's bias towards institutional care has left Americans with few alternatives and tremendous confusion over how best to arrange the options available to them.

While many people equate term long-term care with someone who lives in a nursing home or other institutional facility, almost 80% of the elderly and 41% of individuals with severe disabilities live at home or elsewhere in the community. Many people with disabilities and older persons with functional limitations or cognitive impairments choose to remain in their homes or live in supportive housing if they can receive assistance with activities of daily living such as eating, bathing and dressing.

The heavy bias in Medicaid funding toward institutional care does not reflect this growing preference for home and community supports and services. Ironically, while people with disabilities and a growing elderly population prefer to receive services in the community, the federal government imposes a strong bias toward institutional care through existing Medicaid and Medicare laws.

Clearly, Medicaid has been forced to fulfill a role it was never intended to play. Though many Americans believe Medicaid only provides assistance to individuals with very low incomes, the reality is far different. Many middle class individuals are forced to spend down—or deplete—their income and assets to qualify for Medicaid services and receive assistance with the high costs of long-term care.

Insurance programs—whether public or private—that provide income and health security only for people in retirement will fail to meet the needs of non-elderly individuals with a range of severe disabilities and a different set of life expectations. Because no one set of long-term supports solutions can be appropriate for every American with a disability, we must design income, health, and long-term security programs that build upon each other and are flexible to support individuals of all ages and their families and communities.

Workforce Crisis

In considering long-term supports and services to the elderly and to non-elderly individuals with disabilities, it is crucial to keep in mind that these supports are multi-dimensional in nature. Although financing is the cornerstone of the long-term care issue, our public policy must also consider other issues equally critical in building an adequate, seamless, and effective long-term care system. These issues include: supporting family caregivers, addressing workforce shortages, improving the quality of long-term care supports and services and improving access to transportation and housing.

long-term care services and support encompasses a broad range of assistance to people who need ongoing help to function on a daily basis. These services may range from assistance with daily activities such as bathing, dressing and eating to more complex services such as meal preparation, shopping, money management, medication management, and transportation. long-term care cannot be relegated to specific hours, days of the week, or to services where one size fits all.

ANCOR believes that the lack of a stable, quality direct support professional workforce is a crisis that is one that will plague the entire long-term care field in the 21st century unless national attention is brought to this issue. This crisis is a result of several factors, including the increased demand for long-term supports and services; a traditional labor supply not able to keep pace with demand; and jobs that cannot compete within today's labor market.

The workers who provide the intimate and daily supports to people with disabilities are known by many job titles—but one thing in common is shared by all of them. They are the hands, voice and face of long-term supports. They are the backbone of our nation's formal long-term support system. These paid workers assist with personal care, general health care, people with severe disabilities with medications, preparing and eating meals, dressing, mobility, and handling daily affairs medication administration, life sustaining medical care such as suctioning and tube feeding, transportation, emotional or behavioral support, community participation, financial management and/or any other life areas that an individual with disabilities might require assistance or support.

A majority of these workers are female and often the sole breadwinner of their household. Although employed, the wages they earn keep many families impoverished. The cost of this labor comprises between sixty and seventy percent of the total dollars necessary to provide long-term supports. As Medicaid is the single largest funder of these supports, it is by default our nation's leading payer of these long-

term supports. Yet this system inadequately reimburses providers to cover the cost of wages and benefits to attract, train and retain quality workers.

As the pool of potential unpaid caregivers shrinks due to demographic and economic trends, direct support professionals will play an increasingly greater role in delivering long-term care. However, the relative size of the paid long-term care workforce is not likely to increase with the anticipated demand for paid long-term care. A low wage workforce, unrealistic workloads, inadequate government reimbursement rates, along with the need for additional training and support, as well as labor shortages have all contributed to high staff turnover. Recruitment and retention problems create an unstable workforce and are a barrier to high-quality care. In addition, our current financing system does not support today's wages, and therefore raises serious questions about the ability to recruit future direct support professionals.

