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# *Council Meeting*

of

## NEW JERSEY ADVISORY COUNCIL ON ELDER CARE

*“Testimony concerning health care and caregiving for the elderly”*

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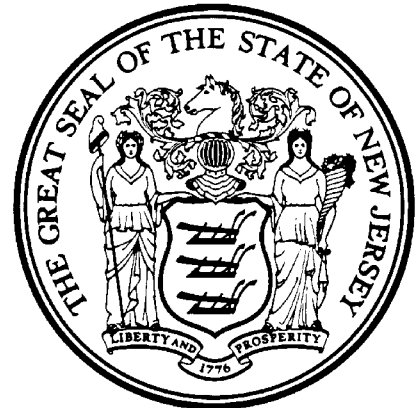
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**LOCATION:** Room 319  
State House  
Trenton, New Jersey

**DATE:** May 14, 1999  
1:00 p.m.

**MEMBERS OF COUNCIL PRESENT:**

Assemblywoman Carol J. Murphy, Chair  
Assemblyman Samuel D. Thompson  
Assemblyman Louis A. Romano  
Susan C. Reinhard  
Renee W. Michelsen  
Bernice B. Shephard



**ALSO PRESENT:**

Irene M. McCarthy  
*Office of Legislative Services*  
*Council Aide*

*Meeting Recorded and Transcribed by*  
The Office of Legislative Services, Public Information Office,  
Hearing Unit, State House Annex, PO 068, Trenton, New Jersey

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**ASSEMBLYWOMAN CAROL J. MURPHY (Chair):** Ladies and gentlemen, if you don't mind, take you seats please. We probably will be joined by more people as the session goes along. And I will ask Commissioner Susan Reinhard -- Deputy Commissioner Susan Reinhard to speak to us about who some of these people will be.

I would like the members who are here to introduce themselves, starting to my far left.

**MS. MICHELSEN:** I'm Renee Michelsen. I'm the manager of senior services for Atlantic Health System and the Chairperson of the Morris County Senior Service Providers Group.

**ASSEMBLYMAN ROMANO:** I'm Assemblyman Romano from north Hudson County.

**ASSEMBLYMAN THOMPSON:** Assemblyman Sam Thompson, Middlesex and Monmouth County.

**MS. SHEPARD:** I'm Bernice Shepard, formerly of the Board of AARP.

**DEPUTY COMMISSIONER REINHARD:** Susan Reinhard, Deputy Commissioner at the Department of Health and Senior Services.

**ASSEMBLYWOMAN MURPHY:** And I thank you all for being here. I do have two things I wanted to just mention before we begin.

We have lost two members of this Committee. They have passed away. Lennie-Marie Tolliver left us a couple of weeks ago -- a week and one-half ago. And, as I'm sure most of you have heard, Senator Wynona Lipman has passed on also. So we certainly do miss their advice. I did not know Lennie Tolliver terribly well, but I will tell you that Senator Lipman was a very

valued person in this state for a great many reasons. And her advice, her concern, her consideration, and her general knowledge of people will deeply be missed not only on this Council, but in the State House and the State of New Jersey.

I also would say today that we're hearing today on long-term care insurance. This has been a subject raised by this Council a number of times in many different arenas and ways. It has never been discussed. We have not heard presentations until today. I would ask all the members of the Council to hold any consideration of legislation until the Council has had more opportunities to discuss this among ourselves. There are some pieces of legislation in the hopper at this point in time on long-term care insurance, but I think many of the suggestions that will come from this in the end need to come from a collaboration of the State and the Legislature speaking together about the different sorts of things that we see and hear. So I would ask people to restrain their natural enthusiasm because, I think, every single one of us would like to aide the system as quickly as we can, and yet we may make it longer by rushing to help. So I do ask that kind of patience and tolerance.

The third thing, Monday night there is a hearing. Sam Thompson has been kind enough to allow us to have a hearing down in Old Bridge, and that will be on Monday night. If there are persons who would like to testify at that hearing, we are particularly looking for the age-group of the baby boomers, since we feel that that is the age-group -- they are the ones who have just turned 50 and don't even have a sense of what is ahead of them. Some of us know. But at any rate, this is the group that we want to hear from in the sense that we're wondering what they do anticipate -- how do they see

themselves as a third age-group and who do they think will be caring for them, what are their plans or thoughts or designs. We'd be very interested in hearing their speculations or peculations, whichever may come to their heads.

So with that, I will move directly to Susan Reinhard.

ASSEMBLYMAN ROMANO: Excuse me, Madam Chair, let me bring to your attention -- I don't know if you had seen her when she came. We have with us, the Director of Pensions, Margaret McMahon.

ASSEMBLYWOMAN MURPHY: Yes.

ASSEMBLYMAN ROMANO: She's just auditing. She's coming for information. I don't think she is going to share anything with us.

ASSEMBLYWOMAN MURPHY: And that is what I think Susan will talk to us about also.

Thank you, Assemblyman Romano.

DEPUTY COMMISSIONER REINHARD: Thank you, Madam Chair.

I wanted to introduce to you the members of the Long-term Care Insurance Advisory Committee who have joined us today for a joint discussion on long-term care insurance. Rich Hruby is the Chair of this advisory committee.

And maybe you could have everyone introduce themselves.

**JAMES T. HOLCOMBE:** Jim Holcombe, New Jersey Retired Educators.

ASSEMBLYWOMAN MURPHY: Now, as you are doing that-- Since we have a recorder here, Jim, we will need you just to put your name down on that piece of paper so that the recorder has it in writing with the

correct spelling and your identification just so that we make sure the record is straight.

Thank you, Susan.

Richard.

**ELLIE STONE:** I'm Ellie Stone. I represent the Jewish community in New Jersey. And I'm here to participate in this whole idea of insurance and particularly to see if there is a type of insurance that children will buy for their parents as assets protection. We see that as a very strong possibility.

ASSEMBLYWOMAN MURPHY: Thank you, Ellie.

**DEBBIE BRESLIN:** Debbie Breslin. I'm a Program Director for the State Council on Health Insurance for Medicare Enrollees.

ASSEMBLYWOMAN MURPHY: I think we need to have you into the microphone. It doesn't pick up from that far, Debbie. If you wouldn't mind identifying yourself again--

MS. BRESLIN: I'm Debbie Breslin. I'm a Program Director for the Senior Health Insurance Program known as CHIME here in the State of New Jersey. I'm with the Department of Health and Senior Services.

ASSEMBLYWOMAN MURPHY: And when you have an opportunity, put your name on that piece of paper signed properly with your identification. It will make it easier for the recorder.

**RONALD MAXSON:** I'm Ron Maxson, representing the State Treasurer.

ASSEMBLYWOMAN MURPHY: Ron Maxson.

**CAROL J. KIENZ, R.N.:** Carol Kientz, Executive Director of the Home Health Assembly.

ASSEMBLYWOMAN MURPHY: Thank you very much. Can you make sure that the recorder has your names in writing.

DEPUTY COMMISSIONER REINHARD: I think we have everybody. There may be others joining us. We've invited them.

ASSEMBLYWOMAN MURPHY: Okay.

With that being said, I think we're going to begin at the beginning. This is such an exciting agenda. If I have omitted something, wave.

Our first presenter today is an attorney. I have not written down Edwin's last name.

So I'm going to self-introduce, if you don't mind, Edwin.

He's come to speak to us about the things that occur in terms of assets and families and people who are moving on.

Edwin, would you like to speak and identify yourself. I know that the clerk has your card.

**EDWIN LEAVITT - GRUBERGER, ESQ.:** Thank you, Assemblywoman Murphy.

My name is Edwin Leavitt-Gruberger. I work at Jamieson Moore Peskin and Spicer, a law firm in Princeton, New Jersey. I practice estate planning for a living. And I came here, this afternoon, to address the members of this Council just to give you an idea of what the process is like, if you will, when a client comes into my office to talk to me about trying to pass their assets down upon their death to the next generation and the different kinds of clients one would meet and the different types of advice I might give to those clients. This is not to be a lesson in estate planning, but rather to talk about

some of the problems that I encounter that my clients are encountering in the process of estate planning.

I'll say that there are, perhaps, for the purposes of this Council, two types of clients that I would be speaking to. There are those individuals that have rather large estates. And what does that mean? As far as the Federal government is concerned, an individual with an estate of \$650,000 or less does not have to concern him or herself with a Federal estate tax. There will be no Federal estate tax if your estate is worth less than \$650,000 because that's the threshold that the Federal government applies to what they consider to be someone who has taxable wealth versus someone of moderate means, which means, in theory at least, that a family of husband and wife should be able to pass \$1.3 million down to the next generation, to their children, without having to pay any Federal estate tax.

There are those individuals who have well in excess of this amount who I have to do tax planning for in an attempt to at least reduce the Federal estate tax, which can go as high as 55 percent. It's a very meaningful, a very serious tax in our Federal tax structure. In New Jersey, I might add, the inheritance tax is not imposed on transfers to spouses or children, so I'm happy to say that typically, New Jersey is not much of a consideration for tax planning.

