P U B L I C H E A R I N G

before

ASSEMBLY AGING COMMITTEE

on

ASSEMBLY BILLS 1130 THROUGH 1133

(Establishes Guidelines for Certain Long-Term
Care Insurance for Senior Citizens)

Held:
April 12, 1984
Room 308
State House Annex
Trenton, New Jersey

MEMBERS OF COMMITTEE PRESENT:

Assemblyman Thomas H. Paterniti (Chairman)
Assemblyman Edward K. Gill

ALSO PRESENT:

Norma Svedosh, Research Assistant
Office of Legislative Services
Aide, Assembly Aging Committee

* * * * * *

TABLE OF CONTENTS

* * * * * *

1-29:TDM

ASSEMBLYMAN THOMAS H. PATERNITI (Chairman): May I have your attention, please? I would like to open this public hearing.

First of all, good morning, ladies and gentlemen. I am pleased to welcome all of you to a public hearing conducted by the Assembly Committee on Aging. My name is Thomas Paterniti. I am Chairman of the Committee.

Before I start, I would like to take this opportunity to mention the names of the other members on this Committee. Some of them may try to make it today; if not, at least you will know who they are. Anthony Vainieri is our Vice Chairman. The other three members are David Schwartz, John Bennett, and Edward Gill.

I would also like to mention that if you have any written testimony, or if you wish to be placed on our witness list, please contact our staff aide, Norma Weiss. I am sorry, her name is not Weiss anymore, it is Svedosh. She was just married, and I want to congratulate her.

The Assembly Committee on Aging has spend more than a year trying to tackle many of the health care problems faced by our senior citizens in New Jersey.

I am sure that you are all aware of the graying of the American society, and the graying of New Jersey in particular. According to the most recent United States Census figures, the 65 and over population grew twice as fast as the rest of the population during the last two decades.

The ratio of elderly to those under 65, will be one to five in 1990, and one to three in 2025. Overall, those 85 and over are expected to be the fastest growing part of the older population. Elderly women now outnumber elderly men three to two. Despite an improvement in the median income of elderly persons over the last two decades, about one out of every seven Americans over the age of 65 lives in proverty. Elderly women are almost twice as likely as elderly men to be poor, and half of the elderly, widowed black women live in poverty. Taking a look at New Jersey, 11.7 percent of the population in our State is aged 65 or older. By the year 2000, that figure will grow to 14.5 percent.

Let us take a look for a moment at the health status of this older population. On a nationwide basis, census data reveal that the very old have a greater need for more assistance than the younger-old. As people age, the patterns of illness change; acute conditions become less frequent and chronic ones more prevalent. There is a dramatic increase, with age, in the likelihood of experiencing a chronic illness, or disabling condition. More than 80 percent of persons over 65 have at least one chronic condition. Elderly persons visit doctors more frequently, are hospitalized more often, stay twice as long as younger persons, and use twice as many prescription drugs. About five percent of the elderly population are institutionalized in nursing homes. Dramatic increases in long-term health care expenses continue, despite efforts to contain these costs.

One way that we can try to assist our senior citizen population in meeting these health care costs is by providing them with broader insurance options. To achieve this goal, I have introduced a package of long-term care insurance bills in the Assembly -- A-1130 through A-1133. This package of bills establishes guidelines for private long-term care insurance for senior citizens. This insurance is designed as a supplement to Medicare, to cover prolonged confinement in skilled or intermediate care nursing facilities. Benefits supplement Medicare coverage and include unlimited confinement in a skilled or intermediate care nursing facility after a hospitalization stay of at least three days, and home health care services, for which one benefit day is equivalent to 1.5 days in a nursing home. The policy may be nonrenewable after 1,098 benefit days are exhausted. A senior citizen who purchases a long-term care insurance policy, and who meets the income and eligibility requirements of the Pharmaceutical Assistance Program, would be eligible for a rebate in the amount of the annual policy premium. Funds would be appropriated from the Casino Revenue Funds to subsidize the rebate.

I would like to ask witnesses to keep their testimony as brief as possible. Anyone wishing to present written testimony for the public record may do so.

Our first witness today is James Cunningham.

JAMES CUNNINGHAM: My name is James Cunningham and I am President of the New Jersey Association of Health Care Facilities, which represents some 200 nursing homes and residential health care facilities across the State.

Our Association is the State affiliate of the American Health Care Association which, several months ago, commissioned a task force to study the issue of long-term care insurance. The Task Force, on which I serve as a member, has been very ably assisted by Laurence Lane, a member of the American Health Care Associations's staff, who has become an expert in the field of health care insurance. Larry is with me today, to help answer any questions you might have.

I want to summarize what our Task Force has learned about long-term care insurance; but, first, I want to congratulate this Committee and its Chairman, Assemblyman Paterniti, for their interest in the issue. The American Health Care Association and the New Jersey Association of Health Care Facilities believe that the development of group and individual long-term care insurance plans is necessary and timely and will be of significant benefit to citizens and government alike.

Our industry is extremely concerned about the spiraling costs of long-term care. Despite our best efforts to curb unnecessary expenses, the provision of skilled nursing care 24 hours a day, with a complete array of physical and social support services, makes nursing home care an expensive proposition, both for the individuals who require it and for the Federal and State budgets which help support it through the Medicaid and Medicare Programs.

Half of the individuals currently receiving long-term care services nationwide have their bills paid by Medicaid. And, I would like to add that in this State it is higher than that; 67 percent are paid by Medicaid. A significant number of these patients were forced to exhaust their private savings to become eligible for medical assistance. The attractiveness of long-term care insurance is that it would not only help protect a patient's personal assets, but it could also reduce the number of individuals eligible for Medicaid.

AHCA's study has disclosed that more than 25 insurance companies are experimenting with policies covering extended long-term

care. Of that number, more than half have made a commitment to expand their share of the market.

While the experimental plans vary, the typical policy provides an indemnity benefit of between $30 to $60 per day for coverage of skilled and intermediate care services in a nursing home for up to four years. Some policies permit beneficiaries to substitute home health care services as an alternative to facility-based care.

One immediate question we had was, are such policies affordable? Our study found that persons aged 60 to 65 can purchase viable long-term care insurance for less than $30 per month. While coverage for an individual above the age of 75 will be more expensive, data on the income and resources of older Americans suggest that long-term care insurance is well within the means of most senior citizens, including those receiving Social Security.

Perhaps the best known company offering such coverage is the Fireman's Fund. Limited policy coverage is also being offered to some individuals by such well-known companies as Prudential, Bankers life, and Mutual of Omaha, while experimental group policies are being tried by Blue Cross of Southern California, Blue Cross of North Dakota, and the United Auto Workers through a plan underwritten by Blue Cross of Michigan.

The nursing home industry is working hard to encourage governmental and private sector interest in such policies. Our Task force is making presentations to senior citizens groups, such as the American Association of Retired Persons, as well as to associations representing State Medicaid Directors, State Insurance Commissioners, and private insurance companies.

We are encouraged by the steps this Committee has taken to initiate a public discussion among all interested parties. The bills Assemblyman Paterniti has introduced to require such coverage in the State are a good starting point.

We believe that policies providing much-needed, long-term care assistance to New Jersey residents can be made available if the insurance industry will join government and health care providers in shaping enabling legislation and regulations.

AHCA and the New Jersey Association of Health Care Facilities are prepared to offer any assistance your Committee may find helpful. We have attached two reports which may be of assistance to your staff.

The first is an overview of the availability of long-term care insurance, the problems facing its expansion, and recommended actions. This report was prepared by Mr. Lane for AHCA. The second report is an overview of the current market for long-term care insurance. it was prepared for the Federal Department of Health and Human Services by ICF, Inc., a Washington consulting organization specializing in pension and actuarial calculations. This helpful report not only provides a detailed analysis of the income and resources of the elderly, but it also reviews many of the individual and group plans currently available.

One side note: Our national staff, and also the Task Force I serve on, has found when meeting with consumer groups that, oddly enough, the children apparently are willing to pay the premium in order that the parent doesn't have to divest himself or herself of any assets he or she may have, and thus get into a bad situation by being left without any funds if and when they need the long-term care.

ASSEMBLYMAN PATERNITI: That's probably true. If they have a small estate, it would probably leave that little estate intact because this would supplement it.

MR. CUNNINGHAM: Right. They wouldn't have to divest. They could keep their houses, and the insurance carrier would be picking up the payment.

We are not too sold on a strict indemnity payment with the limitations seen in most of them now. We are working on something that is a little different, where they can keep their assets, their houses, and maybe use some of their available income; then the insurance company would pick up the rest of the benefits.

If you spread this out, down to age 55, it would cover more of a risk and it might be more attractive. Our staff has had meetings with Travelers Insurance Company and with Prudential Insurance Company. In fact, I think they are meeting again tomorrow with Travelers. We are trying to get some of the bigger carriers interested in this coverage.

There has been legislation introduced -- since yours was introduced -- in Kentucky, and plans are being marketed there. But, the carriers there are rather small, and there is a risk of a small carrier not surviving. We would rather interest the larger insurance companies of the country in this plan. I am sure Larry Lane will report on the great interest shown by the Governors' Association. Apparently the Governors' Association will be co-sponsoring some of the meetings to hopefully move this kind of coverage.

ASSEMBLYMAN PATERNITI: Do you feel that if we started at age 55, rather than 65, we would have more people interested in the program?

MR. CUNNINGHAM: I think it would interest the insurance carriers more, because it would be spread over a greater population at age 55. The biggest problem, apparently, will be the market.

When Larry Lane testifies before you later, he has an informational piece with him that we have developed. It is in print now, and it will be utilized all over the country. The biggest job is the marketing, in convincing people of the devastation that would hit them and how much they would have to divest if this devastation should occur, because most people don't really understand how poor they have to get before they are eligible for Medicaid.

ASSEMBLYMAN PATERNITI: Yes, but this legislation also states that if they qualify for Pharmaceutical Assistance, 25 percent of their premium will be picked up through the use of casino revenues. Perhaps this will give them an incentive to get into the plan -- even the people who have a very modest income.

MR. CUNNINGHAM: We are actually very, very excited about this coverage. I am sure you are all aware of the condition of the Medicaid budget, not only in New Jersey but everywhere in the country, and the need to find other sources of funding for health care -- not only long-term care, but home health care also.

The whole issue is to convince people, and I don't think that will be too difficult when they are shown how far they have to divest their assets -- down to $1500. That is probably one of the main interests of the children, that their parents will not have to divest themselves of their savings and there will be some kind of money, or something -- maybe even the family home -- left for the heirs.

ASSEMBLYMAN PATERNITI: I know. Thank you very much.

Before we go any further, this is Assemblyman Gill. I mentioned his name earlier. He is a member of our Committee, and he is very knowledgeable about the needs of senior citizens.

Assemblyman Gill?

ASSEMBLYMAN GILL: Mr. Cunningham, we have been developing a Home Health Care Program within the State. I am sure you are probably familiar with it. Six hundred welfare people are now being trained to take care of an equal number, or possibly more, of people who are confined to their homes. Ultimately this figure will be 1800 within three years, if it works out successfully, throughout the entire State. How would your insurance program fit into that concept?

MR. CUNNINGHAM: The coverage as I see it-- I usually speak from the long-term care viewpoint, but I am also totally knowledgeable in the home health care area. Most of the plans are probably written on an indemnity basis, as most other policies are now written. In most of these other policies, the home health area would be covered. It probably would be a great asset, because I understand that one of the biggest problems Human Services is having with that program -- in getting it off the ground and getting people into it -- is the co-pay share by the person who is at home. When they find out that a good part of the income they now have has to be paid out as a co-pay share in the payment of that home health care, they are not too interested in participating in the program.

If these insurance policies would at least alleviate that problem, I think the program would take off to a much greater degree than it has to date. We don't fear it. You know, alternate care doesn't bother the nursing homes and the long-term care industry. Unless you have a total system that contains enough parts of all of the system, you will always have a problem. It gives us problems, because we then get oppressive legislation, since all the pressure is on that one area of the payment mechanism. So, we don't fear home health care.