Conclusion: Need for a Sustained, National Dialogue

For the past 60 years, Americans have relied on a combination of social insurance and private means to pool risk and support financial security. The basis for our social insurance programs and most of our private means of pooling risk and enhancing financial security is tied to employment. Social Security, including the life and disability insurance portions for Social Security, and Part A of Medicare are earned rights derived from employment for the worker or the worker's dependent. Most private insurance is organized through group purchases made by employers on behalf of their employees and their dependents. Retirement income is also enhanced through employer-provided pensions and deferred compensation plans. Thus, the American approach to pooling insurable risks and protecting financial security has been a combination of social insurance and tax encouraged private insurance. However, there are gaps in these arrangements as well as gaps between these arrangements. Savings are used to bridge the gaps. And, in the absence of sufficient savings, public assistance is called upon with benefits targeted to those in specific categories with the least financial means.

Unfortunately for those who need extended long term supports and services, public assistance remains the primary financing mechanism. In order to address the issue of how to best finance long term supports and services and then develop comprehensive means for delivering a range of supports and services, a national dialogue is needed today more than ever.

The current fragmented services and supports available to people with disabilities does not reflect the growing need nor preference for long-term supports and is limited by the way in which such services have been funded in the past. Changing long-term care financing will change how long term supports are organized and delivered. A rational approach to financing that looks at all income and health insurance options and maximizing their integration, and not merely one single program, will improve the efficiency and equity of the system. It will recognize an individual's desire to receive supports where and when they need it, and it will improve the quality of the supports.

ANCOR believes there are a number of principles that should be implemented in the development of an ideal long-term services system. These principles include:

- The social commitment to long-term care must be in the form of a public/private system built on the principles of social insurance and private insurance.
- Eligibility for the social insurance benefit should be based on functional limitations as an entitlement benefit.
- Direct support professionals are critical to quality supports and must be recognized and valued by the system.
- Public assistance must be maintained and improved to provide a full range of services and supports to those who are not otherwise covered.
- The financing system must support a range of choices and help maximize personal independence, self determination, dignity and fulfillment.
- Systems should coordinate services for people with multiple needs that change over time, providing a seamless and continuing delivery system.
- Systems for assuring quality of supports should be built into all long-term supports and services programs. Such systems should assure quality and value based on identified outcomes and adequate provider payments.
- The financing of long-term supports should be spread broadly and progressively. This goal may involve tax policy, Social Security, Medicare, Medicaid, private health insurance as well as pensions, social services and housing policies. Both public and private financing mechanisms should be strengthened toward this goal.

ANCOR recommends that the Congress work with the Administration, governors, state lawmakers, providers, workers, families, and individuals who depend upon long-term supports to initiate a comprehensive national dialogue on long term care financing and the looming workforce crisis facing people with disabilities of all ages who need health and health-related supports to live in the community. By initiating and continuing a national long-term care dialogue, we can move forward with a positive and comprehensive plan to help safeguard the health and well being of tens of millions of Americans.

ANCOR again congratulates the Subcommittee for its initiative in calling for this hearing. We hope it is a first step in a national dialogue. ANCOR appreciates the opportunity to submit our written comments on this important issue. We would be happy to provide further information or testify at future hearings.

**Statement of Merrill Matthews, Council for Affordable Health Insurance
(CAHI), Alexandria, Virginia**

On behalf of the Council for Affordable Health Insurance's (CAHI) board of directors and members, I applaud Chairman Johnson and members of the House Ways and Means Health Subcommittee for opening this dialogue on how to improve the long-term care delivery and financing mechanisms in the United States. We appreciate your consideration of our comments on this critical issue.

CAHI is a national non-profit research and advocacy association whose mission is to develop and promote free market solutions to America's health care challenges. Our membership includes health insurance companies (active in the individual, small group, HSA, long-term care and senior product markets), small businesses, physicians, actuaries and insurance brokers.

Our members represent a broad range of health care products, including long-term care and Medicare Supplement insurance, home health care services and prescription drug discount cards. They provide insurance policies that protect families from potential financial catastrophe, as well as critical services to people with disabling conditions and long-term health care needs.

long-term care is the most significant health care funding expense Americans now face. Something must be done to stem the public's massive and growing dependence on government-funded long-term care—and it must be done now.