And I'll sit and talk with an individual, and I'll ask them what their assets are, and I'll ask them about their family. And, after totaling assets up, if I see that the estate is worth less than \$650,000, my initial response might be, "Well, we don't have any real problems here in terms of estate taxes." And then frequently, with an individual like that, sitting across the table from me,

I will get the following response. “That’s not what I’m concerned about.” I say, “Excuse me, you’re not concerned about estate taxes?” And the individual will say, “No.” And I say, “Well, what are you concerned about? Providing for one or more children in a particular way?”

The individual will say, “No, that’s not it either. I’m concerned about losing everything I have to a nursing home.” And I say, “Well, what do you mean?” She said-- And the individual will say to me -- he or she, it really doesn’t matter -- “I’m afraid that when I get older” -- if I’m talking to someone in their early 70s, they’re really projecting out five, six, seven years. “I’m concerned that if I get older and I have to go into a nursing home, I’ll lose everything that I worked for. Is there anything that can be done for me?”

And I’ll talk to them, and I’ll say, “There are laws that apply where the government, State and Federal, will assist somebody by paying for the cost of a nursing home. But in order to qualify for those Programs, you have to be eligible for Medicaid, which is the health-care arm of the welfare system. To be eligible for Medicaid, you basically have to bankrupt yourself.” And if the person on the other side of the table from me is a person of, let’s say, modest means -- they’ve worked their whole lives, they own a house, they have a couple of hundred thousand dollars worth of assets -- they’ll say to me, “Well, what do I have to do to bankrupt myself?” I say, “Well, that’s easier said than done.”

First of all, it’s against the law for me to counsel this individual to do something that they’re legally permitted to do, which is to give away their assets to whomever they choose to give it to, typically family members. But there is a peculiar Federal statute out there that says that it is against the law

to advise someone on how and when and why to give away their assets to qualify for Medicaid. Now, currently, that law is permanently enjoined and was recently enjoined by a court -- a Federal court in the western United States. Nevertheless, it is the law, but the rules, as they apply, work something like this. To qualify for Medicaid, which is the only government program that will pay for the cost of, let us say, custodial care -- a nursing home, you have to reduce your assets down to absolute poverty level. Medicaid was designed to assist individuals who are impoverished. Poverty level means about \$2000 of assets.

Now, to say this to someone who has worked their whole life to achieve some level of dignity is a difficult thing for me to tell them. Yet, to say that if they went into a nursing home, within a span of three or four years they might lose everything that they've worked their lives to save for, including their home -- that's also a scary thing to have to tell someone. So the advice, when I'm permitted to give it, goes something like this. To qualify for Medicaid, you have to-- (interrupted by cellular phone ringing)

I thought that was a bird for a minute. There is peculiar ringing to these cellular phones.

ASSEMBLYWOMAN MURPHY: I did, too. And when he started to run, I thought he was the only one who saw it. (laughter)

MR. LEAVITT-GRUBERGER: To qualify for Medicaid, you have to give your assets away and bankrupt yourself. And not only that, there is a three-year waiting period in which Medicaid-- So it is a 37-month waiting period because, if you were to go into a Medicaid office to apply for assistance, one of the questions that is asked is, "Have you given anything away to anyone

within the last three years?" And if you want to answer that question truthfully, as you must, and if you want to be able to say no so that you can qualify, you have to wait, essentially, 37 months.

So I would tell the client, "You have to accept the fact that you must give away your assets, presumably to your children. And then first wait three years, never knowing, in fact, if you'll ever have to go into a nursing home."

So it's my feeling -- my very strong feeling that this begins to disrupt the family threads -- the family relationships that people have built up over the years because it is almost without exception that an older client will say to me that they'll loath to come to their children and ask for money, even if it's money that they've been forced, in a way, to give to their children to preserve what it was that they saved over 30 or 40 years. Yet they're forced to do this because a nursing home stay -- an average stay is about three years -- will virtually wipe them out financially. So I say to them, "If you want to start the clock ticking, you must make this complete transfer of all of your assets, presumably to your children. And then, if you ever have to go to a nursing home and you have to apply for Medicaid to pay for that, you'll, at least, be able to answer the question truthfully that you have not made any transfers within three years."

If this person had come into my office with the same asset sheet -- same balance sheet and asked me for advice on how to plan their estate, I would never counsel them to give their estate away to their children because this is what they're living on. People typically live within their means. And if that means that they have \$300,000 versus \$30 million, these people are all

living within their means, whatever that happens to be for the individual. And I always tell the clients that -- the last piece of advice I would ever give to them is to give a dollar away to anybody if they're not sure that they won't need that dollar tomorrow for an umbrella. Yet, the system forces them to essentially engage in self-bankruptcy if they want to somehow avoid losing everything to a nursing home stay because nursing homes in New Jersey are extremely expensive, in excess of \$70,000 a year. It doesn't take long to go through a modest-sized estate if you're in the nursing home for three or four years.

And this is what I mean about disrupting family relationships, to have to go back to children where, if they give the money to the children, it may be subject to the financial difficulties that the child is experiencing, divorce or other financial problems. The money may not be there when the parents want it to be there. If they want to get into a nursing home of their choice rather than Medicaid's choice, this money may or may not be available to assist them in getting into a decent home. It's not advice that I want to give somebody, but it's advice that frequently advisors, be they attorney or other individuals, are forced to give clients in an effort to try to save the few dollars that they've been able to accumulate over the years.

And that's basically what I wanted to tell you this afternoon. If you have questions, I'm happy to answer them.

ASSEMBLYWOMAN MURPHY: I do.

MR. LEAVITT-GRUBERGER: Thank you.

ASSEMBLYWOMAN MURPHY: What is the difference, and I don't mean the word difference-- I don't know how to phrase the question. If I spend all my money to be in the nursing home and it's gone, or I give it all

to my children, it's all gone, why is there not a feeling that the most important thing I can do with my resources is care for myself so that my children won't have to?

MR. LEAVITT-GRUBERGER: Well, some people do feel that way. Some people feel that they want to be able to pass some of what they've accumulated over their working career down to their children as an inheritance. And even if they didn't give it to their children, they're so concerned about -- throughout the course of their retirement that they're going to run out of money and not be able to care for themselves with the funds that they have.

ASSEMBLYWOMAN MURPHY: But I guess what I'm saying is that if I'm 75 years old and I'm worried about going into a nursing home at 85 years old, why not just live as I can now and then, at 85 years old, take what I have, invest it in the rest of my life, which is the nursing home, and when it's gone, I'm still on the government the same as I would be if I waited until I was -- if I gave my money to my kids now and had to ask them for something everyday until I got to be 85 years old or until I was put into the nursing home? Am I making any sense?

MR. LEAVITT-GRUBERGER: You are, and a lot of people feel that way, but there are other people who feel that there are sufficient funds within this economy -- within the government that they should not have to exhaust their own resources to live the life of dignity, so to speak, in a nursing home. Am I making myself clear?

ASSEMBLYWOMAN MURPHY: Yes, you are. It's a question that I sometimes really don't understand because I hear it as--

MR. LEAVITT-GRUBERGER: Priorities and values.

ASSEMBLYWOMAN MURPHY: As we talk about elder care a lot, I hear people saying, "But I want to give my house to my children." My answer is, "Sell the house and give the best gift you can give to your children which is that you're going to be self-sufficient." I guess you're right. It is a values question. If there aren't other questions, what is your solution?

ASSEMBLYMAN THOMPSON: Of course, the thing is that the Program was designed for the people who couldn't afford to pay for it. And so what it comes down to is that some people can afford to pay for it but prefer not to because other people are getting without paying for it.

MR. LEAVITT-GRUBERGER: I think--

ASSEMBLYMAN THOMPSON: The Program is not designed to cover everybody.

MR. LEAVITT-GRUBERGER: I think the system distorts values. And that's part of the problem. And you'd like to be able to tell these clients to purchase long-term care insurance, but what tends to happen-- I'm 49 years old, so I guess I'm in that group of baby boomers, or will be in another year or so, that you were referring to. Have I started to seriously think about the purchase of long-term care insurance? Yes, only because I'm confronted with it so often in my practice. Have any of my friends in other professions started to think about it? Absolutely not.

There are two kinds of people that I run across, those who have had the foresight to purchase long-term care insurance, be it because an insurance agent has approached them or however it's come about at a time when they can afford it, which is usually before-- It's like any other type of insurance. It's before you have the need, that's when you can afford it.

Or those clients in their 70s who hear about it and see that perhaps living in retirement communities or see friends, speak to friends who or know people who have gone into nursing homes and now are becoming interested in long-term care insurance and who cannot afford it because the premiums have gone too high over the years that they've ignored the problem. And that's the quandary that people -- that those clients-- I guess I should have mentioned this-- Those clients that come into me and say, "I don't want to lose everything to a nursing home," are clients without the long-term care insurance who cannot afford it at their age and because it's only available on an individualized basis these days. And the premium structure being what it is makes it pricey, if you will, at the advanced age when you recognize the need.

Unfortunately, a lot of the individuals who are going into nursing homes or anticipate that they may go into nursing homes, long-term care insurance wasn't available when they were in their 50s. And that's part of the problem. It's becoming increasingly available now, and the premium structure is becoming better suited and, perhaps, more advantageous to the consumer, but for our parents, 20 years ago, this was a policy that was unheard of.