We do feel that most of the people who would be treated in the home health care setting wouldn't be ours anyway. The average age in a nursing home is 87 years old, and they have multiple ailments, and that type of thing. So, the Home Health Program is needed, because

a lot of people will be served by that program who need service now, and who haven't been getting it.

ASSEMBLYMAN GILL: In other words, your program is aimed primarily at the younger, long-term sick?

MR. CUNNINGHAM: No, this would include both, but it also includes home health care.

ASSEMBLYMAN GILL: Tied into this, of course, is one of the problems we have been experiencing as we have gone around the State, and that is the high cost of nursing homes, where someone must, in effect, impoverish himself or herself before he or she is admitted to a nursing home.

MR. CUNNINGHAM: True.

ASSEMBLYMAN GILL: They have to sign a two-year contract of up to $25,000 a year. How would your insurance program address that problem?

MR. CUNNINGHAM: The insurance carrier would be paying, and there would be no impoverishment. They would not have to divest. They would keep their assets because they would not be going on Medicaid. Private insurance would be paying for their care, and not Medicaid.

ASSEMBLYMAN GILL: Insurance would then pay up to $25,000 per year?

MR. CUNNINGHAM: It depends. It depends on how the policy is written. Many of them are now written as an indemnity. For instance, Fireman's Fund pays $30 a day for four years. If it could be worked out so that they would pay instead of it being an indemnity-type policy, the people would then be able to keep their assets and their houses, and they would use some of their available income -- not assets -- with the insurance company paying the balance. Those people would then never have to go on Medicaid, and they wouldn't have to divest and impoverish themselves. That would be the beauty of this, while it would also help the states with their Medicaid budget problems.

ASSEMBLYMAN PATERNITI: I have a breakdown on cost: what the premium would be if they were to get $35 a day, $50 a day, or $70 a day. This research was done by Mark Miner -- he has a PC from National Health Services Research -- and also Gordon R. Trapp. He is from the Actuarial Research Corporation. These are the people who did some of the research.

MR. CUNNINGHAM: We have that. We have all the reports.

ASSEMBLYMAN PATERNITI: These are some of the figures they gave us. They gave us a breakdown on what the cost would be, whether it was $35, $50, or $70. They also gave us the ages of 65, 70, 75, or 80.

MR. CUNNINGHAM: Right. I think when Larry Lane speaks-- I am sorry you didn't put him on right after us, because his is a follow-up to our statement. He is the staff person to our Committee. He has been working on this for I don't know how many years already. He was originally with the American Association of Non-Profit Homes for the Aged. Prior to that, he was with AARP. I think he will indicate to you also that in his meetings with AARP he found there was an opportunity for them to market this program -- you know, the program is getting that much interest.

He will be able to directly relate to all the varying research. You will find that as his paper develops, he relates to all of them, and he can also relate to the various meetings they have had with Travelers, with Prudential, and with HIA -- which is the insurance group that will be able to say whether the latest data agrees with or refutes this. I would rather he deal with the research projects, because he has dealt with them.

ASSEMBLYMAN PATERNITI: Okay. Thank you very much.

The next witness on our list is Jean Kramer. Jean is with the Home Health Agency Assembly of New Jersey.

JEAN KRAMER: Good morning, Assemblyman Paterniti and Assemblyman Gill. I am Jean Kramer, and I am with the Home Health Agency Assembly of New Jersey. To my right is Winifred Livengood, who is the Executive Director of the Home Health Agency Assembly. And, in the audience we have some of the other members of our organization, Marly Auerback and Marietta Taylor, who will also be available for questioning at the end of our testimony.

The Home Health Agency Assembly of New Jersey represents more than fifty licensed and certified home health agencies, serving citizens of all ages throughout New Jersey. We applaud Assemblyman Paterniti for introducing Assembly Bills 1130 through 1133. For many elderly in our State, the catastrophically high expense of long-term

illness, a cost which might very well reduce them to paupers, looms as a terrible prospect. These long-term health care needs are not now covered by either Medicare or by private-sector insurance. Only Medicaid provides coverage for such care for the very poor. It is this dilemma which Assemblyman Paterniti's legislation addresses.

When the Medicare program was designed, about twenty years ago, it focused on acute illness. Since that time, our elderly population has increased, due in part to improved health care under Medicare. Concurrently, these individuals are more likely to have one or more chronic health conditions for which they may need medical assistance, but for which they have no insurance coverage. Assemblyman Paterniti's bills call for the private insurance industry to provide "Medigap" coverage. It calls for insurance for long-term health care needs which derive from chronic conditions and which are not covered by Medicare.

Home health agencies have for many years been providing home care to patients in their homes and communities. Long-term care has been provided under the Medicaid program since 1974. Let me describe how long-term care works at home. The patient is under physician's charge, and the case is managed by a nurse. An assessment is made by the nurse and a specifically tailored package of services appropriate to the patient's needs is developed. A home health aide makes frequent visits. A nurse periodically visits to monitor the patient's condition and to supervise the aide. When necessary, a physical therapist or a speech therapist visits the patient. If the patient's condition becomes acute, or if the condition of the family care-giver changes, then the nurse makes a prompt referral for whatever care is needed.

Under regular home care, not long-term care, the case is managed not only for patient services, but for reimbursement from a variety of funding sources. Certified and licensed home health agencies routinely arrange for their patients to receive reimbursement benefits from Medicare, Blue Cross, Medicaid, and other third-party payers. When the patient's condition becomes chronic, the agency can transfer to another source of payment, where one is available. At the present time, as was pointed out, the only public funding for chronic care is for the very poor who qualify for Medicaid and, on an extremely

limited scale, for those who qualify for the Medicaid Community Care Waiver. A few communities provide small amounts of United Way or public monies, for a very limited amount of time, to those unable to pay.

While a small percentage of the aging population may have to enter a nursing home because of a debilitating health condition, our experience shows that many of these people could remain at home, and that such home care is cost effective. Insurance coverage ought to be available under private plans. At the present time, home care reimbursed under private insurance is often private duty nursing only, and home health aides are not covered. This would be inappropriate for long-term care in the home. The use of nurses and home health aides is more cost effective. Nursing homes, of course, use an appropriate combination of R.N.'s and aides. Indeed, if all patient care were at the R.N. level in nursing homes, costs would be astronomical. The same logic applies to long-term care in the home.

We are pleased that Assemblyman Paterniti's legislation offers the home health care option for long-term care. We urge that the legislation specify that certified and licensed home health agencies provide the home care. This would follow Blue Cross requirements, as well as New Jersey statute requirements, for new private insurance polices. These certified and licensed agencies have great expertise in managing the services required by patients, as well as the source of payment for their patients' care.

The proposed legislation is designed to cover situations not covered by Medicare. Under the Federal TEFRA legislation, if a Medicare-eligible patient has private insurance, for which there is coverage duplicative of Medicare, the private insurer becomes the first payer. This should be avoided. Hence, any long-term care private insurance for those over 65 must not duplicate Medicare, but be arranged so that patients' benefits can be switched back and forth, to guarantee Medicare reimbursement when needed, while assuring the continuity of care and payment for the patient's long-term needs.

The Home Health Agency Assembly strongly supports the basic concept of this legislation. We have some specific comments about certain sections of the bill, which we are submitting for discussion with your staff. These points include:

Giving nursing home and home care benefits an equal basis; the removal of the three-day prior hospitalization clause; a modification of the incentive provided by the 25 percent rebate; and application of law to new and renewable policies.

We have already met with your staff regarding the eligibility criteria for benefits. We reiterate our support, and we offer our expertise to work out the specifics.

Indeed, although this legislation is addressed to a "Medigap" population, we would recommend that the private insurance industry use their considerable experience to market to a younger age group long-term care insurance which is geared to an expanding population.

ASSEMBLYMAN PATERNITI: Thank you. Assemblyman Gill, do you have any questions?

ASSEMBLYMAN GILL: You aren't necessarily gearing your program to the "aged" aged, that Commissioner Albanese is addressing in his proposed long-term health care plan, are you?

MS. LIVENGOOD: I think our reason for the suggestion there was not that the benefit would start at an earlier age, but the purchase of the policy would start at an earlier age, in order to get the benefit of the higher income while the person is working. But, the benefit would not start until it was needed at the age of 65 or 70 -- whatever the insurance would call for.

ASSEMBLYMAN GILL: That is quite understandable. Yet, I would ask how you would mesh the program now being sponsored by both the Governor and the Commissioner of Human Services, whereby there will be 600, 600, and 600 -- 1800 -- home health care experimental cases? How would you do that?

MS. LIVENGOOD: My observation of that program is that I would be very surprised if any of the people who were eligible for the program would have been in a position to buy private insurance. I say this only from observation. Their income is at such a very low level, I don't know where they would obtain funds to buy private insurance, had it been available, unless it came from some employee benefit they started while they were working.

I see that the Medicaid waiver population is very poor. They would be classified as people who would get a rebate under this legislation if they did purchase such a policy.

I think that common sense would say that the very low eligibility for Medicaid in this State, without a medically-needy program, probably would mean that most of the eligible people would not purchase private insurance; therefore, this would not necessarily cover them. But, that is a personal judgment.

ASSEMBLYMAN GILL: I appreciate that. I guess what troubles me a little bit is one of the problems we have experienced with the Committee of the Aging Study, and that is, there is a large sector of our aging population who probably have to enter a nursing home -- or they certainly have to receive home health care at home. They can't enter a nursing home because they don't have the necessary funds to buy the private-sector contract, and they can't use their Medicare for that, because it isn't enough.

MS. LIVENGOOD: Yes.

ASSEMBLYMAN GILL: That is a gap which we don't seem to be able to address. How do you see that? How can we address that?

MS. LIVENGOOD: I think that the gap that exists now-- The largest gap is for any long-term care. That is the largest gap that the elderly have to address. There is no coverage for basic home health, long-term care, and there is no coverage for nursing home care. That is what is so exciting about this bill.

In the Medicaid population, home care is offered to those who have -- is it $340?

ASSEMBLYMAN PATERNITI: It is $322.

MS. LIVENGOOD: $322?

ASSEMBLYMAN PATERNITI: I think it is under $322.

MS. LIVENGOOD: Yes, that is a very low income. Anyone with an income of $322 a month, I have to repeat, will have a real problem purchasing such insurance. I think coverage for the very poor is always going to be a Medicaid responsibility. I don't see private insurance being able to cover the very poor; I think that is a State responsibility.

I think the gap would occur when private insurance became unaffordable and Medicaid did not take over -- and where that would be, I can't tell you at this time. Somewhere in there, we will probably have a gap. I just can't tell you the numbers involved nor the income involved, because we don't have specific policies to talk about.

ASSEMBLYMAN PATERNITI: The problem with people who qualify for Medicaid is, first of all -- as I said -- they have to make under $322, and they also have to have less than $1500 in assets. With the plan the Governor has now -- with the Medicaid waiver -- I still think they would have to have under $1500, but if they have an income of, say, $500 or $600, the first $322 is covered; however, any money they get over and above that, they have to pay. So, if a person has $600 or $700 income a month and they have to pay rent, buy food, and pay for clothing, they are in real trouble.

MS. LIVENGOOD: Absolutely.

ASSEMBLYMAN PATERNITI: In fact, I passed a resolution asking Margaret Heckler to correct that inequity on the Federal level, because these people-- It would even make it difficult for the State to provide any help with this program, the way it is right now.

This particular type of legislation is really geared to a husband and wife who have worked all their lives; have a little home; have a little bit of money in the bank, and one of them becomes ill. They are going to be wiped out. If they buy into this plan, they are at least not going to have to tap into their resources. At least they will have some kind of security; they will not be wiped out.

It is more or less the really productive people in our society -- those who have worked very hard and have made this country -- who are being penalized. The sad part of it is, if these people have worked all their lives and they put away money, saying, "Gee, we are going to be comfortable" -- God forbid they get sick. They are at a disadvantage because the whole spectrum turns around. It makes a 180 degree turnabout. Those are the types of people who are in trouble now, simply because they tried to provide for their golden years.