Our comments will focus on the following:

- Private long-term care financing options available today, including long-term care insurance;
- Obstacles facing the private long-term care market;
- Solutions to removing barriers to private market growth and reducing the burden on Medicaid.

Today's Private LTC Market

Beginning in 2011 the first baby boomers will turn 65. By 2031, all 76 million boomers will have reached retirement age, many of them woefully unprepared for the cost of long-term health care. Americans are living much longer than in the past and the phenomenal advances in medicine will mean that many Americans will be living not only longer but also healthier and more fulfilling lives.

While these advances were unimaginable just decades ago, they come at a cost. The public policy question facing us is, "Who will pay?" Government cannot—and should not—pay for it all.

The private sector will have to provide workers with ways to protect their future health, independence and assets. The good news is that there are innovative and effective private long-term care financing options available to consumers today, such as long-term care insurance and home equity conversion.

long-term care is usually provided in three venues—the home, an assisted living facility or a nursing home—and is financed primarily by three sources: private pay, Medicaid or Medicare. (The Congressional Budget Office estimates that if converted into dollars, donated care would represent 36% of all spending on long-term care for the elderly. Our focus here, however, is on paid care.)

Private long-term care (LTC) insurance protects assets and incomes from the devastating financial consequences of long-term health care costs. In existence since the early 1970s, LTC insurance policies initially piggybacked on Medicare's skilled nursing benefit, providing short-term indemnity benefits for stays in a Medicare skilled nursing facility. Intermediate care and non-Medicare facility services were covered beginning in the late 1970s. Coverage for home care services emerged in the early

1980s. With the implementation of the National Association of Insurance Commissioners' LTC insurance model regulations in the mid-1980s, coverage expanded to include care in assisted living facilities, and insurers began offering longer periods of covered care, including unlimited lifetime benefits and increased daily benefits.

Due to significant competition in the marketplace, LTC insurers are developing products with very flexible benefits to better meet consumers' needs. Today's comprehensive LTC insurance policies allow consumers to choose from a variety of benefits—including reimbursement for informal caregivers—and offer a wide range of coverage choices. They provide for care to be received in a variety of settings—nursing homes, homecare, assisted living facilities and adult day care—and some of the most recent policies are providing for a cash benefit that the consumer can spend anyway he/she feels is best. Additionally, insurers are coming out with hybrid products that are combined with life insurance and annuities.

Policy options offered by one CAHI member include:

- Short term facility care plan for stays of less than one year;
- A stand alone home health care plan;
- A benefit plan for substandard health risks; and,
- A comprehensive benefit package covering all care settings—facility, home and community.

Additionally, under a first-of-its-kind arrangement with a major university, their newest product incorporates an independent health promotion and disease prevention program, as well as caregiver support services.

LTC insurance allows individuals to take personal responsibility for their long-term health care needs and reduces the strain on state Medicaid budgets. By the year 2030, Medicaid's nursing home expenditures are expected to reach more than \$130 billion a year. Private LTC insurance is the only real alternative to more state Medicaid spending on seniors.

Home equity conversion (HEC)—which allows people to convert the illiquid equity in their homes into a liquid monthly income or a lump sum payment without having to repay the loan while they live in the home—is another private financing option for long-term care needs. Eighty-one percent of seniors own their homes. Seventy-three percent of elderly homeowners own their homes free and clear. Nearly \$2 trillion worth of home equity is held by seniors that could go to offset the cost of long-term care—enough money to solve the long-term care financing crisis now and in the future.¹

These reverse annuity mortgages are available to anyone 62 years of age or older and are strictly regulated by the government. Proceeds of a reverse mortgage can be used for any purpose. For example, when interest rates plummeted, many seniors turned to reverse annuity mortgages as a way to replace lost income.