ASSEMBLYWOMAN MURPHY: You're absolutely right.

Lou.

ASSEMBLYMAN ROMANO: Susan is first, and then I'll go.

ASSEMBLYWOMAN MURPHY: Oh, Susan, I'm sorry.

DEPUTY COMMISSIONER REINHARD: That's okay.

One question. When you are talking with family members about this and you're giving just general information, perhaps some advice, do you

ever tell them that if they do this, if they intentionally bankrupt themselves, that the only option that they're guaranteed under Medicaid is a nursing home placement -- that there is no guarantee of home health or assisted living or anything else? Are they aware of that?

MR. LEAVITT-GRUBERGER: I do tell them that.

DEPUTY COMMISSIONER REINHARD: Okay.

They feel they've run out of options, if you will, and they feel that they have -- just by dint of the fact that we're living longer. They feel that they have no choice to try to do this with the hopes that they won't have to go into a nursing home -- that they'll be able to die in their own home, which is what most people would much prefer to do because they realize there is only one trip to the nursing home, and that's on the way in.

DEPUTY COMMISSIONER REINHARD: Thank you.

ASSEMBLYWOMAN MURPHY: Other questions?

ASSEMBLYMAN ROMANO: Yes, Madam Chair.

I'm familiar with what we're talking about here because too often I have questions asked from the family who's looking to say, "My grandmother or my mother wants to leave me something. She's going for Medicaid, and we're looking to take the money before she goes." Now, in some way-- I have to tell you this. I think that the law about the three years is a good intention because there have been too many games played along this entire area about giving away the money. The whole answer to this, in my mind, is going to become a major -- how should I say? -- national policy in terms of the way we have social security. Are we going to have elder care security? Is the government going to find a way where there will be some sort of sliding scale

that one would pay? As you noted, someone with \$600,000, if they live 10 years, may not make it in that same nursing home. And if I could also say, where some of these insurance companies, if not the nursing homes proper -- those who are large enough and have more than one nursing home -- to come up with plans that if a person pays, let's say, for five years, the amount for that same apartment or whatever the case you have there is decreased. There can be all sorts of deals made. I'm not talking about something that's illegal.

MR. LEAVITT-GRUBERGER: No, I understand.

ASSEMBLYMAN ROMANO: I'm talking about something where you can have some sort of prorated payment. I know of a situation where you buy the condo, and the condo runs about \$175,000 or \$200,000. I still haven't found out what happens when you die because the condo goes back to the group. I haven't seen the fine print of what happens here. I happen to know some of the people who went in there were people of money, and that's where they ended up.

So we can look at this issue, and, eureka, we finally realized that such a thing called nursing home insurance, but this is much larger than that in itself because it's a major policy decision as to, is the State or the Federal government going to take it upon themselves to say, "Look, we're making people live a long time. Now, it's our responsibility to help them continue"? And then there is the other side of the argument. People who have to exhaust their funds-- Good fashion says, "I've worked all my life. I've never collected unemployment. I've never collected this, or I've never collected that. Why must I be wiped out; whereas, the other segment of the population always

remains under the cusp and gets everything?” See, this is my argument about the PAAD Program.

MR. LEAVITT-GRUBERGER: Those people don't come to me for advice.

ASSEMBLYMAN ROMANO: Pardon me?

MR. LEAVITT-GRUBERGER: Individuals without assets are not coming through my door for advice. I agree with you, though.

ASSEMBLYMAN ROMANO: But I'm saying that the--

MR. LEAVITT-GRUBERGER: The State has been taking care of a certain segment of the -- portion of the population.

ASSEMBLYMAN ROMANO: Yes, but I'm talking about the feeling that a certain portion of the population who has been, let's say, the old blue-collar worker--

ASSEMBLYWOMAN MURPHY: Getting ripped off.

ASSEMBLYMAN ROMANO: --who has paid their way through and then says, "How come that woman over there -- it doesn't cost her a quarter? She goes into a nursing home; whereas, we have to be wiped out to do this. We paid our own way." I'm not going to get into the discussion on that view about who is getting it free and who is having to pay for it.

See what I'm saying? There has to be major policy decisions on this aside from the entrepreneur who is the -- who is either the insurance company or the nursing home to come up with some sort of plan. For example, you pay \$250,000, and you're not obligated to pay X dollars for the next few years. We had it. We had it in a bill about the prepaid funeral costs.

Now, the prepaid funeral costs, one argues and says, “Well, if that person has money left over after they were receiving SSI or Medicaid, well, the excess of the prepaid funeral trust goes back to the State.” It’s nice to think that way and say they’re right, but every person is allowed to have \$2000 as you noted. But my argument was that if there’s \$4000 left over, the \$2000 should go to the family, like anybody else would have, and the State only collects the other two, not the entire four. That issue came up. I don’t know if anybody here is an undertaker, but that issue came up when there was talk about putting a cap on what you could put into a prepaid funeral trust. And, in effect, what you’re doing is price fixing a funeral--

MR. LEAVITT-GRUBERGER: Right.

ASSEMBLYMAN ROMANO: --because you could only put \$7500 into it. That means that most people will say, “All I can afford is \$7500.”

MR. LEAVITT-GRUBERGER: Yet there are-- Part of elder care advice, if you will, in terms of protecting one’s assets, is to go out and buy a prepaid insurance -- prepaid funeral insurance policy because that’s not subject to the claims of Medicaid. So attorneys are giving that advice.

Unfortunately, we have insurance for so many things, and so frequently insurances offer it on a group basis to spread the risk, which is what insurance is about, risk shifting, be it life, auto, home, whatever. It’s risk shifting. We offer insurance in so many ways on a group basis, which helps to keep the premiums down and to make them more affordable like the health insurance, but there is no type of-- Well, it’s only now beginning to come

about where we have group long-term care insurance. Some large companies are beginning to offer it.

The demographics of this country and this state are going to force us in that direction eventually, I believe, because we have an aging population.

ASSEMBLYMAN ROMANO: Excuse me, what do you mean by group?

ASSEMBLYWOMAN MURPHY: A company buying a group policy because the company offers it.

MR. LEAVITT-GRUBERGER: A company can offer it as a group benefit.

ASSEMBLYMAN ROMANO: Oh, the employer.

MR. LEAVITT-GRUBERGER: The employer.

ASSEMBLYMAN ROMANO: Okay.

MR. LEAVITT-GRUBERGER: Whether it's a State employer or a private employer, the logistics of offering it on a group basis makes it more affordable.

ASSEMBLYWOMAN MURPHY: And do you have other suggestions or ideas about how we could relieve some of this? Would it be to raise the threshold of the \$2000?

MR. LEAVITT-GRUBERGER: That's going to be difficult to do because Medicaid is jointly administered by the Federal government and the State government.

ASSEMBLYWOMAN MURPHY: Correct.

MR. LEAVITT-GRUBERGER: So I don't know how you are going to go about doing that unilaterally.

ASSEMBLYWOMAN MURPHY: Well, no. We couldn't do it unilaterally. But do you see that as a cure, or does that just escalate everything and the problem stays the same?

MR. LEAVITT-GRUBERGER: I think it-- I think the problem will remain the same. I think, hopefully, the greater availability of long-term care insurance, which I think is really burgeoning in popularity over the last five or six years -- and as more and more reputable insurance companies have entered the market and made the policies more consumer friendly, this has been beneficial. But we have to enlighten the public. We have to enlighten my generation that the time to start to think about this is not when you're 70 years old, but rather when you're in your 50s.

ASSEMBLYWOMAN MURPHY: I do hope you will spend a lot of time talking about this at any kind of occasion when you are with people of this age because I'm beginning to feel like we're the only ones in the world who do. Is that why we're being invited to fewer occasions? I don't know. I walk into the party and someone says, "Will you have a drink?" And I say, "Yes, let me talk to you about your dying." Anyway, it's not quite that bad.

ASSEMBLYMAN ROMANO: One further comment if you'll allow me.

I assume you know IRS -- you know the tax laws.

MR. LEAVITT-GRUBERGER: Yes, sir, I practice in that area.

ASSEMBLYMAN ROMANO: Now, when we talk about nursing home insurance and the employer picking it up-- It happens to be one of those facts of life. Whatever fringe packages people are getting tax -- how should I say? -- after taxes -- because you're getting that and you're not charged for it

as far as your income tax. It's not-- You don't get a 1099 in the amount of \$10,000 which is your health plan. This is something that is just shoved to the side.

If an employer then, with their own bargaining unit or whatever the case is, makes the point that they would pick up the group insurance, and of course, there would have to be a consideration back in salary or whatever the case is.

MR. LEAVITT-GRUBERGER: It's all part of a compensation package. That is correct.

ASSEMBLYMAN ROMANO: Okay, so that might be a way, Director McMahon, when you want to make a deal of that nature because that's the way it is. You know, some companies give fringe benefits with legal fees--

MR. LEAVITT-GRUBERGER: Yes.

ASSEMBLYMAN ROMANO: --dental, optical. What else is there? There is a new one today. There is another one coming out, and this might be it here. With all your health benefits, they get fringe packages to the tune of \$15,000.