MS. LIVENGOOD: Well, I think that is what is so exciting about this legislation.

We have just come back from Washington, and we took the same message to Ms. Heckler, and to the Congressional Delegation from New Jersey. I know the Commissioner is also talking to the Delegation down there, because it is an impossible restriction. The program won't work. Here the Governor is all set, and the Federal waiver won't let it take place.

ASSEMBLYMAN PATERNITI: The cost, in years to come, because the population is increasing so dramatically, will be astronomical. We have to come up with something to offset Federal and State funding. We have to find some incentive in order to get the private sector interested in this.

MS. LIVENGOOD: Yes. There has to be an opportunity for someone to help himself or herself. Right now, there is no opportunity for people to help themselves.

ASSEMBLYMAN PATERNITI: Do you see this Home Health Care Program as somewhat similar to the insurance programs that have been offered by AARP, the American Legion, and the Veterans' of Foreign Wars, which, in effect, say if one pays so much per month at a certain age, he or she is assured of a bed and certain medical care for weeks and weeks and weeks? Do you see that as being similar to this?

MS. LIVENGOOD: I think this would be a supplement to that. I think this bill would offer insurance for a greater period of time than is offered now under AARP, for home health care. Because, generally speaking, anything under private insurance for home health care is most often for acute care, not for long-term care.

ASSEMBLYMAN GILL: Hospitalization?

MS. LIVENGOOD: No, for acute care at home -- two, three, or four weeks. It is the exceptional policy that offers anything more than that. There are some. I have friends who were able to get it. It is a very exceptional policy that their employer took out while they were working for him; that is how they got the benefit.

Right now, the option for any individual to purchase a cost-effective program, such as the one we have described which uses the home health aide in conjunction with nursing, is practically zero. That is where you are going to get your best cost savings, through the use of the home health aide in conjunction with nursing. So, nursing care isn't in there as much; it is used to supervise the patient.

ASSEMBLYMAN PATERNITI: Thank you very much. Are there any further questions? (no response) Thank you.

The next witness I would like to call upon is Edwin Soefing from the Health Insurance Association.

EDWIN SOEFFING: Good morning, Assemblymen. Thank you for allowing me to speak. My name is Edwin Soeffing, and I represent the Health Insurance Association of America, which is comprised of approximately 300 major health insurance companies in the United States.

I want to make the point at the beginning that I am not against the concept of long-term care, per se, but I find this bill difficult to support, and I have to oppose it because I don't think it is sufficiently drafted.

I am also going to add that this is not meant as a criticism, because I think this is a new concept, to a certain extent, and it is very difficult legislation to draft.

For that reason, HIA has just done a study, resulting in a publication entitled, Long Term Care: The Challenge to Society. I thought I might give a copy of it to you. If we can be of any help to you, we would like to assist you.

ASSEMBLYMAN GILL: Did you bring more than one copy?

MR. SOEFFING: I have an extra one for you. I was only able to get several of those before leaving the office last night, but if your Committee needs more, and the counsel for your staff would like to write to me, I would be happy to send more to you.

I do not want to take a lot of your time, but I would like to just break down some of the points that are made in this booklet, and some of the things we feel about the concept in general, and this bill.

One of the problems is with how you define long-term care. Now, the bill does mention skilled nursing and intermediate nursing, and it relates it to Medicare and those types of things. I think it can be defined a little better. I won't go into that in length, but my point is how you define who this is going to affect; how it is underwritten; and, what the cost will be. So, we have to be very precise in the beginning in order to get it exactly right, especially since this bill provides for some pretty wide discussion by the Insurance Commissioner. If he comes out with different regulations, or if he differs with the intent of the Committee, we could have some problems. So, I think we need to define, in terms of long-term care, what we are really talking about.

The second point I want to make is the cost. Assuming we want to do this -- and perhaps we do -- then how are we going to finance it? This is really, as I see it -- and as I think our industry would see it -- partly a public service need, and we are not sure we are equipped financially to handle it, or to underwrite it. We would like to see a combination of public and private-sector money used to finance such a program, if, indeed, such legislation were to pass. And, again, if you look at the booklet, it addresses certain points on that which I think will help you.

Finally, I want to make a couple of other short points. I think the way the bill is drafted will encourage adverse selection. That is, the people who most need it will use it, and the people who do not need it at the moment will not use it, which will result in a tremendous upward surge in premiums. What that may mean is the people who really need it won't be able to get it because the price will be so high they will not be able to afford it.

I liked some of the previous testimony, and I was impressed by one other person who said the way his program works is that a physician is in charge, and a nurse supervises the program. It sounded to me as though that was a rather organized, supervised, and well-thought-out program. But, there is nothing in this bill that would, as I said, urge the Commissioner it should be developed that way: That there be a certain set of controls, or an organized fashion of dealing with things. That concerns us.

I think that pretty much emphasizes my main points. As I said, it is difficult to discuss it any further, except in terms of the bill, until we address some of these problems, but I want to answer any questions you may have.

ASSEMBLYMAN PATERNITI: Okay. When somebody takes out regular hospitalization -- Major Medical -- do you have certain guidelines set up that we don't have in this bill? Are you saying that?

MR. SOEFFING: No.

ASSEMBLYMAN PATERNITI: For example, I have people who work in my office and they belong to a group plan. I pay their hospitaliation. They are under 65; they are in their 20's, 30's, and

40's. If they are single, it costs me roughly about $800 and some odd dollars a year, which comes to about what? What would that come to? It comes to less than $50 a month, am I correct?

MR. SOEFFING: For the purpose of argument, let's accept your figure.

ASSEMBLYMAN PATERNITI: And, those people are not only-- In this bill they are only covered for a period of three years, maximum. In the other bills they are covered indefinitely. If someone becomes injured, paralyzed, or has a stroke, he or she can stay in a nursing home for ten years and you will be picking up the cost. If there is a need for around-the-clock nurses, you are still picking up the cost.

This one has limitations. You have it set for no more than three years, and when they have exhausted it, they don't get any more. The other thing takes over where Medicare leaves off. Medicare will only cover a person for 90 days. I mean, you are starting to set some limitations. In fact, we set some parameters to more or less fit in coming up with a specific premium, or a specific cost. I just don't understand what you are trying to say.

MR. SOEFFING: All right. Well, I think I would like to bring in some experts with me to answer your questions. I will answer them as best I can. I am going to be honest and frank with you; but, at the same time, I want to be able to admit that what I don't know, I don't know.

I think what you are talking about is the usual group insurance concept. I understand there are certain things in there that you are including.

ASSEMBLYMAN PATERNITI: This would be more or less a group plan, basically. You would be getting people of all ages, and the older will be paying more and the younger will be paying less.

MR. SOEFFING: I think you have made a lot of assumptions there that I guess I am not willing to assume. You are not going to get-- The way this bill is drafted, I don't think you are going to get people of all ages.

ASSEMBLYMAN PATERNITI: Well, first of all, do you feel that--?

MR. SOEFFING: (interrupting) I think there is going to be an adverse selection; that was one of my suggestions.

ASSEMBLYMAN PATERNITI: I know, that's why we are looking for some input. Maybe we have to say in the legislation, they have to be in the plant for a certain period of time before they are eligible. Maybe they would have to pay into it for six months, eight months, or a year, etc. That's why we have these public hearings. We want input. We want to come up with something that everybody is going to be able to live with, but which is something that will be affordable to the elderly. It is something that we really need.

MR. SOEFFING: I understand your question. Far from being cheap, I think the Task Force of our organization, who came up with this, defined long-care services. Let me just run down this quickly: They would include homemaker services; chore services; social services; health-related services; and skilled services, including not only skilled nurses, but physical and speech therapists. So, that is not where the argument is.

I think what I am telling you is, if we want to do it, let's do it right. That's what we are saying. I think the argument is, how are you going to underwrite it, and how are we going to be able to provide a quality service at a lower cost, or at a reasonable cost -- if you want to put it that way? How are we going to keep costs down so they don't skyrocket because people misuse the program, or because it hasn't been well thought out? That is all I am encouraging you to think about.

ASSEMBLYMAN GILL: Are you saying if we do it right, it will cost too much -- it will be too expensive?

MR. SOEFFING: To be quite honest, that may happen. As I said, that is why-- I am not trying to be begged, but I would want to see the bill and see how it would work. I would want to have an actuary come down and go over it with me.

Just to give you an idea, we testified here on health insurance for the unemployed, and I brought an actuary with me. He made some very significant suggestions, which were very well-liked by the committee holding the hearing, and they wrote a bill on that basis.

I am saying that if you do this, what you may run into is the other side of the coin, which is what Medicare has run into. You know, it was a very fine program, but the cost just skyrocketed, and

now the Administration is trying to cut the Federal deficit by cutting Medicare.

You have to make choices -- difficult choices. What I am saying is, one of the first things you have to think about is how you are going to finance it. Then you have to go from there and consider what portion the public sector is going to pay and what portion the private sector is going to pay, so that you can encourage the private sector to get into it and stay in it.

ASSEMBLYMAN PATERNITI: Well, we are having a public hearing. That is why we held this public hearing. Why didn't you bring these people with you? We are interested in coming up with legislation that we can live with. Why didn't you bring these people with you?

MR. SOEFFING: Well, let me finish.

ASSEMBLYMAN PATERNITI: Okay.

MR. SOEFFING: I am here, and there are some people from Blue Cross here. And, there are other people here also. Let me just say that I didn't know what kind of questions were going to be raised, so I didn't really know who to bring with me. We don't have that many people. We probably have three or four people in our organization who are really into this kind of thing and who can answer your questions.

As I said, if you want to, send me a list of written questions within the next ten days or so, I will be happy to get back to you with the answers in 10 or 20 days. And, I am not going to limit it to that; I would be happy to appear again if you hold another public hearing. I am not trying to wait until the next hearing.

On the other hand, if you want us to appear at the next hearing, we will be happy to do that. I am saying until I point out to you our general areas of concern and get feedback from you, I really don't know who to bring because I don't know what specific questions you have, and I can't bring four or five people with me. The cost is too high.

ASSEMBLYMAN GILL: Mr. Chairman?

ASSEMBLYMAN PATERNITI: Mr. Gill?

ASSEMBLYMAN GILL: Just building on one of the comments you made, in approaching, or in introducing a health insurance plan such as

this, some people may avail themselves of it, and some may not. I guess that implies a possibly that the older people would be more interested in it than the younger people would be. Of course, that has always been the case.

We are a Committee on Aging. We are biased towards programs which address the aging. If you are saying the bills, as introduced by Assemblyman Paterniti, are biased towards the aging, that is not bad. That is not all bad.

MR. SOEFFING: Well, I am not sure. I am certainly not here to be argumentative.

ASSEMBLYMAN GILL: And, we are not here to solve all problems for all people.

MR. SOEFFING: I am not here to be argumentative, but I hope you don't have-- I am going to be aging someday too. On the other hand, I hope you don't have too much bias toward the aging, because in addition to representing the Health Insurance Association, I also happen to be a citizen of New Jersey. I live here. So, I would like to hope that we aren't just doing something to be biased, or just to do it, but that we are doing something which is going to be good for all the citizens of New Jersey. Certainly, we want to do something for the aging citizens. I have a mother and a father who are still living. I also have two in-laws who are still living. I have tremendous respect for them and I want to see them taken care of in a proper way, and they are.

At the same time, it is my impression that too many of these programs are just thrown together without any thought. What I am saying is, we ought to take one step back so we can take two steps forward. We ought to think about some of these concepts. How are we going to finance it? How are we going to define what we are going to provide? And then, how are we going to provide it in the most cost-effective, efficient, and decent manner to these people? Then, let's go ahead and do it, if we want to do it.

To the extent we can help you, we will bring in people who will help to answer your questions and move you along the road. I am offering to do that.

ASSEMBLYMAN PATERNITI: All right. Thank you very much. Are there any other questions? (no questions)

The next witness I would like to call is Larry Lane, American Health Care Association.