Properly done, reverse mortgages are medically underwritten so that the mortgages are priced so that they do not come due while borrowers are still able to live at home. In other words, the lender is taking on risk that the borrower may live in the home longer than anticipated. Thus, the product is insurance, not just a loan. Borrowers can never lose their homes and do not pay back the reverse mortgage until they leave or sell the home, usually as a result of death or nursing home institutionalization. At that time and only then, the lender recoups principal and all accrued interest.

Recently, the Centers for Medicare and Medicaid Services and the National Council on the Aging (NCOA) have encouraged the use of home equity to pay for long-term care. In an estimate prepared for the NCOA by the Lewin Group, reverse mortgages could save Medicaid \$3 billion to \$5 billion annually by 2010 if sales reached certain levels.

Obstacles to Private Market Growth

Most seniors are financially ill-prepared to meet potential long-term care needs. According to the Congressional Budget Office, only 7% of American seniors have enough saved to cover one year of nursing home care.

Consumer education about the need for long-term care planning is critical. The largest disincentive to buying private LTC insurance, however, is Medicaid. As originally conceived, Medicaid was mainly intended to be an acute-care safety net for poor women and children. To this day, approximately 75% of Medicaid recipients are poor adults, mostly women and children, who account for only about one-third of Medicaid's costs.

¹ Steve Moses, "The Long-Term Care Dilemma: What States are Doing Right and Wrong," 2004, http://www.cahi.org/cahi_contents/resources/pdf/LTCStudy2004.pdf.

The remaining 25% of Medicaid recipients are aged, blind or disabled, but they account for two-thirds of the program's costs. The main cost driver for this group is long-term care, principally nursing home care.

Medicaid spent \$50.9 billion on nursing home care in 2002 and paid for two-thirds of all nursing home residents.² Medicaid also spends a large and rapidly increasing amount for home and community-based long-term care. Long-term care accounts for one-third to one-half of total Medicaid expenditures in most states.

The American public is in denial about the risk of long-term care because Medicaid and Medicare have paid for most expensive extended care services since 1965. When a care crisis occurs and large expenses begin to be incurred, families frequently turn to the public benefit programs and learn that qualifying for Medicaid is easier than they thought and that Medicare, although very limited in its benefits, has no means test to obstruct eligibility. Consequently, few people plan, save, invest or insure for long-term care and most people end up dependent on the public programs.

To qualify for Medicaid's long-term care benefits, someone must be aged, blind or disabled and medically in need of nursing-home level of care. Beyond that, there are two financial tests that must be passed: one is based on income and the other on assets.

Income eligibility is determined in two ways. Thirty-four states and the District of Columbia have "medically needy" income eligibility systems.³ In those states, medical expenses—including private nursing home costs, insurance premiums, medical expenses not covered by Medicare, etc.—are deducted from Medicaid applicants' income. If they have too little income to pay for their care, they are eligible for Medicaid—not just for long-term care but also for the full array of Medicaid services.

The remaining states have "income cap" Medicaid eligibility systems.⁴ In these states, anyone with income over \$1,692 per month (300% of the SSI monthly benefit of \$564) is ineligible for long-term care benefits. But \$1,692 is not enough to pay privately for nursing home care and one dollar more is too much to qualify for Medicaid, a Catch 22. So Congress approved "Miller Income Trusts" in the Omnibus Budget Reconciliation Act of 1993 (OBRA '93) that allow people to divert income into the trust and become eligible for Medicaid. The trust proceeds must then be used to offset their cost of care, and any balance in the trust at death reverts to Medicaid. Nevertheless, Miller Income Trusts allow people with incomes substantially over the limit to qualify for Medicaid, enjoy the program's low reimbursement rates and receive its extensive range of additional medical services.

Thus, whether you're in a "medically needy" or an "income cap" state, you don't have to be poor to qualify. You only need a *cash flow problem*. There is no set limit on how much income you can have and still qualify, as long as your private medical expenses are high enough and, if you are in an "income cap" state, you have a Miller Income Diversion Trust. Thus, income is rarely an obstacle to Medicaid long-term care benefits, as long as medical expenses are high enough. Only the top 10% or 15% of seniors would have too much income to qualify.