MR. LEAVITT-GRUBERGER: It's called a cafeteria plan. And I think, inevitably, this will be one of the choices offered, not that the premium is deductible, but when done on a group basis, the premium can be moderated and made more affordable.

ASSEMBLYMAN ROMANO: The other point I'm making is that the person is never really paying the premium out of -- after tax dollars, but the premium is being paid before tax dollars.

MR. LEAVITT-GRUBERGER: To the extent that the company may be subsidizing some of that premium, the answer would be yes.

ASSEMBLYMAN ROMANO: Then the whole cost of the premium is included into the fringe package.

MS. MICHELSEN: No, no, no. The employee pays. For long-term care insurance, I don't think there is any company--

MR. LEAVITT-GRUBERGER: It's not deductible.

MS. MICHELSEN: Even the Fortune 500 companies offer the plan at a lower price than if you went to purchase it as an individual, but they don't cover the cost. The employee-- It's deducted from the employee's salary or paid for in another way.

MR. LEAVITT-GRUBERGER: But it is subject to income tax. Let's say my salary is \$100 a week, and I choose to have \$5 allocated to some of these benefits. I'm still going to pay tax on that \$100 a week. The attractiveness of having my employer offer this program is that I'm able to opt into certain insurance programs on a group basis, and the premiums will be lower on a group basis than they would be if I went to the local insurance company and tried to buy the policy.

ASSEMBLYMAN ROMANO: I understand that.

MR. LEAVITT-GRUBERGER: Okay.

ASSEMBLYMAN ROMANO: My only comment here is, if somehow the employees could negotiate on what that that is a package to be provided for by the employer, that money is not taxable. That comes directly in a fringe benefit.

ASSEMBLYMAN THOMPSON: Before it gets deducted for--

ASSEMBLYWOMAN MURPHY: If it's not voluntary, you're saying. If it's compulsory the employer has to give this--

ASSEMBLYMAN ROMANO: He has it in a negotiation -- a fringe benefit.

MR. LEAVITT-GRUBERGER: Well, I think what you're saying, Assemblyman, is that if through the employer we're able to get some sort of reduced rate, that's, in a sense, a fringe benefit, that's not taxable to us.

ASSEMBLYWOMAN MURPHY: Yes, even at that level.

ASSEMBLYMAN ROMANO: And if you got it at no cost--

ASSEMBLYWOMAN MURPHY: It's even cheaper.

ASSEMBLYMAN ROMANO: If the employer picks up the entire tab--

MS. MICHELSEN: Sounds unlikely to happen, and they're not even getting medical insurance for no cost.

MR. LEAVITT-GRUBERGER: There's no such thing-- They say there's no such thing as a free lunch. I think that's correct.

ASSEMBLYMAN ROMANO: Look, while we're sitting here, there are people trying to think of how they can come up with something new. So who knows tomorrow what the story will be.

By the way, your comment to give away the money to the children before they pass away-- I think before they do that, they better read *King Lear*.  
(laughter)

ASSEMBLYWOMAN MURPHY: There speaks the professor.  
Thank you very much, Lou.

And thank you, Edwin, very much for taking time for coming here today.

MR. LEAVITT-GRUBERGER: Thank you, Assemblywoman.

ASSEMBLYWOMAN MURPHY: I know you have to go back to court. So I appreciate the fact that you would take time out of what is--

MR. LEAVITT-GRUBERGER: It's been my pleasure. I appreciate the opportunity.

Thank you, all.

ASSEMBLYWOMAN MURPHY: Thank you.

The next person who will speak to us regarding where we are, presently, in the state is Rich Hruby, who chairs the long-term commission -- Long-term Care commission (*sic*) that is working on this issue.

It's very nice to have you here today, and thank you so much for coming.

**RICHARD HRUBY:** Madam Chair, distinguished members of the Council, since Edwin credentialed himself, I will just say that I am 51 years old. I'm on the vanguard of the baby boom generation. My crossing the bridge will not collapse it. It will be the boards behind me.

The Department of Health and Senior Services established the Long-term Care Insurance Committee to study how the State can best promote and encourage the purchase of long-term care insurance, both as a way of maximizing seniors' choice of care and as a means of controlling Medicaid long-term care expenditures.

The Committee, consisting of Department of Health and Senior Services staff, Treasury, and Office of Management and Budget

representatives, representatives of the Department of Banking and Insurance, the Department of Human Services, nursing facility and home health care associations, as well as consumer representatives and other interested parties began meeting in July, 1998.

In addition to reviewing volumes of written material relating to long-term care insurance, its marketing, and its affordability, we had a presentation on the New Jersey statute and regulations as well as the oversight role of the Department of Banking and Insurance. An elder law attorney explained the difficulty in getting people to plan eventual long-term care expenditures at an age when insurance premiums are most affordable. An insurance broker, dealing solely in long-term care insurance products, described, from her perspective, the obstacles to the sale of these policies. We were very fortunate to have the directors of both the Connecticut and the New York Long-term Care Insurance Partnership Programs explain the successes and frustrations of the public-private initiative linking the purchase of long-term care insurance with Medicaid eligibility. The Committee also heard a presentation from an actuary who is in the room today and can serve as a reference, Mark Barterelli (phonetic spelling) of Apex Management Group, who described long-term care plan design, features, and cost-driving factors related to those plans.

New Jersey, with all states, is confronted with incessant increases in the Medicaid costs associated with long-term care. It is clear that this constant growth is not sustainable within a reasonable context of public expenditure. The aging of the 76 million baby boomers may cause the publicly financed long-term care system to collapse. By 2030, individuals age 85 and

older will increase from 3.9 million to 8.5 million. By the year 2050, the number of individuals 85 and older will be about 18 million. According to the General Accounting Office, we face two to four times the current number of disabled elderly.

In a recent survey of current retirees, 45 percent report that they are not confident that they will have enough money to cover long-term care, if needed. That presupposes that current retirees have a reasonable idea of the cost of long-term care. Among persons who were identified as savers, in that survey, only 17 percent described themselves as confident in having enough money for long-term care.

In 1995, the national median net worth of families age 65 to 74 years old was \$104,000 and for families over the age of 75, \$95,000. But for both age-groups, that value includes a median value of a home worth of \$80,000. This illustrates that many current seniors are ill-prepared financially, even with liquidation of the home property, for the costs associated with long-term care.

It is clear that the current public funding mechanism of Medicaid will strain and perhaps collapse under the weight of so many persons in need of long-term care services. Because of lower birth rates, the generation behind the baby boomers is significantly less populated. There will be fewer taxpayers to support the increased demand for long-term care services.

Other significant future impacts are that the decrease in the size of the workforce can predictably create a shortage of formal caregivers increasing the costs for services. Smaller family sizes will result in fewer informal caregivers for an increased population in need of services. A

surprising 35 percent of all current workers report that they have saved no money for retirement. A considerable portion of current wealth is home property. With the reduced size of the generation following the baby boomers, we can anticipate a reduced demand for housing and a consequent deflation in home value reducing future net worth. Further, personal savings in the United States is at or near the lowest level since the end of World War II.

All of this suggests that the current generation of retirees is financially ill-prepared for the possibility of requiring long-term care services, and it appears likely that the next generation will be equally or less prepared. While it may not be the total solution, there is a significant role for long-term care insurance in the funding of future care expenses.

The Committee has not yet met to deliberate recommendations to the Commissioner of Health and Senior Services. However, judging by the focus of discussion in the meetings, the following are likely to be considered among, no doubt, others.

1. A New Jersey-specific consumers guide. Insurers in New Jersey are required to provide potential purchaser of long-term care insurance a “Shoppers Guide to Long-term Care Insurance,” which is published by the National Association of Insurance Commissioners. Many other states have published their own shopper’s guides specifically tailored to the types of policies offered in the state and illustrating the local costs of long-term care. The Department of Health and Senior Services, in conjunction with the Department of Banking and Insurance, could produce its own shoppers guide, addressing the likelihood of long-term care needs, specifying long-term care options and their costs, and advising readers of policy terminology and what

to look for in a long-term care insurance policy. This would be a way of the State demonstrating its endorsement of long-term care insurance. Given wide distribution, this could generate public interest in long-term care insurance as well as providing guidance for the purchase of that coverage.

2. Model regulations and legislation. And since the Chair asked that I address specifically the current status in general of New Jersey's regulations and statute, I did a quick bit of research and found that there is no specific State legislation addressing long-term care insurance. The authority that the Department of Banking and Insurance uses to regulate long-term care insurance in New Jersey is derived from supplemental health-care provisions of the State statute.

The National Association of-- The Health Insurance Association of America has produced both model legislation and model regulations to serve as a guide for states in implementing regulations in a very complicated field. New Jersey's regulations have not been updated in many years. In a state-by-state comparison of compliance with key model standards, New Jersey ranks 46th in the nation, meeting only 11 of the 28 provisions. Because of competitive pressures within the insurance industry, policies offered New Jersey residents adhere reasonably well to the model standards. Nonetheless, the State could demonstrate its commitment to long-term care insurance and the public by updating its statutes and regulations to conform with the current national standards. I would add, though, that there is probably some risk to strictly adhering -- or at least there is an argument against strictly adhering to the model because this is still a very young industry, and it's a dynamic and

fluid situation. And once you've locked into a set of statutes and regulations, it sometimes is very difficult to respond quickly to changes in the industry.