LAURENCE F. LANE: Good morning, Mr. Chairman. I have a prepared statement to submit to the Committee. However, I will limit my remarks because of time, and also because Mr. Cunningham said a number of things in his statement that I mentioned in my written statement. At the outset, let me emphasize that the American Health Care Association believes long-term health care services is an insurable risk. This perspective is shared by a number of companies underwriting the cost of such services, by the academic community, and by the Health Care Financing Administration in the Department of Health and Human Services.

No longer is the issue "should there be private long-term care insurance?"; the policy questions are timing of market development, and movement in the area of expanding services, coverages, and types of coverages.

I mentioned that I have a written statement. It summarizes some research which I have done. It points out that long-term care insurance is available; it is affordable; it is adequate, in the sense that it is an indemnity policy that covers part of the care; and, particularly when dovetailed with public programs, it helps to deter the spend-down which is currently occuring in public programs. And, it is expanding.

With respect to the specific pieces of legislation that are before the Assembly, I have a couple of comments that are not in my written text. After I reviewed the pieces of legislation, in a section of my written text, I talk about the considerations which American Health Care sees as being necessary in a long-term care insurance policy. These are very adequately covered by a number of the provisions in both the preamble and in the technical provisions.

However, I would make a few points from my own work in the field, and also from the observations of the Association. There are a couple of concerns, or considerations -- and I don't put them forward as concerns -- with respect to the Section 4 provision empowering the Insurance Commissioner to have a broad grant, to go forward with developing a specific framework for policies. The non-cancelable

provision in 4 (a) is a fairly broad mandate. One of the items that is not included in there is payment of premium. One would obviously, from an insurer's standpoint, want to have the opportunity to cancel somebody who isn't paying the policy.

At the same time, I might point out that a couple of the policies on the market -- United Equitable, and, I believe, Fireman's Fund -- do have provisions for individuals who are in an institutional setting. After "x" number of days of coverage benefits; they do not have to pay for their policy. So, you may want to look at that type of provision.

Section 4 (c), the use of the Medicare supplemental policy language, might create some problems with the minimum Federal standard for a Medicare supplement. Therefore, I would encourage you not to obfuscate your intent a little bit more by saying it is intended to be secondary to coverage provided by the Medicare Program.

Increasingly, a body of literature that gives meaning to the term Medicare supplement makes you fall into a problem with the legislation because of Federal mandate and Federal regulation.

Four (c), the prior hospitalization requirement -- that is an area that increasingly leads one to sense that the prior hospitalization as a gatekeeper may be a problem, in terms of cost consequence. You are, in fact, stimulating -- and there is a constant debate going on right now around the Medicare program -- as to whether the skilled nursing benefit should be triggered by a hospital stay. There has been a body of research done, some of it inconclusive, but increasingly showing that prior hospitalization is not a necessary component, particularly for skilled care.

Also, I would just comment on a technicality. You used the term unlimited coverage, even though in a later subsection you use the term limit of contract days. It may be unclear as to whether you are covering more than the length of the contract in that particular provision.

What is missing from that list, and it is referenced in the broad guidelines for policy development that we are looking at, relates to utilization control. And, the gentleman from HIAA just referenced that, I believe. There is a valid concern here that utilization may be

induced if there is a payment formula, or a payment provision available. Therefore, deterring that utilization review -- which is the same problem the State has addressed in its Medicaid Program for institutional care -- has triggered a mechanism regarding a utilization review program. A fair amount of work has been done on geriatric assessment instruments that are useful because they not only measure the medical needs of an individual, but they also measure the social, environmental, and economic factors that make placement in a long-term care setting the most appropriate, or they trigger a home care intervention within an individual's home. So, I would comment your attention to that utilization control.

Section six of the bill, contains a broad grant for the State Insurance Commissioner to come up with loss ratios. As a strong advocate for the expansion of this market, I believe that a fair amount of deference may have to be given to the insurance industry regarding what they perceive as a high risk, limited data area. Therefore, I would call to your attention the need to work very carefully when giving a grant of authority, so that the loss ratios defined here are not too rigidly defined, and are not based strictly on experiences in either accidental, health, or auto-type policies, where one has to go to a ouija board to come up with some pretty specific figures.

We are really talking about a developmental type policy, where a fair amount of flexibility may be given, and where, interestingly enough, our most positive development may be linking the health-benefit type policy with an annuity cash payout type policy. An individual could then accrue credit by combining what has been done on the life insurance side with what has traditionally been health care.

Our Association has been looking at this, and we see this as probably one of the most positive developments in the HIAA Report. The Health Insurance of America has said: "It is a feasible area for development." We think there is need for a public debate concerning that development.

One of the strait jackets that could stifle that debate would be imposing loss ratios that make it very difficult to underwrite this expanding area. I do believe it is valid that questions be asked, and

for all of the concerned parties to give you their comments. Certainly, there should be a series of questions that deal with what what is actuarially possible and not possible. Our Association provided the actuarial work for Kentucky for a similar piece of legislation that was considered there on a group plan basis. Through the services of a "think-tank" group, ICF, which is the subcontractor to the Office of Planning and Evaluation in this area, we were able to come up with some basic answers.

We have also worked with Mark Mynor and Gordon Trapp in a study which the National Center for Health Care Research has put out, in which there are some actuarial formulas provided. We find that insurance companies are increasingly willing to learn from us about aging, and we are learning from them about finance. So, that may be the best of all worlds.

I have just one final comment, if I may, on Bill No. 1133, the group plan coverage provision. That, of the three pieces of legislation, may be your best opportunity to relax the stipulation of age 65 for coverage. The legislation which was introduced in Kentucky did make it through Committee; however, it caused a great deal of "heartburn" among those who didn't think it would make it out of Committee, but they we were able to find a rule to keep that from happening. It was group plan coverage that pointed out there are about two million, one hundred thousand individuals who have group plan coverage in the State of Kentuckey. Only 16,000 of that number are over the age of 65. But, 285,000 are over the age of 50. When you spread the risk that would underwrite the cost of the long-term care coverage to that larger pool of 50 and above, those who have this coverage because of employee negotiations of recent years, probably will carry that coverage into retirement. You are, in fact, looking ten years ahead and saying, that is the year we may not have to worry about eventually spending down and becoming eligible for Medicaid. So, that is a provision that needs to be looked at.

I would just commend you for your effort. New Jersey is one of four states I know of that has even give this subject any attention. Kentucky, as I said, had hearings in the latter part of March, on legislation similar to this. I understand there is

legislation in California to establish a Study Commission. And, in Connecticut, about a year ago, there was legislation established for a Study Commission.

This type of public debate, which is called for by the insurance companies themselves, is very fruitful. The time is now, because given the constraints on public spending for long-term care, if we don't stimulate the private market, we will face the question of having no capacity for service, or a limited capacity for service. This is an opportune time, and for those of us who have been involved with aging for a number of years, this is the fruit of our victory. We have helped to improve the income levels of many elderly persons. Approximately one-quarter of the elderly do have disposable incomes of over $20,000 a year. It is that share of the elderly that we can encourage to look toward their future needs. And, there are very promising signs, particularly among the elderly who are aged 55 to 65, that they are aware of long-term care need in the future. That is because many of them have experienced the "pauperization" which comes from caring for a loved one through the process of the present care system.

Thank you for your attention. We stand to work with you. Through Jim Cunningham, we are available as a resource to this Committee. Thank you.

ASSEMBLYMAN PATERNITI: Thank you very much.

The next witness I would like to call upon is Dr. Edward Campbell, New Jersey Optometric Association

DR. EDWARD S. CAMPELL: Good morning, Mr. Chairman and members of the Committee. My name is Dr. Edward S. Campell, an optometrist from Trenton, and a member of the Board of Directors of the New Jersey Optometric Association.

The Association has come before you today to testify on behalf of the quality of life experienced by our senior citizens, and to inform you of the current and potential vision care alternatives for our senior citizens here in New Jersey.

I am sure Committee members are well aware of the increasing reliance of senior citizens on quality vision as they age and as their activities become increasingly sedentary. Reading, watching

television, playing card, sewing, and other such activities increasingly occupy the time of our senior citizens. Indeed, vision care has consistently ranked among the highest priorities for our senior citizens, as determined by the White House Council on Aging.

Yet, there is currently no mechanism in place to provide our senior citizens with routine vision care and eyeglasses, and no mechanism to assist our senior citizens in meeting the expenses associated with routine vision care.

A curious situation has, in fact, developed. Vision care and eyeglasses are covered under Medicare only when the senior citizen has a medical complaint, or a well-developed medical problem. In fact, in terms of routine vision care, the best financial alternative for a senior citizen is to be afflicted with cataracts. Medicare covers the cataract removal operation and routine office visits thereafter -- at no cost to the senior citizen, other than the normal deductibles for medical care.

Routine vision care and a correct, up-to-date prescription for eyeglasses, can frequently dramatically improve a senior's vision, as well as providing the opportunity for early diagnosis and treatment of relatively common eye diseases of the elderly, such as retinal degeneration and diabetic retinopathy, which are the leading cause of blindness, and glaucoma. Early detection and treatment of disease is the most critical factor in the prevention of blindness.

Members of the Committee, what we have here is a classic cause of it's better to be sick than healthy. In fact, the more deteriorated a senior's vision becomes, the more extensive becomes the financial coverage under Medicare. We must recognize that preventive health care is a most important aspect of cost-containment in health care, an aspect that is sorely lacking in the vision care needs of our senior citizens.

We here in New Jersey have a unique opportunity to address this important quality of life issue for our senior citizens. During the last session of the Legislature, Senator Kennedy of Monmouth County, introduced a bill, Senate 3088, providing for the establishment of the Eyecare Assistance to the Aged and Disabled Program, to be funded by casino revenues.

According to the fiscal note provided by Legislative Services, this proposal would cost a modest seven million dollars annually, if P.A.A. eligibility and Medicaid standards of reimbursement were utilized.

I am confident that the Committee has heard frequently during the course of these hearings about the importance of the quality of life for our senior citizens, as well as hearing about the financial burdens that the rest of the population would consider necessary and routine.

The Eyecare Assistance to the Aged and Disabled offers New Jersey an unique opportunity to make a significant improvement in the quality of life for our senior citizens at a modest cost. I encourage the Committee to further explore this proposal. I am confident the Committee will find widespread approval for the program

Mr. Chairman and members of the Committee, on behalf of the New Jersey Optometric Association and the vision care needs of our senior citizens, I appreciate this opportunity to express our views, and I look forward to working with the Committee in addressing the concerns of our senior citizens.

Mr. Chairman, there are volumes of data and reports indicating that routine vision care is one of the highest priorities of of our senior citizens, and also indicating that blindness is the greatest fear of the elderly, as well as the American population in general. We are not covering all of this in our brief comments today. If it please the Chairman and the members of the Committee, we will provide theCommittee staff with backup data and reports. Thank you.

ASSEMBLYMAN PATERNITI: Thank you, Dr. Campell.

ASSEMBLYMAN GILL: I have just one quick question, if I may. We heard some testimony before concerning optometrists, etc. How would you envision the optometrists, in what you are specifying in your remarks here, fitting into this program of long-term insurance care for senior citizens?

DAVID F. GRIMM: Under the proposal that Senator Kennedy put forth, for P.A.A. eligibility, the P.A.A. bureaucracy would process reimbursement; for Medicaid eligibility, Medicaid would process reimbursement; and Medicaid providers, both physicians and

optometrists, would deliver the care. It seems to me that this would fit very well into the overall program of long-term health care, home health care, as well as cost and payment for some of these programs.

Because of the importance of early detection for many of the visual diseases that afflict the elderly, particularly in terms of some of the latest advances in laser treatment for senile degeneration, and the importance of a drug regime for the early stages of glaucoma, we believe it is important to call to the attention of the Committee that what happens now is an after the fact situation, when the horse is already out of the barn. The senior citizen goes through life, and when there is a problem, when there is a serious complaint, when the senior citizen wakes up with dizziness, or with spots in his or her eyes, or with floaters, then it is up to the doctor to treat it. A lot of the longer-term problems can be effectively, efficiently, and cost-effectively addressed with an early detection, early diagnosis, and early treatment program.