Most states allow individual Medicaid applicants to retain at least \$2,000 worth of otherwise nonexempt liquid assets. What you don't hear so often is that Medicaid also exempts the home and all contiguous property regardless of value. Simply express a subjective "intent to return" to the home and it remains exempt, whether or not there is any medical possibility the patient will ever be able to return. According to the Social Security Administration's Program Operations Manual System (POMS), Medicaid also exempts:

- One business, including the capital and cash flow, of unlimited value;
- A prepaid burial space for "the individual, his or her spouse, or any other member of his or her immediate family is an excluded resource, regardless of value";
- Unlimited term life insurance with no effect on eligibility;
- Home furnishings up to \$2,000, but they are rarely counted;
- One car of unlimited value, assuming it's used for the benefit of the Medicaid recipient. (And because it is exempt, giving it away is not a transfer of assets to qualify for Medicaid.)

²See: <http://www.cms.hhs.gov/statistics/nhe/historical/t7.asp>; "Table 7: Nursing Home Care Expenditures Aggregate and per Capita Amounts and Percent Distribution, by Source of Funds: Selected Calendar Years 1980–2002" and C. McKeen Cowles, *2002 Nursing Home Statistical Yearbook*, Cowles Research Group, Montgomery Village, MD, 2003, p. 64.

³See "SI 011715.020 List of State Medicaid Programs for the Aged, Blind and Disabled" at <http://policy.ssa.gov/poms.nsf/1nx/0501715020>.

⁴Ibid.

Many upper-middle-class people qualify for Medicaid by consulting legal specialists, known as elder law attorneys, who use an array of qualification techniques, including the purchase of annuities, irrevocable income-only trusts and life care contracts. Thus, even beyond Medicaid's extremely generous basic eligibility rules as described above, savvy seniors with cunning legal advisors can stretch Medicaid long-term care eligibility much further still.

Medicaid planning has negative consequences beyond overloading the program with recipients who could have paid for their own care. Elder law attorneys routinely advise their Medicaid planning clients to retain enough "key money" to pay privately for at least a year of nursing home care. That's because it's common knowledge that patients cannot count on getting into a quality nursing home unless they can pay privately for an extended period of time. Once they're in, however, state and federal laws prohibit nursing homes from removing them just because they convert from private-pay to Medicaid. So, the well-to-do divest or shelter most of their wealth, but save out enough to pay privately for a year, lock into a good nursing home, and later transfer the financial burden to Medicaid, tax payers and nursing homes. The tragedy is that poor people, whom Medicaid is supposed to help, do not have key money and consequently must occupy the less desirable beds in nursing homes more heavily dependent on Medicaid's low reimbursement rates.

Although state Medicaid programs have been required since OBRA '93 to recover benefits paid from the estates of deceased recipients—and arguably from the estates of the spouses they predecease—few states do so efficiently and effectively.

Two states—Michigan and Texas—have not implemented estate recoveries to this day. Most states make only a half-hearted effort. CMS reports that state Medicaid programs recovered only \$350 million from estates in 2002 while spending \$46.5 billion on nursing home care—an almost negligible return of only 0.75%.

Even states like Oregon that pursue estate recoveries aggressively are hamstrung by restrictions in federal law that protect large amounts of money from recovery.⁵ Nevertheless, Oregon recovered \$13.7 million from estates in 2002, which is 6.9% of what the state spent on Medicaid nursing home benefits that year.⁶ If every state were as successful as Oregon, estate recoveries would total \$3.2 billion.⁷

With a growing industry devoted to helping individuals qualify for Medicaid, and with little or no effort on the part of the states in pursuing estate recovery or otherwise limiting Medicaid eligibility, it should come as no surprise that consumers view long-term care as an entitlement, and see no value in using their own money to purchase private LTC insurance or long-term care services directly.

Solutions

Encouraging individuals to plan for their own long-term care needs, and providing incentives to access the private market products to do so, are the two most important ways we can improve long-term care financing and delivery, and contain the growth of Medicaid.

Tax Incentives: While pure demographics should spark some increased interest in LTC insurance, the onslaught of the baby boom generation is not enough in itself to encourage the purchase of the product.