3. A Partnership for long-term care insurance. With Robert Wood Johnson Foundation funding, four states, New York, Connecticut, Indiana, and California, created long-term care insurance policies linked to Medicaid eligibility for long-term care. Two models exist. One, New York, requires an individual to purchase three years of long-term care coverage. If at the end of the three-year coverage period the individual is income eligible for Medicaid, all of the individual's resources are exempt from consideration in the determination of Medicaid eligibility. This enables the individual to protect his or her resources against the possibility of an extended period of need for nursing facility care. The state stands to benefit because the policies reduce the incentive to transfer or otherwise hide assets to qualify for Medicaid.

Under the other model used in the other three states, the individual purchases a policy for a period of one or more years. Should the individual ever need to access Medicaid for payment of long-term care services, he or she would receive a dollar protection of resources for each dollar of insurance expenditure for long-term care paid by the policy.

Since-- One of the difficulties and one of the frustrations that both of the directors of the Partnerships in Connecticut and New York expressed is the lack of reciprocity, since these policy are only good -- the policies are only available in four states, and they only affect the Medicaid eligibility in that state. And that makes it a difficult sale for younger people

where the premiums would be cheaper because they have to understand that they plan to stay in the state of New York for the rest of their lives.

Also, since the implementation of these model Programs, a revision to the Social Security Act essentially precludes any state from creating new partnerships. Should it be decided that this is something worthy of pursuing, we would need to work with Congress to obtain an amendment to the Federal law so that the Program would be feasible. There are some indications that Congress might react favorably, particularly since there are other states that are interested in implementing Partnership Programs.

4. State employee long-term care insurance plan. A number of states, as well as many other employers, are offering private group long-term care insurance policies to their employees and families, with premium payments made through payroll deductions. This would allow State employees and their relatives easy access to long-term care insurance at insignificant cost to the State. The State could provide a good example for other employers, and the offering would generate publicity that would help stimulate public awareness of the need for long-term care insurance.

Another idea would be something similar to what California has established through its public employee retirement system. I will not address that at this point because we're going to have testimony to that effect later.

5. Report card of long-term care coverage. Long-term care policies are very complex and deal with terminology such as activities of daily living with which the public has very little familiarity. Subtle language variations in policies can be significant when the individual is in need of care in order to assist the public in evaluating long-term care insurance policies and develop a

report card of policies offered in the state. This could enhance policy offering in the State as well as promote quality competition among insurers.

6. Tax credits. Tax credits are believed to provide some financial incentive for the purchase of long-term care insurance. And also it demonstrates a commitment by the State of the value of long-term care insurance as a matter of public policy. These credits can be either for the individual purchasing or it could be through an employer -- credit for the amount that the employer contributes to the cost of those plans.

I thank you and would be happy to answer any questions.

ASSEMBLYWOMAN MURPHY: Thank you very much, Rich. Questions?

ASSEMBLYMAN THOMPSON: Do you have some ballpark figures as to what such policies might cost for somebody in their 20s, 30s, 40s?

MR. HRUBY: I should have prepared for that.

ASSEMBLYMAN THOMPSON: We're probably talking about a total dollar value--

ASSEMBLYWOMAN MURPHY: I think our next speaker may have more of that information for us.

ASSEMBLYMAN ROMANO: Could you kindly explain that -- when you said there were two models -- the first model?

MR. HRUBY: The New York model.

ASSEMBLYMAN ROMANO: Yes.

MR. HRUBY: An individual is required to purchase three years of long-term care insurance coverage. By doing so, they are exempt from consideration in the Medicaid eligibility process should they need care after

that three-year period. All of their assets-- If they had \$200,000 to protect-- If they insured themselves for three years, all of that asset would be protected. Oftentimes, people, particularly entering a nursing facility, don't live three years, so I think part of the design of that model is that there is a reasonable expectation that most people will not access the Medicaid Program.

The other model, which is employed by the other three states including Connecticut, you get dollar-for-dollar protection of Medicaid assets or assets from Medicaid consideration for each dollar of insurance policy expenditure. Connecticut requires a minimum purchase of one year of long-term care insurance coverage. When you're young, this might be a very difficult decision because it's hard to project what your asset level might be. So if you purchased one year of coverage -- \$50,000 worth of coverage at the age of 50, and at the age of 70, when you needed to access that care, you found yourself with \$250,000, after the expiration of that policy, Medicaid would count as a resource \$200,000.

I guess, at least personally in viewing the models, that's what makes the New York model seem somewhat more attractive because it doesn't require people to be nearly as predictive.

ASSEMBLYMAN ROMANO: You're saying, though, that in New York, if they use their own money, not even an insurance policy -- if they pay for three years--

MR. HRUBY: No.

ASSEMBLYMAN ROMANO: It has to be an insurance policy?

MR. HRUBY: It has to be a Partnership Plan sanctioned by the state.

ASSEMBLYMAN ROMANO: Partnership Plan, what does that mean, insurance?

MR. HRUBY: It's a particular type of insurance. It's a certified insurance policy certified by the Partnership Plan itself. They require certain minimum coverages and alternative coverages for other avenues of care besides nursing home care.

ASSEMBLYMAN ROMANO: Let me go back just for a moment. What I'm saying is that-- Let's say the person had the cash up front and put up the money for three years of whatever you're talking about. If they still had \$500,000 when they were done, they would not have to pour down, they could keep the whole amount and then get Medicaid?

MR. HRUBY: No, only if they've purchased a partnership long-term care insurance plan. A person who self-pays -- at the end of self-paying for three years and they still have \$200,000 left, Medicaid would count that \$200,000.

ASSEMBLYMAN THOMPSON: But you are saying, if they purchase a three-year policy, and they still have assets left after that, they can keep their assets?

MR. HRUBY: That's right.

ASSEMBLYMAN THOMPSON: And since this is contrary to the basic Federal rate, etc., New York has a waiver with the Feds on this?

MR. HRUBY: That's right.

ASSEMBLYMAN ROMANO: Interesting, isn't it?

ASSEMBLYWOMAN MURPHY: It is. It is that one specific policy--

ASSEMBLYMAN THOMPSON: Sounds like this is what the last gentleman should be advising his clients about.

ASSEMBLYWOMAN MURPHY: New York state has a private-public partnership, apparently, with an insurance company or a group.

MR. HRUBY: There's a number of approved policies -- different companies.

ASSEMBLYWOMAN MURPHY: All right, a number of approved. But the state has agreed to these policies as part of the coverage.

MR. HRUBY: That's right.

ASSEMBLYMAN ROMANO: That's a good--

MR. HRUBY: But again the limitation is-- If the individual gets tired of the winters in Watertown, New York--

ASSEMBLYWOMAN MURPHY: Goes to Florida.

MR. HRUBY: --and decides to move to Tampa, Florida, Medicaid will not recognize the provisions of that policy.

ASSEMBLYWOMAN MURPHY: Yes.

MR. HRUBY: They will grant-- I mean, you can use the policy in Florida to pay for long-term care, but you don't get any special Medicaid consideration.

ASSEMBLYWOMAN MURPHY: Susan.

DEPUTY COMMISSIONER REINHARD: Madam Chair, first of all, I want to thank Rich Hruby for giving you a very thorough, yet succinct, summary of almost 10 months' worth of discussions by the members of this group.

You really did an excellent job.

And also, to point out that his summary of the items, that we are probably going to debate, was just reflective from the discussions that we've had. And I cannot say that the members of this Advisory Committee have endorsed them in any way, and I'm sure there were some that would not endorse every one of those. And also, we have not conducted any fiscal notes on any of this. So what it would take to develop a report card, how difficult that might be, the cost of consultants, or any of that-- But I did think it was worthwhile for you to hear the kinds of things that people have been deliberating on, and I'm sure we're going to have another two months, at least, worth of discussion on it.

ASSEMBLYWOMAN MURPHY: I am sure you are, too. I think the members here would encourage you to do exactly that, to keep looking at these issues and keep involving yourself.

And you did, Richard -- you did a wonderful job--

MR. HRUBY: Thank you.

ASSEMBLYWOMAN MURPHY: --of presenting that to us all. We may well ask you for those notes at a future time.

Our third speaker this afternoon has come to us from California with firsthand and concrete experience in long-term care insurance. His name is Craig Hartung. He is retired from the life which he will discuss the most with us and has moved into another life.

And, Craig, I'm going to let you clear up that mystery yourself.

**CRAIG W. HARTUNG:** Thank you, Assemblywoman.

I worked for CalPERS from 1973 through about 19 -- last year when I retired. I had a variety of hats there from Chief of Administration to

research. And the last few years I worked on the long-term care program. It came under the auspices of my division.