In our testimony today, we are urging the Committee to take a look at the front end, as well as the long-term end.

ASSEMBLYMAN PATERNITI: Thank you very much.

MR. GRIMM: Thank you.

ASSEMBLYMAN PATERNITI: I think that completes our list of people who had asked to come here and testify. If there is anyone in the audience who would like to testify, you are welcome to come up before this Committee and be heard. Is there anyone who would like to testify on these bills? (no response)

Well, if not, I want to thank you all for coming. Naturally, we will address the input. I think it will be very helpful in establishing a good piece of legislation. Thank you very much.

This hearing is now adjourned.

(Hearing Concluded)

APPENDIX

HOME HEALTH AGENCY ASSEMBLY OF NEW JERSEY, INC.
760 Alexander Road CN-1 • Princeton, New Jersey 08540

Center for Health Affairs
(609) 452-9280

Proposed Changes in A1130-1133
Thursday, April 12, 1984
State House, Trenton, NJ

1. Nursing care.

Page 1, section 1. d, line 16: the word "nursing" should be changed to "long term." In the home health setting, as in nursing homes, the services of nurses and home health aides are more cost effective and more appropriate than just nursing. This change in language would then be more consistent with the thrust and language of the rest of the bill.

2. Requiring prior hospitalization.

Page 2, section 4. d, lines 15 and 16: the language is ambiguous as to whether home health care must be preceded by a three day hospitalization. The three day requirement for home health care should not be required. Medicare has not required a three day prior hospitalization for its home health care benefit for several years. Often home health care can prevent hospitalization. It is not cost effective to incur the cost of hospitalization when a person's condition does not warrant it. An example is when a diabetic needs a nurse to teach him to self-administer insulin injections. This teaching can be done at home without going to the hospital.

3. Comparing the home health and nursing home benefit.

Page 2, section 4. d, lines 16 to 18 state: "One home health care services benefit is equal to 1.5 days of nursing home care." We are not sure what this means. If there is to be a limit on the number of benefit days, then it should follow that more, not fewer, home care days should be allowed in an equitable arrangement, because, in most cases, home care costs are less than nursing home costs.

Further, the language does not reflect the current reimbursement practice for privately paid home care. Privately paid home care services are reimbursed on an hourly rate, not a daily rate. We recommend that services be reimbursed at an hourly rate, and that the total for a day would not exceed the maximum daily nursing home rate. Benefits should be assigned to the agency provider so that payment is guaranteed.

4. The waiting period for a pre-existing condition.

Page 2, section 4. f and g, lines 21 to 30: the language seems obscure and ambiguous. Data shows that most people at the age of sixty-five have a chronic health condition. A one year disclaimer for payment of "pre-existing condition" seems a very long waiting period for this population. While we understand that some waiting period is necessary to prevent people from purchasing insurance at the onset of illness, we think a shorter waiting period (3-6 months) is more reasonable.

5. The 25% rebate may not be a sufficient incentive in certain income groups.

Page 3, section 7, lines 1 to 8: a rebate program toward defraying the costs of policies for that population which qualified for the PAAD program. Our observation is that at the lower income levels, the 25% rebate will probably not be enough of a financial incentive for the purchase of such policies. We observe that federally imposed co-payments are a great disincentive for the use of the "Medicaid Community Care Waiver" in New Jersey.

6. Changes in statement language.

Page 3, in the Statement to the bill: after the second sentence, we recommend the words "and home health care" be added to show more clearly the intent of the legislation.

There should be an explanation in the Statement that home health care would not be tied to prior hospitalization and the home health and nursing home benefits would be equitable.

7. Specific benefits and eligibility criteria.
The legislation does not list the specific benefits available under long term care, not does it discuss the criteria by which a person's health condition would be judged to enable him or her to qualify for benefits. We recommend these be added.

8. Policy renewals.
The legislation should be amended to have the statute apply to both new issues and renewals of policies, whether they be individual, group, Blue Cross or HMO policies. Without this, the legislation would have little effect as most policies are renewed and not newly issued.

Statement of
Laurence F. Lane
American Health Care Association
before the
Assembly Committee on Aging
of the
New Jersey State Legislature
April 12, 1984

Mr. Chairman:

I am Laurence F. Lane, Director for Non-Proprietary and Special Programs for the American Health Care Association. The American Health Care Association is the largest national organization of long term care providers, representing nearly 8,500 licensed facilities. I am honored by this opportunity to appear before the state legislature to discuss private insurance coverage for long term care services.

There is a growing consensus among our members that private insurance offers a promising approach to purchasing quality long term care services. I wish to briefly share with the committee:

(1) the reasons for this support of private insurance,

(2) the minimum coverage principles, and

(3) the findings of a study which we prepared earlier this year discussing the available of private insurance for long term care, obstacles to expansion and actions which our association see as necessary to develop the market.

At the outset, let me emphasize that we believe the exposure for the costs of long term health care services is an insurable risk. This perspective is shared by a number of companies under-writing the costs of such services, by the academic community, and by the Health Care Financing Administration of the Department of Health and Human Services. No longer is the issue should there be private long term care insurance; the policy questions are of timing of market

development, of the nature of coverage provisions and of the relationship of the private market to public programs.

(1) Reasons for Support of Private Insurance:

Our Private LTC Insurance Task Force has identified the following items as important reasons for the public pursuit of private insurance for long term care:

- o provides financial support for the purchase of quality service,
- o enhances the opportunity for consumer choice,
- o preserves the dignity of older persons to prudently plan for their potential long term care needs,
- o reduces federal and state exposure for the costs of future long term care services,
- o overcomes the reliance upon public programs as the source of payment for services, and,
- o assures market competition and entices the expansion of diversified service delivery.

While this is not a exhaustive list of reasons, the point is clear that developing the private insurance coverage will benefit the consumer, insurers, government and providers.

(2) Nature of Coverage:

Enticing a positive response from the private insurance sector will require a constructive dialogue. The recently released report of the Health Insurance Association of American (HIAA) entitled, "Long Term Care: The Challenge to Society," offers a useful framework for stimulating the public debate.

In a similar cooperative effort, I offer the initial comments of the AHCA Private LTC Insurance Task Force on the nature of coverage. While these ten points do not reflect an official position of the Association, they are representative of the input which we are receiving from members:

- o long term care insurance must truly reflect financing for the longer stay patient in need of skilled and/or intermediate care,

- o long term care insurance should not be tied to Medicare Part A requirements nor linked to definitions of levels of care utilized by the Medicare program,

- o approved utilization screens should be based upon geriatric service needs,

- long term care insurance should reflect payment for both institutional and non-institutional long term benefits provided that the same geriatric screen criteria for utilization be used to ensure prudent utilization of the coverage,

- long term care insurance should afford the opportunity for children and others to purchase the coverage on behalf of a qualifying relative and for the purchaser to receive the benefits of available taxation deductions and credits,

- an indemnity insurance approach is acceptable provided (a) the rate reflects the true costs of providing necessary services to an individual, and (b) the rate includes a trending factor to compensate for inflation.

- eligibility criteria should not negate coverage for a large number of older person, i.e., policy exclusions should not prevent coverage for chronic conditions closely correlated with the normal aging process,

- pre-existing condition requirements should be limited to a defined prior care timeframe,

- policies which offer differential rates based upon resource utilization should be periodically updated to reflect the true costs of care, and

- o strengthening of the private insurance market should be synchronized with changes in the Medicaid program so as to promote the private approach without abandoning current Medicaid eligible populations.

(3) Findings of AHCA Study:

Earlier this year, I conducted a study for the American Health Care Association of the private insurance market (appendix #1). Findings document that private long term care insurance coverage is:

- o available
- o affordable
- o expanding
- o adequate

The report indicates that over 25 insurance companies are experimenting with policies covering extended long term care services. Of that number, more than half have made a commitment to expanding their share of the market. While the experimental policies greatly vary, the typical policy provides an indemnity benefit of between $30-$60 per day for coverage of skilled nursing and intermediate care services for up to 4 years of nursing home placement. It appears realistically possible for an individual between the ages of 60-65 to purchase viable long term care insurance at a premium of less than $30 per month. While coverage for an individual above the age of 75 will be more expensive, data on the income and resources of older Americans suggest that long term care insurance is well within the means of most senior citizens.

Among the significant obstacles to the growth of the private long term care insurance market are consumer under estimation of their potential need for long term care coverage and over estimation of the available coverage of their existing insurance policies and of public programs.

The study concludes that a variety of approaches can be taken to make long term care insurance a reality across the country. One of the key recommendations of the report is for the American Health Care Association and its state affiliates to assume the leadership in spearheading coalitions with other interested groups to promote the marketing of long term care insurance. Such initiatives would work to raise public consciousness of the need for insurance coverage, entice the cooperation of major insurers to extend coverage into the long term care market and cooperate with federal and state government officials to secure necessary legislation to make private insurance viable. (appendix #2 is a draft pamphlet outlining our ACTION strategy).

Conclusions:

This hearing is a pioneering effort focusing attention on a void in our programs for older persons. To my knowledge only three other states are exploring the role of private long term care insurance, Connecticut and California through study resolutions and Kentucky by legislation similar to the proposal introduced in this Assembly.

Medicare provides scant coverage for nursing home services and other long term care care. Supplemental insurance policies, so-called "Medigap" coverages,

use Medicare definitions. Most policies are restrictive in coverages and provide no real protection against long term care costs. Without Medicare or insurance protection, individuals must rely upon their own savings to pay for long term care services. Nursing home expenses are the largest catastrophic expense for individuals age 65 and over. Many people spend their resources until they are so poor as to be eligible for Medicaid. To the extent that private insurance can help people from needing Medicaid, the costs to government for supporting the indigent could be reduced.

The members of our association stand ready to work with you in this challenge of enticing usable private long term care insurance policies.

LL/ll
April 10, 1984
849.16

A CALL FOR ACTION!

from

THE AMERICAN HEALTH CARE ASSOCIATION

THE NATION'S LEADER IN QUALITY
LONG TERM HEALTH CARE

PRIVATE INSURANCE FOR LONG TERM CARE:

AN IDEA

WHOSE TIME HAS COME!

Private insurance offers a promising approach to purchasing quality long term care health services. For years, underwriters hesitated to provide health insurance benefits to older people. During the mid-1950s this barrier was successfully pierced for acute care services. However, older Americans still confront obstacles to realistic private insurance coverage for nursing home and other long term care services.

This leaflet is the American Health Care Association's CALL FOR ACTION to resolve the lack of adequate private long term care insurance!

WHY SHOULD WE CARE ABOUT LONG TERM CARE INSURANCE?

(1) People are living longer!

The 20th century has seen average life expectancy in this country grow from under 50 to over 70 years of age. Presently, one in nine Americans is over the age of 65. By the year 2000, one in eight will be over the age of 65; one in 16 will be over age 75. Life expectancy at age 65 has dramatically increased during the past decade alone, adding as much as four more years of life.

(2) The need for long term care services increases with age!

WIth older age comes an increased risk of chronic disease and impairment. The percentage of people who are dependent in at least one activity of daily living function increases ten times from the age 65-75 group to the age 85 and over group. A serious chronic condition is more likely to lead to nursing home admission. For instance, a hospital stay for an older patient will often need to be followed by a recuperative stay in a long term care facility.

(3) Medicare does not pay for long term care!

Medicare provides scant coverage for nursing home services and other long term care. Medicare requires hospitalization before a beneficiary becomes entitled, and then only for the skilled nursing facility benefit. The program so eligible services so tightly that average approved lengths of stay are under 30 days. Supplemental insurance policies (so-called "Medigap" coverages) use Medicare definitions. Most policies are restrictive in coverages and provide no real protection against long term care costs.

(4) Long term care costs can deplete savings!