Today's private long-term care market continues to evolve with policy improvements, consumer protections and administrative efficiencies. It is competitive and innovative, changing to meet consumer demand. So why aren't consumers buying it?

Studies of "non-buyers" show that if LTC insurance could be purchased with tax incentives, they would seriously consider buying a policy. By giving Americans a tax break to purchase LTC insurance, Congress can help millions of families enjoy a financially secure retirement. While an income tax deduction is one way government has encouraged Americans to purchase LTC insurance, the deduction applies only to premium amounts that exceed 7.5% of adjusted gross income, thereby limiting it to very few taxpayers. Pending legislation would provide an above-the-line income tax deduction for LTC premiums.

One new LTC financing option is a Health Savings Account (HSA), which allows a worker to tax-shelter LTC insurance premiums. However, few people have an HSA, and some employers may never offer that option.

⁵ See SEC. 1917 [42 U.S.C. 1396p] of the Social Security Act, "Liens, Adjustments and Recoveries, and Transfers of Assets," at http://www.ssa.gov/OP_Home/ssact/title19/1917.htm.

⁶ Moses.

⁷ Moses. This estimate is based on applying Oregon's probate recovery rate of 6.9% to the national total Medicaid nursing home expenditures for FFY-02 of \$46.5 billion. Using the 8.1% estate recovery rate estimated by Oregon staff gives a total national estate recovery potential of \$3.8 billion.

Congress can do much more. Many Americans are saving for their retirement years through IRAs, 401(k) and 403(b) plans, with personal contributions matched in whole or in part by employers. Allowing taxpayers age 50 or older to use funds from those plans, without withdrawal penalties, to buy LTC coverage can: (a) encourage the purchase of LTC insurance at younger ages when premiums are lower and people are healthier; (b) motivate consumers to take responsibility for their long term health care needs; and (c) if restricted to just IRAs, would be almost tax neutral.

However, when Congress or the state legislatures create new options, they sometimes feel compelled to impose new regulations on those options. It is important that Congress and the states not do to long-term care insurance what they—primarily the states—have done to health insurance: impose numerous mandates and restrictions that drive up premiums and reduce access to affordable coverage.

Long-Term Care Partnerships: The private long-term care insurance market is robust and competitive, with products that offer consumers comprehensive benefits and financial security. However, the ease with which people can shelter or transfer their assets reduces the incentive to purchase private LTC insurance and increases the number of people who rely on Medicaid for their long-term care.

Four states—Connecticut, California, Indiana and New York—have addressed the LTC problem by establishing public/private partnerships. These programs encourage people to purchase private LTC insurance by allowing insured persons to protect their assets in whole (New York) or in part if they exhaust their private LTC benefits. Thus, if partnership participants exhaust their LTC policies, they will not forfeit their estate once they enroll in Medicaid. In other words, if people go to reasonable lengths to act responsibly and protect themselves by buying LTC coverage, their assets are not at risk if they must eventually turn to Medicaid.

While the current partnership programs are a step in the right direction, their mandated product design and administrative burdens encumber insurers. As a result, the products are expensive. Moreover, the Omnibus Budget Reconciliation Act of 1993 effectively precluded the establishment of partnership programs in new states by prohibiting the states from allowing participants who buy LTC coverage to be exempted from Medicaid's estate recovery provisions.

Yet the fundamental concept behind LTC insurance partnerships is sound and could attract consumers if the restrictions were removed.

A fresh, full examination of LTC partnerships is needed. An affordable partnership program would link the public and private sectors, allowing consumers to purchase private LTC insurance and making Medicaid the last option for long term care. What to do? First, Congress should allow states to establish an LTC partnership program by repealing the OBRA '93 ban on the forgiveness of estate recovery liability. Then, state legislators should advance public/private partnership programs that promote the development and availability of affordable, voluntary, private LTC insurance products.