Right now, I've retired and opened up an insurance agency in California. I sell only property and casualty insurance for certain obvious reasons. I'm not involved in long-term care. I have dedicated about 10 percent of my time to assist other states on long-term care issues related to insurance. I've been involved in it for over 10 years now, and during that time, I've acquired a lot of personal knowledge related to long-term care insurance and related subjects. And so-- About 20 states that I worked with over the last couple of years as a consultant--

CalPERS started this -- down this path around 1989, and the reason was because we began -- as we began to look at what was going on nationally, we saw that there was a -- was going to be a Federal problem in terms of cost for long-term care insurance. We looked at the quality of products out there at that time, and we didn't like everything that we saw. We also looked at the pricing.

At the same time, there were two other or three other energies that were pushing towards us to look at them. One was the Assembly Office of Research who was looking at what was going to happen to California in terms of Medicaid costs related to long-term care. And they determined that by the year 2040, their Medicaid long-term care expenditures -- it's called MediCal in California -- would be over \$40 billion.

The state budget this year, I think, for the entire state is less than \$80 billion. So we're really looking at an expense that's just enormous. This means that the average taxpayer is going to be burdened, in California, with

somewhere around \$3000 a year to \$4000 a year. The money isn't going to be there. There just isn't that kind of money available. So we began to look at other solutions. The Assembly Office of Research was projecting that they were going to go broke in the year 2020 if they didn't start to stem some of these costs and shift the responsibility somewhere else.

The employer associations came to us, and they were terrified. They were bringing us horror stories of states being gobbled up. And the biggest thing is, if one person goes in, in a married situation, the other one is impoverished. This is usually the female because the female is usually slightly younger than the -- in a married situation, at least in our population, and then she outlives -- she has about a six-year longer lifecycle, so she becomes the caregiver and winds up in care -- in destitute.

We had looked at what was going on out there. We had looked at different kinds of programs that weren't successful. We looked at the private industry out there, and the sales were miserable. So we began to look at concepts which would give us control over premiums to design (indiscernible) plan flexibility and cost control and determined that we can put together a program that would do this.

We needed to take a look at ways of protecting our membership. We came up with a program that was -- where we would have to sell it differently to people. We would have to educate them. We had a whole different type of education program to let people understand that they're not covered. I went out and gave lectures in the early '90s, and 60 percent to 70 percent of the people felt that they were covered by long-term care insurance in either Medicare or in their acute health-care program. So we developed a

massive education program. Part of the result of this is that CalPERS is now probably the sixth- or seventh-largest company in the United States in terms of its long-term care program. There is over-- At the end of this year, there will be 130,000 people enrolled in the Program. The average age is 58 years old. We have as many people under the age of 58 years old in our Program as we have over the age. We have a Partnership Program included. We went out to 13,000 of our members to design this Program for them. What they wanted was a simple program with simple choices. We've overcomplicated something that needs to be understood a lot better.

We feel that with our Program, we will be-- We began a shifting of the purchase of the product in California. The year that we went out with our education program, educating them on partnership programs, on lifetime programs, and on shorter programs-- The first time we went out, we sold 72,000 policies, and we're going to double it this year. And that's just over a three- or four-year period, which is unheard of in group plans.

When we began offering it to our public employees, we had the state teachers making themselves eligible for our Program. We had the county employees make themselves eligible. Virtually, every public employee in California is eligible now for our Program. In 1996 or 1997, the Legislature made themselves eligible for our Program -- and the judges.

The CalPERS Program developed a lot of innovations into the concepts that are now being developed by commercial plans. We do the pot of money, flexible home care accounts, alternative care. We think there are all kinds of ways that you can structure your program so that you can control quality. We have a quality control network built in. We have-- It's a totally

portable account. We have what's called a care advisor, which is a totally voluntary aspect of our Program. And that is the person who will guide you through what your needs are and match care with your needs and give it to you, and you get to choose what you want. It's totally voluntary, and it is at no cost to the participants. We are in the mode of looking to see if we can offer that to everybody in the PERS Program, those enrolled and those not enrolled. And that is something that's planned for the future. And by negotiating contracts with care providers, this might be done at no cost to anyone. So there are innovations that come out of this. The more people that you get enrolled, the more people that you have shift.

We anticipate that properly done, we can shift somewhere between 20 percent and 30 percent of the cost of long-term care to private plans. The private plan in ours is a self-funded program, which means that the participants of the Program own it. So if there is any surplus, they go back to the participants in the form of reduced premium cost or expanded benefits.

The Program is one of the most successful programs ever launched in the United States. It's a half a billion dollars right now in assets. It's running surpluses that I will put up against any plan in the United States that's offered to be able to identify it. They have our benefit to administrative cost-- In insurance language, that's your loss ratio. We have a projected 90 percent to 91 percent going to benefits and around 10 percent to administration so that it is well managed. The prices are running about 20 percent to 30 percent below average costs.

But what is happening is that when I started this Program, I thought what we should do is lock arms with the private industry because what

California needs is a statewide solution, not a CalPERS solution. And that's why I'm still in it and still giving advice. I locked arms with some of the biggest organizations in long-term care insurance, which is Bankers, which is owned by (indiscernible), GE which is the old AMEX, and a number of others. All of their sales went up in the first year that CalPERS went up -- between 50 percent and 65 percent. So there is a growing trend there. There are lots of things that need to be done to assist it. The biggest thing we need to do is the education, and the education is that you're putting yourself at risk.

We had-- When the teachers joined us, they became 20 percent -- over 20 percent of our enrollment now, I think. And they're not a member of CalPERS. They're a member of a different organization. The most likely person to buy that in that program was a 45- to 50-year-old -- 55-year-old single teacher, female, knowing that she didn't have the guarantee-- There's nobody guaranteeing her that she's got Medicaid help when she needs it. There is no one guaranteeing her that she has choices. There is no one guaranteeing her that she is going to have some opportunity to look at the quality of care and have some control over that. Those teachers are buying -- those single teachers are buying long-term care insurance for this.

I can go on. What I did was I ran some of the cost against what I saw as -- were New Jersey costs, but, remember, these are just estimates on that. I tried to take the California figures and look at the distribution of cost in New Jersey. And under worse-case scenarios, we see that based on my figures as compared to California, the distribution would be a similar distribution for their population size, and I use the American Hospital Association's distribution of 1995 for Medicaid long-term costs as 3.4 percent

of the total showing a worse-case scenario of somewhere in the year 2040 of \$4.7 billion to \$6.6 billion, which would then be translated to \$2000 to \$3000 and maybe even \$4000 for taxpayer family in cost at that time.

A 30-year-old-- And again we're pushing down the average age of sales because we're direct marketing. You can't individually market a program to a younger person because their annual premium is not great enough to make the reward for the salesperson to go out and spend the time. So they're really going to target the 55-year-olds and older. I don't sell long-term care insurance, but I would not have an agent go out under anything less than a group plan for the younger persons. So the group plan has got to be out there.

We see about-- We need to get the states interested in an aggressive program to shift some of this responsibility to the individual. And again we feel that that figure can be somewhere between the areas of 20 percent or 30 percent, which is a huge, huge savings when you compute that against the long-term care liability. We need to educate people on the potential and financial devastation, the potential loss of control of care settings, loss of quality choices, and one of the big things-- When we went out to our 13,000 members, the older they were, the less they wanted to become a dependency to their spouse or their family, which is a really high risk in today's world. And you got a real good presentation on the tax-related issues and cost shifting, which we see tightening down, rather than loosening -- that this is going to become less and less of an opportunity in the future. Some of the things that we're talking about there is to penalize estate planners even more than include that as an alternative in care.

MS. MICHELSEN: (indiscernible)

MR. HARTUNG: Right.

MS. MICHELSEN: Some states are examining--

MR. HARTUNG: There's Federal legislation in the proposal form that goes back to 60 months and then tightening down the circumstances -- many trusts are already at 60 months -- and reward the financial planners who look at insurance in this form as a form of investment.

A 30-year-old can buy, in the CalPERS Program-- A 30-year-old can buy lifetime with 5 percent compound inflation for about \$30 a month, which by the time they get into the benefit horizon is protection of somewhere between \$750,000 and \$1 million depending on their lengths of stay. If they happen to be one of the larger stays-- We know that after the age of 65, somewhere between 57 percent to 60 percent of those people will spend some time in a long-term care setting. This long-term care setting, for 18 percent of them, will be two years or more, which is, in New Jersey, in today's dollars, \$140,000 or more. In a married couple's setting, that absolutely devastates most of the settings.

We support-- California uses its energy to support all of the tax solutions that were brought before you today. We think that the New Jersey, as well as the California-- The University of California made themselves eligible. They now teach the need of long-term care as a financial tool in the planning of a person. They made themselves eligible. They're a separate umbrella in the state of California. They're not part of the state, actually, even though they're public employees.

The education-- My son just graduated from the state college, and he graduated in business and business planning -- financial planning. Not once

did anyone bring up the need for long-term care insurance in his plan, but they covered fire insurance. I don't know why because his chance of needing fire insurance is about 25 times less than long-term care insurance.