Without Medicare protection, individuals must rely upon their own savings to pay for long term care services. Nursing home expenses are the largest catastrophic expense for individuals age 65 and over. Many people spend their resources until they are so poor as to be eligible for Medicaid.

(5) Public expenditures for long term care are a public burden!

The bills of half of the individuals currently receiving long term care services are paid by Medicaid, the federal/state health program for the medically indigent. Many of these individuals were not poor until they required medical assistance. While some have transferred their resources to become eligible, most have used up their savings to purchase care. The burden of supporting necessary services is a strain on most states and the federal government. To the extent that private insurance can help people from needing Medicaid, the costs to government for supporting the indigent could be reduced.

WILL INSURANCE COMPANIES COVER LONG TERM CARE BENEFITS?

A study carried out by staff of the American Health Care Association indicates that more than 25 insurance companies are experimenting with policies covering long term care. More than half of those have made a commitment to expanding their share of the market. The typical experimental policy provides a benefit of between $30-$60 per day for coverage of skilled and intermediate care services in a nursing home for up to 4 years of admission. Some policies permit beneficiaries to substitute home health care services as an alternative to facility-based care.

ARE THESE POLICIES AFFORDABLE?

It appears possible for an individual between the ages of 60-65 to purchase viable long term care insurance at a premium of less than $30 per month. While coverage for an individual above the age of 75 will be more expensive, data on the income and resources of older Americans suggest that long term care insurance is well within the means of most senior citizens. A recent study in one state shows that group plan coverage is also affordable, costing plan members a nominal amount for adequate protection.

WILL OLDER PEOPLE PURCHASE COVERAGE?

Older Americans do not want to be wards of the state. They want to be independent and responsible for their own actions. Long term care insurance can help elderly people maintain control of their lives and estates. As realistic affordable policies are developed, there will be increased demand for private offerings. The explosive growth of retirement centers is proof that many older Americans plan for their older years. Long term care insurance can be a significant part of assuring security in case of chronic impairment.

WHAT ARE THE BARRIERS TO MARKET EXPANSION?

A significant obstacle to the growth of private long term care insurance is lack of consumer awareness of potential need for coverage. Most Americans give little thought to their retirement health needs. Few consider the costs of nursing home and home health services, assuming that public programs will provide necessary coverage. Others are misled into believing their "Medigap" insurance provides long term care coverage. Few individuals understand their probability of needing quality long term care health services.

WHAT CAN BE DONE?

The American Health Care Association recommends the following **ACTION** strategy:

A = **ADVOCACY** stimulating State Legislatures to encourage the private market to be more aggressive in expanding private long term care insurance coverage.

C = **COALITIONS** of providers, consumer advocates, and public interest groups, cooperatively pursuing the objective of expanding private long term care insurance.

T = **TAX INCENTIVES** in Federal and state revenue laws encouraging individuals and families to purchase private long term care insurance, while instilling family responsibility for their relatives and promoting private savings for future long term care needs.

I = **INSURANCE REGULATION REFORM**, removing rules that prevent coverage and adopting those that facilitate the expansion of private long term care insurance.

O = **OVERCOMING INDIFFERENCE** to the plight of the frail and vunerable by broadening public understanding of the important role of professional long term care services.

N = **NEEDS AWARENESS**, raising the consciousness of the public at large to the changes which longer life will make in society.

AMERICAN HEALTH CARE ASSSOCIATION
1200 15th Street, N.W.
Washington, D.C. 20005
(202)833-2050

AHCA INITIATIVE ON LONG TERM CARE INSURANCE

EXECUTIVE SUMMARY

A study carried out by staff of the American Health Care Association indicates that over 25 insurance companies are experimenting with policies covering extended long term care services. Of that number, more than half have made a commitment to expanding their share of the market. While the experimental policies greatly vary, the typical policy provides an indemnity benefit of between $30-$60 per day for coverage of skilled nursing and intermediate care services for up to 4 years of institutionalization. It appears realistically possible for an individual between the ages of 60-65 to purchase viable long term care insurance at a premium of less than $30 per month. While coverage for an individual above the age of 75 will be more expensive, data on the income and resources of older Americans suggests that long term care insurance is well within the means of most senior citizens.

Among the significant obstacles to the growth of the private long term care insurance market are consumer under estimation of their potential need for long term care coverage and over estimation of the available coverage of their existing insurance policies and of public programs. Continual focus by public programs to the goal of prevention of premature placement in a facility based long term care program has misled the public that the risk of paying for a nursing home does not exist.

The study concludes that a variety of approaches can be taken to make long term care insurance a reality across the county. One of the key recommendations of the report is for the American Health Care Association and its state affiliates to assume the leadership in spearheading coalitions with other interested groups to promote the marketing of long term care insurance. Such initiatives would work to raise public consciousness of the need for insurance coverage, entice the cooperation of major insurers to extend coverage into the long term care insurance market and cooperate with federal and state government officials to secure necessary legislation to make private insurance viable. A special task force on Private Long Term Care Insurance has been appointed by the President of the American Health Care Association to coordinate the Association's leadership on this issue during 1984.

For further information contact: Laurence F. Lane
American Health Care Association
Washington, DC 20005
202/833-2050

PRIVATE INSURANCE FOR LONG TERM CARE:

Availability, Problems and Actions

Prepared by: Laurence F. Lane
for the
American Health Care Association

January, 1984

AHCA INITIATIVE ON LONG TERM CARE INSURANCE

PRIVATE INSURANCE FOR LONG TERM CARE

In response to the preceived need for enhancing private sector financing for long term care services the Division of Federal/State Relations has undertaken an intensive review of the potential for long term care insurance. As the following review of activities indicates, there is a significant potential for a private insurance response to the payment for long term care services. This report will:

-- provide an assessment of current policies,
-- discuss the reasons for the market's failure to provide coverage,
-- identify on-going activities, and
-- make recommendations for additional AHCA involvements.

(1) Background:

Skilled nursing care, and related forms of extended care, such as home health care, intermediate care and domiciliary care, have become an increased source of national expenditure, increasing tenfold between 1960 and 1980 (Gollub/SRI International, 1983). Forty-three (43) percent of outlays for nursing home care came from private sources in 1977 (NCHS, 1979). HCFA data indicates that for the year 1979, of the $17.8 billion expended for nursing home care, $7.7 billion reflect private funds. Private insurance is estimated to contribute only $117 million of such sums (HCFA, 1983). Nursing home expenses are cited as the largest catastrophic expense for those aged 65 and over (Birnbaum, 1981). Area specific data accumulated by GAO suggests that a significant number of nursing home residents enter as private pay patients and become eligible for Medicaid after exhausting their resources. For example, in Minnesota, data indicates that one-fourth of the patients admitted to Medicaid coverage in nursing homes between 1977-1979 had actually entered nursing homes at some point earlier as private pay patients and subsequently converted to Medicaid (GAO, 1983).

The two features of the structure of the nursing home industry which makes it unique are the limited capacities of its consumers and the dominance of government as both payer for nursing home services and regulator of the activities of the industry (Vogel, 1983). The National Center for Health Care Statistics found that on one day in 1977, sixteen (16) percent of the 1.3 million residents had been there from three (3) to five (5) years, and thirty-three (33) percent from one(1) to three (3) years. While the median length of stay for nursing home residents on the day of the survey was under three (3) months -- (seventy-nine days) -- a small proportion of residents stayed far longer, so that the average stay was calculated as being over one(1) year -- four hundred and fifty six days (NCHS, 1979). A statistical model developed by the General Accounting Office suggests two profiles of nursing home residents, one with characteristics of short-stay (average of less than two months of residency), and one of a longer stay (two and one half years average) (General Accounting Office, 1983).

To examine the potential role of private financing of long term care, it is important to understand the resources of different groups of the elderly.

In a June 1983 preliminary report to the Office of the Assistant Secretary for Planning and Evaluation (HHS), ICF, Inc. (a Washington, DC consulting organization specializing in pension and actuarial calculations), provided a detailed analysis of income and resources of the elderly. According to the research, if older persons had the opportunity to "annuitize" their income and resources, approximately one-third (33%) of elderly couples and over one-quarter (26%) of single persons had wealth which could produce an annual annuity value of $5,000 or more. Adjusting this amount for age using actuarial assumption projections, the research indicates that almost forty (40) percent of the elderly over age 80 could convert their assets into an annuity of $5,000 (ICF, 1983). Such findings are consistent with the data collected by the National Center for Home Equity Conversion (Scholen, 1983). Separate from the analysis including resources, ICF estimated the percentage of families to whom long term care might be affordable based upon available income. As shown below, a significant share of the elderly could afford premiums which would be less than ten (10%) percent [five (5%) percent] of cash income:

ICF Estimates of Affordability at 10% (5%) of Income:*

	Age 65-69	Age 70-74	Age 75-79	80+
married couples	82% (50%)	67% (27%)	38% (12%)	23% (6%)
single persons	80% (44%)	65% (27%)	41% (16%)	29% (10%)
total	81% (47%)	66% (27%)	40% (14%)	27% (9%)

* assuming an annual premium in 1983 dollars for an individual age 65-69 of $450, 70-74 of $550, 75-79 of $775, and 80 and over of $900. Premiums for couples are twice these levels.

(2) <u>Assessment of Current Policies</u>:

Private insurance offers one of the more promising of the market approaches to underwrite the costs of long term care. For years, there was great hesitation by the insurance market to provide health benefits to older persons. During the mid-1950's this barrier was successfully pierced with the advent of group plan coverage for retired teachers and retired professionals under the auspices of the National Retired Teachers Association/American Association of Retired Persons. While the market remained small, in part because of the political debate for a Federal program, there was a positive growth curve throughout the decade prior to Medicare. With the advent of Medicare, the focus of the health insurance industry shifted to a supplemental role providing coverage of deductibles and coinsurance features. During the 1970's this market grew substantially. According to one recent analysis, about two-thirds of the aged population had private insurance supplemental to their Medicare coverage (Carroll & Arnett, 1981). This coverage was primarily purchased by the individual.

As the market for supplemental insurance, the so-called Medigap insurance, grew during the past decade the benefits altered to meet the competitive demand. In 1976, less than six million (6,000,000) supplemental insurance policies indicated coverage for nursing home care of any type. Nineteen seventy-nine (1979) data

indicates more than a doubling of coverage with over thirteen million (13,000,000) policyholders receiving some Medigap coverage for nursing home services. At the same time, the number of individuals covered by a supplemental health insurance policy only grew by about three million (3,000,000) policyholders (Carroll & arnett, 1981). This data would suggest that nearly half of the elderly (estimate of 48%) have some coverage for at least a share of the costs of nursing home care. Unfortunately, the depth of coverage appears to be tied closely to the coverage afforded by Medicare. Thus, while the breadth of coverage has been extended, the depth of protection has remained limited. Most of the nursing home coverage afforded by Medigap policies pays for required deductibles and coinsurance mandated under the Medicare program for skilled nursing care between the 21st and 100th day. Some policies are slightly more generous providing a fixed number of days of payment in a skilled nursing facility but delimit their coverage to utilization controls of the Medicare program.

An attempt has been made by ICF to estimate the size of the population which has been able to secure insurance coverage for long term care services more extensive than those covered by the typical Medigap policy. The preliminary estimate suggests that upwards to fifty thousand (50,000) individuals have been able to secure market coverage for comprehensive long term care services (ICF, 1983). A composite of the research available suggests the following companies as providing offerings covering long term care:

- Fireman's Fund, San Rafel, CA
- Federated American Life/Sterling Credit Life, Springfield, OH
- Massachusetts Indemnity and Life, St. Louis, MO
- Great Republic Life, Seattle, WA
- United Equitable Insurance, Skokie, IL
- Health Insurance Corporation, Milwaukee, WI
- Equitable Life and Casualty, Salt Lake City, UT
- Kemper group, Long Grove, IL
- Merchants and Manufacturers Insurance, OH
- Pacific Benefits, Seattle, WA
- National Foundation and Life, Oklahoma City, OK
- Columbia Accident and Health, Bloomsburg, PA
- Mutual Protection Insurance, Omaha, NE
- Transportation Life, Fort Worth, TX

Limited policy coverage:

- Prudential (AARP Plans and other group coverages)
- Bankers Life (reportedly a supplemental rider)
- Mutual of Omaha (reportedly a supplemental rider)
- American Life and Casualty
- Aetna (limited offering as a supplemental rider)
- Montgomery Wards (NAMP group plan)
- Colonial Penn (old AARP plan)

Group offerings:

- Blue Cross of North Dakota (still experimental)
- Blue Cross of Southern California (Ultracare -- HMO Plan)
- United Auto Workers/Blue Cross of Michigan
- S/HMO of Brooklyn (ElderPlan)
- S/HMO of Portland (Kaiser)

Attachment #1 is a summary of the four most cited long term care plans offering coverage as taken from the ICF June 1983 report. Attachment #2 are summaries of additional plans reviewed by Mark Meiners of the National Center for Health Services Research.