Home Equity Conversion: Seniors' home equity is the biggest potential source of private long-term care financing that could relieve fiscal pressure on Medicaid. Home equity represents over half the wealth of the median elderly household. Yet home equity is not being widely used to finance long-term care. Why? Because Medicaid exempts the home and all contiguous property regardless of value for any recipient who expresses an "intent to return" to the home. Under federal law, the medical feasibility of returning to the home is immaterial (except in three or four 209b states⁸). Expressed intent is all that matters. Thus the Medicaid home exemption and the ease of transferring the home to avoid estate recovery liability chill the market for home equity conversion products.

The federal Medicaid program should require home equity conversion as a condition of qualifying for Medicaid-funded long-term care, and states should encourage the use of this program. This approach would prevent Medicaid from being "inheritance insurance" for baby boomer heirs as it is now, and it would wake up the boomers to the risk and cost of long-term care. With home equity genuinely at risk, most people would plan early to save, invest or insure for their long-term care needs. They would be less likely to ignore the problem until it's too late, as they do now, because if they did, they would have to consume their biggest asset before receiving public assistance. This approach would also unleash the long-term care in-

⁸ "209B states," refers to the states which retained the right, under Section 209(b) of the Supplemental Security Income (SSI) program, to continue to use their own eligibility criteria in determining Medicaid eligibility for the elderly and disabled rather than extend Medicaid coverage to all who qualify for SSI benefits. *The Medicaid Resource Book*, Kaiser Commission on Medicaid and the Uninsured.

surance and home equity conversion markets, thus creating jobs and adding to state and federal tax revenues.

Medicaid Long-Term Care Eligibility: Medicaid's income and asset limits are very severe for people who need acute care. The rules are much more generous for seniors who need long-term care. Income is rarely an obstacle to eligibility because applicants' medical expenses, including nursing home expenditures, are deducted from their income in 30 "medically needy" states. In the remaining "income cap" states, applicants can divert excess income into "Miller Income Trusts" in order to qualify for Medicaid coverage.

The key is to control eligibility. Many states have tried to reduce costs and improve service delivery by de-emphasizing nursing home care and encouraging home and community-based services. But in so doing, they've made their Medicaid programs more attractive and private financing less attractive. If they could control eligibility, however, so that people would access Medicaid only after consuming home equity, fewer people would become dependent on Medicaid, and the state could better afford to provide the most attractive home and community-based services (HCBS) and pay adequately for them.

Congress and CMS should encourage states to study their Medicaid eligibility systems to determine how much they lose as a result of generous Medicaid eligibility rules, early wealth transfers and Medicaid estate planning. Then they should consider:

- Tightening income and asset limits;
- Enforcing the rules more strongly;
- Joining Connecticut, Minnesota and Massachusetts in their 1115 waiver request to extend Medicaid's "look-back" period for asset transfers; and, to eliminate the "half-a-loaf" loophole (giving away half your assets and spending down during the resulting shortened eligibility penalty) by starting eligibility penalties at the date of Medicaid qualification instead of the date of the transfer.

Medicaid Estate Recovery: Every state Medicaid program is required to recover the cost of care from the estates of deceased recipients (Omnibus Budget Reconciliation Act of 1993). Few states aggressively enforce the estate recovery requirements, however, and none effectively inform the public of this liability in advance. Oregon leads in estate recoveries, annually recouping 4.1% of its Medicaid nursing home expenditures from recipients' estates. If every state recovered at the same rate, estate recoveries could generate nearly \$2 billion in nontax revenue to supplement Medicaid's limited resources. If states warned citizens about the risk and cost of long-term care, the downside of enrolling in Medicaid—such as loss of independence and choice—and the use of estate recovery, many more people would plan earlier to save, invest or insure for long-term care costs, thus reducing the burden on taxpayers and the Medicaid program.

States should review their Medicaid estate recovery programs. If recoveries do not meet or exceed 5% of nursing home expenditures, states should consider: changing laws to encourage stronger recoveries; implementing "best practices" from other states; adding staff until recoveries are maximized; and publicizing the program to encourage responsible long-term care planning by consumers who are still young, healthy and affluent enough to purchase private insurance.