There also is a way of supporting alternative care settings. The alternative care setting, between the home care and the nursing home care platform, is a greater quality of life. I just-- My mother died last summer of advanced parkinsonism. She was in a long-term care setting for almost eight years. We went through \$400,000 trying to give her some semblance of life. That's the types of costs people are facing. Fortunately, she was in a financial position that it didn't completely devastate her estate, but it almost did. When my father died, I tried to get her into a long-term care insurance program. She was already suffering from parkinsonism, which she had hidden from her children, and she was not eligible for long-term care. You have to have-- You have to be free of long-term care risk in the next four years to be eligible for long-term care insurance; otherwise, everybody would wait until they needed it to buy it, and it would be a self-destructive program. It would have cost me \$3000 a year to get her an insurance policy had she qualified then, in her late 70s. It would have been the best investment I ever made. So there are things that you need to look at.

I began to talk about these interim care -- these interim platforms. We put her through some questionable settings that were really new and not monitored in California, but I monitored them, and I had our care advisors monitor them. And the care advisors in our Program, and it's the same thing you can set up here in New Jersey -- most of them are spinoffs from the University of California, Gerontology Department, who work part-time in this

setting, qualifying plans, evaluating, and assisting the people on matching the care. It took me forever to match the care that she needed with the right institution.

But developing that interim and putting out government advantages or at least stimulating the growth in those areas-- When she-- We put her in, even though she had disabilities -- physical disabilities, in a quasi Alzheimer setting for about a third of a cost of a nursing home platform at about three times the quality of life. So there is a whole new area that you can support with these types of programs.

I won't go over the Federal solutions. I really wanted-- I know that we're going to be running out of time. I really wanted to devote most of my time to trying to answer some of the questions that you had. There were some of them that were asked earlier that unfortunately I didn't write down -- to give our response. CalPERS offers the Partnership Program, and it represents between 4 percent and 5 percent of our sales. And it does have an alternative, but what it's preserving is the amount of coverage that you purchase in addition to the Medicaid spenddown, basically. And there are variations of that depending on the states. There has not been one state approved for a partnership plan since about 1992 or 1993. And I can go into my reasons why that's happening, but I don't have enough background and I haven't checked it enough. It's just that there seems to be some opposition in Washington, D.C., to approving different states for it, but that may break down. And we work closely with Robert Wood Johnson on our Partnership Program.

We talked about people who were preserving their estates or whether they should preserve their estates for a lot of reasons. There are thousands of other reasons why people will want long-term care insurance and our buying it. Choice-- I think the top 10 reasons, by our 13,000 members, was the independence of choice. They didn't want to use the government as their insurer because they could not project what would be there when they needed it, which could be five years from now or ten years from now. They wanted choices in settings. They wanted to have flexibility to live anywhere in the United States. They wanted inflation protection. They wanted the simplicity of choice. They wanted dependency on quality. A lot of this happened in the early-- These questionnaires were going in the early '90s when there was some question as to the quality of care that is being provided.

If you look at 1965 and what was going on in nursing and compare it to 1985, there were huge advances. There were advances that were even larger than that between 1985 and 1995. As more insurance companies get involved in this and start selling products out there, there is more demand for quality. And the standards that we require for people to be eligible to participate in our Program are very high. We want to give our members the choices of staying in the home as long as possible and getting into the alternative care situations. So we have that flexibility built into our program.

Interestingly enough, these are usually lower-cost platforms. And what happens to this is-- There was an original assumption that this was going to drive the cost of long-term care up. It didn't, it extended the care. It lengthened the value of the benefit, so they spent a portion of that time that they had spent in the past in nursing home care in a less-expensive, higher-

quality setting. So there are all types of nuances to this and what the cost really means.

So let me just stop now and see if there is any questions related to this.

ASSEMBLYWOMAN MURPHY: I'm going to--

Speak first, and then we will have Sam repeat the question he started with before if that's agreeable.

MS. MICHELSEN: Did you-- Have you found, in your history of selling these policies, that people ask you, "Well, what if the insurance company doesn't exist? If I'm 45 years old and I'm buying such a policy and I buy it from Bankers or wherever or CalPERS, what if, when I'm 85 years old and I go to make a claim--" You know, that's a long time ahead to project.

MR. HARTUNG: Well, that's with anything.

MS. MICHELSEN: It is, but this is a new kind of insurance for Americans. I know it's been around for 15 years and 20 years as a nursing home kind of insurance. How are the policies-- People ask me, "Is it insured like an FDIC kind of thing, where I know that if I give you this money, you're still going exist in business when I need that policy -- when I make that claim?"

MR. HARTUNG: Generally, under the regulatory bodies of the State-- These programs are sold. It's not the high-risk type of insurance that health is. And I would say that it's going to be -- that it's a risk in terms of financial stability is a lot greater than a health plan that has a 12-month cycle in it. This has a 30-year cycle in it.

MS. MICHELSEN: Right. Now seniors are scared because they see an HMO is going out of business.

MR. HARTUNG: But to compare the two-- One's closer to a pension program than it is to a health-care program.

ASSEMBLYWOMAN MURPHY: Yes.

MS. MICHELSEN: Absolutely.

MR. HARTUNG: My first three years of trying to explain what long-term care insurance was right in the area that you're talking about. It took me three years to explain to our board that the risks were totally different -- that they were much more familiar with the framework of the financing related to this because they had been pension plan managers for 64 years.

MS. MICHELSEN: It really is a pension plan mentality. If I'm 45 years old when I buy it, you might have 45 years to invest my money before I ever make a claim. So that insurance company should do pretty well. If you get younger people to buy it, you have -- the company has a lot of money to use to keep the company going for a long time.

MR. HARTUNG: Well, I don't know whether it's to keep the company going, but when an insurance program is designed, there are certain elements of it -- there's a profit incentive in some private programs. But if the insurance companies who are making those types of profits-- That's all CalPERS would be investing in, but the insurance companies' profits -- the average aren't any higher than anyone else's. So that's, to me as a member of CalPERS and working for them and with its \$130 billion in investments-- The insurance companies are scrutinized for their management, and we look for high quality there.

The ability for insurance companies to maintain these programs is strong because--

MS. MICHELSEN: There is no history of it. That's what I think scares people about buying it. There's no--

MR. HARTUNG: And it's our responsibility to explain to them the history of-- I mean, there is no history for Medicaid. All we know is that it's going broke, and if that's history-- And your long-term care program has-- There isn't a program in the United States that doesn't have the ability to adjust premiums so that if the deficit starts going up, you make a 5 percent correction here, and you make a \$20 million improvement. But on a self-funded program, if it goes the other way and you have a \$20 million surplus, it still belongs to the-- And that's the hardest thing that you have to try to explain to someone, that it is a very easy -- it's less risk than a lot of types of insurance products. It's a lot less risky than fire insurance because, if you have tornados or you have earthquakes, you can find yourself operating in the red and taking 10 years to recover. With a long-term care insurance product, the average insurance company can make the correction if they make it early enough, because the history is so long and far in advance, with 5 percent corrections, which is not the types of corrections you see when California gets devastated by earthquakes.

MS. MICHELSEN: I imagine it's rather predictable.

MR. HARTUNG: So it's an education program. We need to understand this risk value and be able to portray to them that the risk with this isn't any different than any other programs that are out there.

MS. MICHELSEN: And, in fact, the risk is probably is much more predictable than an earthquake risk.

MR. HARTUNG: Very predictable. And that's where we need to educate the folks.

MS. MICHELSEN: Okay, thank you.

ASSEMBLYWOMAN MURPHY: Sam.

ASSEMBLYMAN THOMPSON: I think you may have come close to answering my question already. You indicated that for someone in their 30s, it would cost roughly \$36 a month, maybe about \$400 a year. And then you mentioned, in the case of your mother, that in their 70s, the policy would have been \$3000 or--

MR. HARTUNG: Yes, and this was in 1989 or 1990. So it's changed, but the question was duly noted, so I brought my trusty-- The program is now open in CalPERS, and I asked them to send me a monthly premium cost. And what we want to look at is a comprehensive plan. That means that what, in my language -- I know it's not the best worded-- I wasn't an artful salesperson and marketer when I was coming up with words. The comprehensive was understandable to the focus groups. It covered any kind of care once you hit the triggers. And a lifetime for a 70-year-old -- that's with compound inflation protection -- would be \$269 a month--

ASSEMBLYMAN THOMPSON: A 70-year-old would only be--

MR. HARTUNG: --as opposed to \$4500 to \$6500 a month for care.

ASSEMBLYMAN THOMPSON: A 70-year-old would only be about \$270 a month?

MR. HARTUNG: Two hundred seventy dollars a month on this Program.

ASSEMBLYMAN THOMPSON: I'm astounded that it would be that cheap.

MR. HARTUNG: Well--

ASSEMBLYMAN THOMPSON: At that age.

MR. HARTUNG: You need to make comparison with self-funded versus-- We're not going to invest in an insurance company, and we're a big investor in insurance companies. We invest in the market.

ASSEMBLYMAN THOMPSON: Right.

MR. HARTUNG: And so we had whatever percentage they are of the market -- we have that invested in them. And we're not going to invest in any company that's nonprofit.

ASSEMBLYMAN THOMPSON: Well, I'm just thinking in terms of--

MR. HARTUNG: But this is a nonprofit.

ASSEMBLYMAN THOMPSON: As I said, if the person went into a nursing home, it could cost \$70,000 a year, and at the age of 70, you're getting close to where there are pretty high odds that you'll be in a nursing home soon.