It is most important to note that the available offerings provide indemnity benefits for extended nursing home stays. The benefits vary with regard to the amount of indemnity paid, the length of time benefits are provided, the waiting period before benefits become effective and the conditions upon which benefits will be paid. The indemnity benefit limits the insurer's liability and reduces the risk of providing insurance. Many of the initial health policies underwritten for older person, including most of the group plan policies marketed through the American Association of Retired Persons were indemnity coverages.

Another characteristic of the current policies is a deductible or a reduced benefit period as a means of controlling unnecessary utilization. Most of the existing policies limit their benefits to facility based services, although it is possible to get a rider for home based care. Attachment #1 provides several good examples of the variety of coverages for custodial and intermediate care benefits. Likewise, most of the current policies restrict benefits to a period of three or four years.

Premiums for most of the available policies are aged rated, i.e., premiums increase with the age of initial insurance purchase. This practice has been questioned by Meiners in his writings. Mark has developed a prototype policy for the National Center for Health Service Research which suggests financing similar to a whole life insurance policy with level premiums. The age related approach is more analogous to term life insurance. It is unclear whether the current debate on discrimination against women in insurance coverage will impact upon the development of a long term care benefit. The aged rated benefit could be shown to factor the longevity of women, and, therefore, have an element of discrimination.

Most of the current plans have elaborate utilization controls. These include the use of one or more of the following:

- medical screens and physical examinations
- pre-existing condition limits
- prior hospitalization requirements
- restrictions on coverage for mental, alcohol and drug related requirements
- definitional restrictions on types of coverage and services purchased.

As emphasized by the ICF data, the market experience is limited. While the number of policies purchased has grown, the utilization of the coverage has limited documentation. Therefore, it is difficult to define the range of service utilization.

(3) **Reasons for Limited Market Development:**

Several researchers have explored the problems of developing insurance coverage for long term care. Each have cited their findings for the slow expansion of the private sector into this important area of coverage.

In perhaps the most exhaustive study of the subject, Mark Meiners suggests the following factors which he characterizes as "market failures:"

- o traditional insurance concerns of adverse selection, moral hazard, administrative diseconomies, and premium pricing difficulties due to inflation.
- o absence of reliable data on which to base estimates of utilization, costs and experience.
- o state insurance regulations which inhibit or prohibit coverages.
- o the availability of public long term care programs which serve as as safety net for those who are poor or may become poor.
- o consumer preference for first dollar coverage.
- o consumers under estimation of their potential need for long term care coverage and over estimation of the available coverage of their existing insurance policies and of public programs.

This latter point is perhaps most important. Writing in the AHCA Journal two years ago, AARP's staff insurance expert Ron Hagen pointed to several additional problems: misinformation, deception, and less than complete understanding of the potential policyholder's coverage and its limitations. Hagen also suggests that the restrictive underwriting requirements to compensate for insurance risk might be a significant market disincentive. More recent papers prepared by Dr. Friedman at Northwestern University and by the staff of the Health Consortium at Brandeis reiterate these points as market problems.

In looking at this list, it is interesting to note that the experience of medical screens for both Fireman's Fund and Pacific Benefits document that they have rejected a greater number of applicants under the age of 65 than over the age of 65, indicating that adverse selection in the purchase of long term care insurance may be a greater problems for the younger age group. Pacific Benefits has also documented a rejection of policy applicants over the age of 80, but the experience has been limited compared to the total applicant pool. Current policies tend to restrict coverage through the use of pre-existing conditions restrictions and coverage exclusions. Many of the current policies would not cover organic brain disorders (including Alzheimer's Disease) and mental health services. In some instances, the pre-existing condition limitations have included maternal related complications.

Attention should be directed to two of the cited market failures. First, there is widespread public misunderstanding of both the risks they confront in the normal aging process and of the protections which they have purchased through their insurance coverages. The Medigap policies have sometimes been marketed without clearly stating the protections afforded for long term care. Continual focus by public programs to the goal of prevention of premature placement in a facility based long term care program has misled the public that the risk does not exist. Second, the interplay between the Medicaid program and the purchase of long term care needs to be carefully assessed. The evidence which supported changes in the divestiture provisions of the Medicaid program suggests widespread public "gaming" of the system to avoid assuming the responsibility for purchasing services. The Medicaid nursing home protection has been characterized as a "middle-class" catastrophic care program where in residents of nursing homes enter as private pay and spend down to become eligible for the public entitlement. Whether this is fact or an overstatement of reality needs to be carefully analyzed.

(4) On-Going Activities:

Slowly, research is being generated to stimulate the private market to extend coverage for long term care. The following is brief annotated review of identified activities:

- National Center for Health Services Research: Dr. Mark Meiners has been in the forefront of raising the private insurance issues. Meiners has authored a number of articles, including one for the AHCA Journal, March, 1980. Meiners' prototype policy presented in his paper, "Private Coverage of Services Not Covered by Medicare: The Case for Long Term Care Insurance," October, 1982, is at the center of the debate.

- ICF: John Valiente has received a grant from the Assistant Secretary for Planning and Evaluation (HHS) to study private financing. The June, 1983 interim report on the subject is most interesting. This report is being revised with further analysis and direction (I recently assisted John on the revisions) and should be available early next year.

- Health Consortium at Brandeis: Several policy papers have been prepared by Stan Wallack and staff. Christine Bishop has continued her work on a social insurance approach which would mandate long term care insurance via public mechanisms. The Health Consortium provides the support to the Social HMO (S/HMO) demonstrations, two sites of which are developing insurance coverages. Wallack has become very interested in retirement centers which share the risks among residents. A paper was delivered at the Aging 2000 Seminar in October, 1983, (conducted by the Texas Research Institute for Mental Sciences) outlining the status of work on insurance by the Health Consortium.

- Prudential/AARP: Ron Hagen has been given lead responsibility in working with the Prudential Insurance group plans to perfect coverage for the American Association of Retired Persons. Hagen outlines the directions he is pursuing in his September, 1982 article in the AHCA Journal.

- Center for Health Services and Policy Research, Northwestern University: Friedman's group has a marketing project underway, attempting to identify the issues which would influence acceptance of insurance coverage by the elderly. Information from the project which was designed about a year ago should be forthcoming.

- Health Insurance Association of America: Art Lifson (Equitable Life Assurance Society of U.S.) and Purlaine Lieberman (HIAA staff) have led a task force looking at the prospects for market development. In an overview to the report presented by Lifson in a program sponsored by the Ritter Department of Geriatrics and Adult Development (see below), he questioned the merits of the private sector underwriting long term care. Lifson raised a number of technical problems in developing insurance coverages, i.e., available data, market failures, uninsurable risks, and he suggested that firms should look to the next generation of elderly (those between 35 and 55) as the market segment which could be insured. The HIAA Report has received a great deal of attention.

- SRI International: Jim Gollub has been spearheading SRI's review of Medicare Supplemental Insurance (Medigap) policies. This is a market and it can be penetrated. Gollub will be writing on long term care insurance in the upcoming series on LTC by the Healthcare Financial Management Association. Gollub would like to get funding for his approach of building private and public decision teams working to develop a better understanding of aging, long term care and coverages.

- Mt. Sinai/Ritter Department of Geriatrics and Adult Development: Dr. Butler is most interested in developing private insurance for long term care. As his first act as director of the Mt. Sinai program, he put together a symposium on private insurance coverage. Butler has floated the idea of putting together a Blue Ribbon Panel of leading figures to spearhead a development task force. This plan might get off the ground (I have been involved in developing this approach).

- AHCA: The leading national organization pushing for development of an insurance approach has been AHCA. For the past two years, key members have been exchanging information and interacting with the players cited in this section. Last September, the AHCA Journal featured a series on developing private insurance. In addition to stimulating attention to the need for broadening coverage for long term care in general, AHCA has also devoted attention to partial coverage for special requirements, e.g., head injury, spinal cord injury.

- Market: In response to an inquiry from ICF, many of the firms cited as offering coverage suggest they will expand their marketing during the current year. For instance, the Equitable plan mentioned above has been adopted by this policy. Thus, we can assume that inspite of the HIAA report, the market is responding to the growth potential.

(5) **Stimulating New Approaches:**

Overcoming the market failures identified above will require tremendous momentum in the developing of a long term care insurance offering. AHCA has made a tremendous investment in stimulating the development of private financing. This effort should continue with attention to raising the public's awareness of the need for long term care insurance. As a first step in providing this leadership, a special Task Force on Long Term Care should be appointed to coordinate staff, membership and state affiliate activities with developing the private insurance market. We should anticipate a significant demand upon our technical resources to provide information educating the public to the need for long term care insurance and we should expect that our advocacy network will be called upon to provide the lobbying power to stimulate appropriate legislative and regulatory responses.

Among the tasks which need to be undertaken are the following:

- Public awareness: There is a tremendous public information effort needed to raise the consciousness of the public at large to the changes which longer life will make to society at large. Emperical studies indicate a longer actuarial lifespan for older persons than self-perceived. There is a widespread public stereotyping of the elderly which does not relate to the age 75+ population. There appears to be a significant problem among the elderly and the professionals working in the aging enterprise to accept risky and frail behaviors as parts of the normal aging process. Beyond our continued efforts stimulating the Administration on Aging and the National Institute on Aging to focus on the full spectrum of needs of an aging population, we might wish to encourage the health promotion and health financing agencies of the Federal government to be more aggressive in educating the public. Likewise, we might encourage the AD Council to devote public service announcements to expanding public awareness.

- Documentation and data: Our homes are the laboratories for developing insurance policies. There is a great need for the nursing home industry to parallel the hospital industry in developing baseline data. Simple data, such as the number of persons entering as private pay and converting to Medicaid, is not readily available. AHCA can encourage homes to work with researchers exploring the development of insurance. We can use data collected from our members in informing both the public and research communities to the realities of the market. We can disseminate data which has been collected from other sources to expand general knowledge about long term care.

- Working with insurance companies: While AHCA has initiated some liaison with the private sector and it has worked with SRI and HIAA, there is need for additional direct approach with the market. Just letting them know that we exist and that we are willing to help with technical support in their endeavors would be a first step. Certainly, there may be a role for the Service Corporation in developing specific plan specifications and soliciting companies to bid to provide an expanded role in the market. AARP initially entered the market with Colonial Penn in a very limited offering. Over time, the relationship served both the carrier and the association.

- Working with state Medicaid programs and consumer groups: The crisis of funding for Medicaid has created a favorable environment for providers, consumers and payors to stimulate the private market. AHCA should encourage its state affiliates to approach both Medicaid officials and representatives of consumer organizations to initiate a dialogue on the issues. One idea which moves us toward the objective of broadened coverage would be to have the state government sanction a committee of providers, consumers and state officials to stimulate market development. AHCA should place the issue of private insurance on its agenda for liaison with the Medicaid State Directors and in our cooperative initiatives with consumer groups.