Conclusion

The United States is the richest country in the world. We have more than enough wealth to ensure access to long-term care for all American citizens. Yet our long-term care service delivery and financing system is seriously dysfunctional.

By making Medicaid nursing home benefits routinely available to virtually anyone since 1965, we created a nursing home-based, welfare-financed long-term care system that fails everyone, especially the poor.

While it is understandable that seniors want to protect their assets in order to pass something on to their families and friends, the best way to do that is to take financial responsibility and protect their assets by purchasing long-term care insurance, not becoming dependent on the Medicaid system.

The private LTC insurance industry continues to serve consumer expectations well in the design and offering of quality products. Disincentives to buy the products do not come from a lack of benefit plans—excellent, affordable coverage is available and new products continue to be developed. Concern for the stability of premium rates for these products has been addressed by the National Association of Insurance Commissioners, while meaningful consumer protections have been put in place in the states.

By providing individuals with the proper incentives to plan for their own long-term care financing, Congress can reduce the number of people dependent on Med-

icaid and allow the program to do a better job for its proper clientele: the poor. Medicaid could afford to offer home and community-based care, not just nursing home care, and perhaps it could pay long-term care providers something closer to market rates.

Thank you again for the opportunity to share our comments. Please feel free to contact me if I can provide any further information.

Statement of Barbara Haselden, Hometown Insurors, Inc., St. Petersburg, Florida

Sixteen years ago I formed a corporation and opened a neighborhood Long Term Care Insurance Agency in St. Petersburg, Florida. My family had experienced the long term care needs of both of my grandmothers each lasting for seven years, one at home and one in a nursing home. I witnessed the financial and emotional impact this exacted on all close members of my family and when I became aware of the emerging product of insurance to cover these events I was hooked. Surely this would be a life's work that, once understood by the public, would provide both a good living and rewarding service to others. In my naivety, I had no idea of the road I was about to travel filled with years of struggle, moments of hope dashed by years of disappointment.

I will not take your valuable time to relive the history of this industry as I know you have plenty of testimony covering this aspect. I will say that interest in the product peaked perhaps as long as five years ago. At that time the promotion of Medicaid planning Seminars by Elder Law Attorneys and Insurance Agents began to proliferate promising to assist families in escaping the consequences of uninsured long term care.

One such seminar entitled "Just Say No to Long Term Care" drew crowds of 60 to 100 people consistently for years all over the southern half of the state. Another Seminar given by a young local Elder Law Attorney entitled, "FINALLY, Answers to Your Medicaid Questions and Long Term Care" has been running monthly for the past five years and in fact is in the St. Petersburg Times just this past Sunday. These seminars are actually held in public libraries and senior citizen centers.

There are thousands of Purveyors of Medicaid nationwide each with their own approach to marketing Medicaid to the public for their own personal gain. I have attended many of these seminars in Florida and have been so disappointed by the general willingness of everyday Americans to engage in schemes to become eligible for Welfare and to escape paying an insurance premium to finance their own future personal needs. But, most seminars start out with a long pitch proclaiming Medicaid as an Entitlement Program guaranteed to every American if you only know how to play the game and, after listening to the distorted message, one walks away from these convincing half-truths thinking only a fool would buy long term care insurance. After all, you paid taxes all these years . . .

Today we are losing more policyholders monthly at my agency than we are able to add. They are going on claim at a rate that exceeds our growth due to the low interest in our product. If something isn't done quickly to assist our industry in reaching the public I fear the industry will collapse. The languishing legislative action on building a financially strong long term care delivery system thru adequate financing via insurance, like all other major risks in our society, threatens to rob us of our future ability to care for our aged in their own homes, assisted living or nursing facilities.

While it is certain that the Medicaid Planning industry must be stopped, I fear the number of years that it may take to outwit 5000 attorneys into submission. Therefore, I am asking for an above-the-line tax deduction *now* to give us compelling incentives to those that will listen to purchase long term care insurance. Then quickly shut every loophole you can to false impoverishment to send a clear message to all Americans that, if they can afford it, long term care insurance is their appropriate vehicle to finance their future care if they do not want to risk their savings.

Thank You.