- Stimulating state legislative activities: just as above, the AHCA state affiliates are a powerful tool to leverage market change. Legislative panels could be encouraged to look at prohibitions in the current state regulatory structure which are disincentives to coverage of custodial and intermediate care. Restrictions on indemnity policies and reserve limitations serve as major disincentives. The other area which needs to be considered is the dovetailing of the Medicaid program into the private insurance coverage, i.e., beginning the process of having the private sector as primary coverage rather than secondary. Among the actions which need to be taken are steps to overcome the problems of pre-existing conditions limitations, premium supports and coverage for those unable to meet the medical screens.

- Effecting public sector incentives encouraging the purchase of long term care insurance: public expenditures for long term care may be appreciably reduced if positive incentives were offered to stimulate greater private market coverage. The ideas generated by the AHCA Payment Committee recommending specific taxation policy changes (a) to alter the gross income requirements for dependent care, (b) to modify the dependency test, (c) to remove the disincentives for older persons to use their individual retirement accounts (IRA's) and (d) to stimulate reverse annunity mortgages unlocking homeowner equity need to be advanced. Moreover, AHCA must lobby to ensure that pending changes in the federal Internal Revenue Code proposing to place a ceiling on insurance protection for health care be structured so as not to inhibit the development of a long term care insurance market.

- Enticing the public sector to act as reinsurance for private initiative: one of the significant breakthroughs might be to stimulate a private-public partnership with the government acting as a reinsurance agent to absorb some of the market risks. Such an effort would help to overcome the diseconomies of moral hazzard and adverse selection, while keeping the private sector as an available option. A reinsurance strategy encourages the private sector to expand into the market knowing that government will assume some of the risks and it will help to bail them out if the risks are too great.

- Enticing the private sector to act as a reinsurance mechanism: in conjunction with the above approach, for certain service approaches, e.g., continuing care retirement communities, the private market might accept the risks of providing reinsurance especially if there as taxation incentives to move in that direction. CCRC's market to a private pay market and they have actuarially designed approaches to meet future costs. Specific proposals for reinsurance have been discussed in the private sector. Reinsurance frees capital and helps meet reserve requirements. Such an approach could lead to market rated bonds for CCRC development if structured correctly.

LL:cjw
8433.04
January 31, 1984

AHCA INITIATIVE ON LONG TERM CARE INSURANCE

Attachments:

#1 Table 2 from ICF, Private Financing of Long Term Care: Current Methods and Resources, Interim Report to the Assistant Secretary for Planning and Evaluation, HHS, JUne, 1983.

#2 Table 1 from Meiners, The State of the Art in Long Term Care Insurance, National Center for Health Services Research, Working Paper, revised July, 1983.

TABLE 2

LONG TERM CARE INSURANCE POLICY BENEFITS

	Skilled Nursing Care		Custodial, Intermediate Care		Home Health Care	
	Benefits	Conditions	Benefits	Conditions	Benefits	Conditions
United Equitable	$20-50/day for 4 years	After 3 day hospital stay; care must be received in SNF which could meet Medicare standards and which has 24 hour nursing service under supervision of RN. Patient must receive skilled nursing care (using professional nursing methods and procedures) on a daily basis	$10-25/day for 6-12 months	Only after SNF stay of 20 days or more; in SNF or licensed ICF or custodial nursing facility; under supervision of RN or LPN	None	
Kemper	$10-20/day for 100 days; $20-40/day for 101st-1,095th days	After 3 day hospital stay; in SNF licensed by state and which has 24 hour nursing service under supervision of RN/LPN	$10/day for 60 days	Only after SNF stay of 20 days or more; in SNF	$12.50-25/day for private nurse for 3 yrs	Must be house-confined. Services must be recommended by physician.
Fireman's Fund	$10-50/day for 4 years	After 3 days hospital stay; in SNF which provides continuous (24 hour) skilled nursing care under supervision of RN. For injuries/illnesses which are not at first primarily custodial, but which may become custodial	$10-50/day for 4 yrs	Only after SNF stay; in SNF which provides continuous skilled nursing care under supervision of RN	50% of SNF/ICF benefit for 100 days	
Pacific Benefits	$30/day for 4 years	Same as Fireman's Fund	$30/day for 4 years	Same as Fireman's Fund	None	

Appendix 2

Table 1. Long-Term Care Insurance Examples

Policy Features of Insurance Companies

Policy Features	Insurance Company: Fireman's Fund American Life Insurance Company	Massachusetts Indemnity and and Life Insurance Company	Equitable Life and Casualty Insurance Company
Skilled care covered	Yes	Yes	Yes
Intermediate care covered	Yes	Yes	Yes
Custodial care covered	Yes	No	Yes
Home care covered	Yes	No	Yes
Indemnity benefit	Yes, choice of up to $60 per day for nursing home $30 per day for home care.	Yes, $50 per day for skill care or $40 per day for intermediate care.	Yes, choice of up to $60 per day for skilled care, $30 per day for intermediate care, $15 per day for for custodial care, and $7.50 per day for home care.
Waiting/Elimination deductable period	Choice offered - 20 or 100 days	60 days	Choice offered-0, 20, or 100 days.
Length of coverage	4 years for any nursing home confinement, 130 days for home health.	$75,000 lifetime maximum benefit allows 4.1 years of skilled care or 5.1 years of intermediate care.	24 months for skilled care, 12 months for intermediate care, 5 months for custodial care, and 30 days for home confinement with a $90,000 lifetime maximum benefit.
Sales screened for health status	Yes, general questions asked about institutional and physician care in previous months and ability to perform daily activities.	Yes, but limits evaluation to those hospitalized or in a skilled nursing home in prior 12 months.	Yes, detailed list of condition information requested.
Preexisting condition period	90 days	12 months	6 months for conditions occurring in previous 5 years.
Prior hospitalization required	Yes, confinement must begin within 90 days after hospitalization of 3 or more days.	Yes confinement must begin within 28 days after hospitalization of 3 or more days.	Yes, confinement must begin within 14 days after hospitalization of 3 or more days.
Use must be recommended and reviewed by physician	Yes confinement must be recommended by physician and physical exam can be required at company's expense.	Yes, confinement must be recommended by physician and must be recertified every 30 days.	No explicit statement, but physical exam can be required at company's expense.
Covers mental and nervous disorders	Yes, if demonstrable organic illness.	Yes, if demonstrable organic disease.	Yes, if demonstrable organic disease.
Guaranteed renewable	No, non-renewable at-decade.	No, non-renewable on group basis.	Yes
Company can change premiums	Yes	Yes	Yes

Table 1. (continued)

Policy Features of Insurance Companies

Policy Features	Insurance Company		
	Federated American Life Insurance Company	Lamper Group	Great Republic Life Life Insurance Company
Skilled care covered	Yes	Yes	Yes
Intermediate care covered	Yes	Yes, but very limited	Yes, added as optional rider.
Custodial care covered	Yes	Yes, but very limited	Yes, added as optional rider.
Home care covered	No	Yes, private duty nurse	Yes, private duty nurse.
Indemnity benefit	Yes, choice of up to $30.	Yes, $20 per day for days 1-100 and $40 per day for days 101-1095; $10 per day for less than skilled care; $25 per day for private duty nurse at home.	No, pays actual charge up to $20 per day for days 1-100 and $40 for days 101-1095 for skilled care; $25 per day for private duty nurse at home; 70% of actual charge up to $40 per day for intermediate or custodial care.
Waiting/Elimination deductible period	20 days	None for skilled nursing home care or private duty nurse	None for skilled nursing home care or private duty nurse, 90 days for intermediate and or custodial care benefit.
Length of coverage	4 years	3 years for skilled nursing home care and private duty nurse, 2 years for intermediate or custodial care benefit.	3 years for skilled nursing home care and private duty nurse, 2 years for intermediate or custodial care benefit.
Sales screened for health status	Yes, general questions asked about institutionalization and physician care in previous 12 months and ability to perform daily activities.	Yes, specific questions asked about illnesses and institutionalizations.	Yes, specific questions asked about illnesses and institutionalizations.
Pre-existing condition period	30 days	12 months	1 year for conditions appearing in previous year.
Prior hospitalization required	Yes, confinement must begin within 90 days after hospitalization of 3 or more days.	Yes confinement must begin within 28 days after hospitalization of 3 or more days non-skilled care must also follow 20 days of covered care in a skilled nursing facility.	Yes, confinement must begin within 28 days after hospitalization of 3 or more days.
Use must be recommended and reviewed by physician	Yes, confinement must be recommended by physician and physical exam can be required at company's expense.	Yes, confinement must be recommended and reviewed by physician.	Yes, confinement must be recommended by physician and physical exam can be required at company's expense.
Covers mental and nervous disorders	Yes, if demonstrable organic disease	No	No
Guaranteed renewable	No, non-renewable statewide	Yes	Yes
Company can change premiums	Yes	Yes	Yes

Table 1. (continued)

Policy Features of Insurance Companies

Policy Features	Insurance Company		
	Merchants and Manufacturers Insurance Company	Health Insurance Corporation	United Equitable Insurance Company
Skilled care covered	Yes	Yes	Yes
Intermediate care covered	Yes	Yes, by rider.	Yes
Custodial care covered	Yes	Yes, by rider.	Yes
Home care covered	Yes, private duty nurse	No	No
Indemnity benefit	Yes, up to $40 per day for all nursing home care, up to $50 per day for private duty nurse at home.	Yes, intermediate and custodial care paid at 1/2 of rate chosen for skilled care.	Yes, choice of up to $40 for skilled care benefit, 1/2 chosen rate for intermediate or custodial benefit.
Waiting/Elimination deductible period	None	None	Choice offered - 0, 20, or 100 days; intermediate or custodial benefit must follow at least 20 days in skilled nursing care.
Length of coverage	4 years for skilled nursing home and home health benefit, 2 years for intermediate or custodial care.	1 year for care in a skilled nursing facility; care in an intermediate and custodial facility is subject to the amount of skilled care received on a 2 for 1 day basis for up to 730 days.	4 years for skilled care benefit, choice offered of 6 or 12 months coverage for intermediate or custodial care.
Sales screened for health status	Yes, specific questions asked about illnesses and institutionalizations.	No	Yes, asks for detailed information about institutional care in previous 5 months and illness and activity restrictions.
Preexisting conditions period	6 months	12 month	180 days
Prior hospitalization required	Yes, confinement or home care must begin within 14 days after hospitalization of 3 or more days.	Yes confinement must begin within 30 days after hospitalization of 3 or more days.	Yes, confinement must begin within 30 days after hospitalization of 3 or more days.
Use must be recommended and reviewed by physician	Yes, physician must certify at least once a month that beneficiary needs no greater or lesser care.	Yes, confinement must be recommended by physician and physical exam can be required at company's expense.	Yes, confinement must be recommended by physician and physical exam can be required at company's expense.
Covers mental and nervous disorders	No	No	Yes, if demonstrable organic disease.
Guaranteed renewable	Yes	No, nonrenewable statewide	Yes
Company can change premiums	Yes	Yes	Yes

Table 1. (continued)

Policy Features of Insurance Companies

Policy Features	Insurance Company		
	Blue Cross of North Dakota	Blue Cross of Southern California - UltraCare	United Auto Workers
Skilled care covered	Yes	Yes, but limited to Medicare gaps	Yes
Intermediate care covered	Yes	No	Yes
Custodial care covered	No	No	No
Home care covered	No	Yes	Yes
Indemnity benefit	Yes, choice of up to $50 per day.	No	None
Waiting/Elimination deductible period	100 days.	No	direct trade-off of nursing home days (2 for 1) and home visits (3 for 1) with hospital days.
Length of coverage	Choice offered of Nursing 2-5 years	Nursing home benefit covers days 20-100, Home health benefits as needed.	No
Sales screened for health status	Yes, specific questions asked about illnesses and institutionalizations.	No	No
Pre-existing condition period	180 days.	No	No
Prior hospitalization required	No	Yes, for nursing home, no for home health	No
Use must be recommended and reviewed by physician	Yes	Yes	No specific statement.
Covers mental and nervous disorders	Yes	Yes	Yes, but only up to 90 days.
Guaranteed renewable	No	No	As long as employed.
Company can change premiums	Yes	Yes	Not applicable, employee benefit.