MR. HARTUNG: Right, its entry-age rated, just like life insurance. The closer you get to utilization, the higher the premium.

ASSEMBLYMAN THOMPSON: I'm surprised it's so low. That's what I'm saying.

MR. HARTUNG: Oh.

DEPUTY COMMISSIONER REINHARD: Can I just add to that?

ASSEMBLYWOMAN MURPHY: Susan.

DEPUTY COMMISSIONER REINHARD: Since you just said that you'd have to compare that to a private, maybe individual, insurance, what would that look like?

Isn't that what you were asking?

MR. HARTUNG: It might be as much as 25 percent more/30 percent more.

ASSEMBLYMAN THOMPSON: That still seems like a real bargain to me when you're that close to the possibility that you might be using it for claims of \$70,000 a year.

MR. HARTUNG: But you understand the risk, and so that makes sense to you. You know what's on the other side of that. The average person doesn't, and that's what -- that's our big role and our big mission and New Jersey's big mission. You've got to help those people understand what's out there and that they're really not protected.

ASSEMBLYMAN THOMPSON: The illustration of the attorney that was speaking here. I mean, people with \$600,000, and so on, if they can buy the coverage for \$3000 a year, they don't have to worry about Medicaid, losing their money, and everything else. That seems to be their answer, pay \$3000 a year and buy premiums.

MS. MICHELSEN: Right, don't transfer their assets.

ASSEMBLYMAN THOMPSON: They don't have to transfer assets.

MS. MICHELSEN: The risk of transferring your assets is extremely high, and sometimes that not a piece of education we give seniors.

I've seen seniors, many times, transfer their assets, and then the son ends up in some financial trouble, spends the money, fully expecting he is going to pay the mother back or put the money back in that account that is the mother's account, and he never does. And then she needs a nursing home and discovers she can't go to the nursing home of her choice under Medicaid, so she wants that money back for year-one's payment to pick a place, and the money's gone.

MR. HARTUNG: Yes, as a pension plan, it's been around since 1932. We have so many protections against children's misuse of funds that it's amazing, and we didn't create those rules and regulations because we thought they were necessary. We found out they were necessary, and transfer of assets is very risky.

MS. MICHELSEN: Very risky.

MR. HARTUNG: When you transfer your risk and the kid runs over a three-year-old girl, watch what happens to your assets.

MS. MICHELSEN: Or even something less dramatic than that, he just gets divorced.

MR. HARTUNG: In a divorce, he loses half of it.

MS. MICHELSEN: Right.

ASSEMBLYMAN ROMANO: What if he becomes a playboy?  
(laughter)

MS. MICHELSEN: You don't have to run over a three-year-old girl for the child to lose the money--

MR. HARTUNG: No, a divorce situation--

MS. MICHELSEN: --it can be much more typical.

MR. HARTUNG: --a medical problem in the family, a problem with his child. There are so many--

MS. MICHELSEN: Maybe he loses his job.

MR. HARTUNG: Right.

DEPUTY COMMISSIONER REINHARD: And then there was the earlier reference to King Lear.

MS. MICHELSEN: Right.

MR. HARTUNG: Right.

There were 100 different things that I wanted to go over with you, but--

DEPUTY COMMISSIONER REINHARD: Well, I have some questions. I wanted to ask you, as a State person, what would be your recommendation to New Jersey? Why should we self-fund? Why should we offer this as a voluntary benefit to New Jersey employees? What other states are doing this? And what advice would you give us as a state or to the Legislature?

ASSEMBLYWOMAN MURPHY: Susan, would you just explain voluntary benefit, meaning the state would volunteer to give this to everybody?

DEPUTY COMMISSIONER REINHARD: That this would be something the employee would have to, essentially, purchase, but the State would offer it through a group plan, which makes it cheaper.

MR. HARTUNG: Right. That's what CalPERS, essentially, is doing.

There were a couple of things that my board laid on me, and one was, "Don't design anything that's going to be a problem for us." And the

other thing was, “Don’t design anything that would be a burden on the employer or the state, period. If you come back with something like that, you’re looking for a job the next day.” And that’s what we designed, and that’s the way these should be developed originally.

If somebody wants to do something later with it, and it becomes-- I’m very much in support of the cafeteria plan, very much in support, but I’m not in real support of making it a burden of the employer right now because what that does is just take cash out of the person’s product. As an employer-- Now, every time I create a benefit, I’ve got to lower salaries or redline salaries for three or four years until the growth catches up, and then they lose the choices on that.

There are some advantages to long-term care insurance that are great under the Kennedy-Katzenbaum. That is that you can selectively let people get into it, or you can-- And I think this is the way it’s going to come through the employers is that the employers now have the ability to offer it to anybody they feel like without penalty of prejudice. So it’s going to come down to the officers first, and then it’s going to come to the managers, and then it may expand after that with pre-tax dollars. But, I mean, those are things that you can’t count on as being part of the future.

The basic things that we wanted to do is-- When we understood the risk of this and that if we had a pool of 10,000 people in your program, regardless of their age because it’s entry-age rated -- we didn’t care whether they were all over 60 years old or all under 60 years old -- that you have -- you’ve mitigated your risk. As long as your underwriting is that you don’t write anybody in that’s at high risk of long-term care in the next four to five

years, your risk is gone so that's-- That becomes a (indiscernible) question, I would think, for New Jersey with the size of eligibility that it has.

You have the ability to control the funds and invest the funds. If you're passing the funds on to a third-party administrator or insurance company, they're the ones investing it, and their expenses are probably higher. We can invest the funds in the neighbor of 20 to 60 basis points, which is a percent -- first number percent. Twenty is 0.2 of 1 percent up through 0.6 of 1 percent for the investment on this. This all translates to higher returns.

We used very conservative figures in our Program. We used an estimated 8 percent return for the life of the product and used a 10-year horizon for the investment pattern on it. I don't even want to say what the investment returns have been on this since we-- But we can't project that out for 40 years, so it's better to be safe.

We have a lapse rate, which is those people who drop out of the plan and forfeit their premiums. That's much more conservative than the private world. We think that that was a conservative measure and that it was a safe measure because we think, as more people understand this Program and get into payroll deduction, that there is going to be less falloff. So we use conservative approaches to that, but you have control over this when you have a self-funded program. You can do these things.

When (indiscernible) bill, as I mentioned earlier, became law, it took eight months for people to adjust their programs and get them through the Department of Insurance and decide what they wanted to be when they were tax qualified. We did it. We were ready January 1, when the bill came in. We had designed our Program around the possibility of it, but we could

have changed it because we were self-funded. We think that the middle ground is going to be developed, so we put a clause into our Program.

It's like, whatever we can figure out is the way we'll deliver care. We have something that was called assisted living. We didn't even define what assisted living is because we don't know what it's going to be in 2005. So we wanted that type of flexibility. What it's turning out to be is a higher quality of life at less cost. It was a tremendous advantage.

We wanted to control the quality of care to be able to be recommended. We had this independent group that did the advising of care. We wanted to be able to market it the way we thought was right. One of the things I was told by some of the insurance companies was that there are two things you can't sell to a public employee besides long-term care insurance. You cannot sell lifetime, and you cannot sell compound inflation. And I said, "Why?" And they said, "Because we only sell 30 percent lifetime or less and 35 percent compound inflation." I said, "That's because you can't sell it. We can sell it." We have-- Seventy percent of our sales are lifetime. Almost that same figure is compound inflation.

I spent 1996 with CalPERS as a consultant, as I passed the baton on to Dan Shrepford (phonetic spelling), on long-term care insurance talking to CNA, talking to Transamerica, talking to (indiscernible) on how they need to redesign their programs to sell the products that we're selling. We wanted to be able to go out and tell people and write what we wanted to write. We wanted to write the story of what long-term care is, how it's needed, and be as honest as possible and not try to pablumize it and do a few good-- We did a "Here's what the story is." We wanted to sell that. We wanted to touch them

as much as we could. We found out that sales are the best if we touch them at least three or four times.

We wanted to do seminars out there. We did -- the first year and one-half there were 400 to 500 seminars. We would have people come in, and we would explain to them in group settings what it was that was long-term care insurance and why they needed it. We wanted to be -- change that. We thought that television and radio could be used for a limited market, and it was costing us 10 times as much for a conversion to a policy, so we dropped that. We wanted to have the flexibility of making those types of changes. You can do that with a self-funded plan. If you want to change the way that the structure is, you can do that, and you don't lose any money because all the money belongs to the beneficiaries of the program. So those are some of the reasons that we went self-funded.

DEPUTY COMMISSIONER REINHARD: Can you tell me what other states are doing this?

MR. HARTUNG: Right now there's a IFB invitation to negotiate in Florida. Dade County, in Florida, has a partially self-funded program, and there's a public entity in Colorado, not the state of Colorado, that has a self-funded program. All of those self-funded -- the actuary that's watching over it is Towers Parent (phonetic spelling). They're a strong proponent and understander of long-term care and of self-funding and understand the risks associated with that. They're an independent actuary that looks over the third-party administrator and our Program and gives us biannual reports. Our board is -- my former board -- as a member of PERS, I guess it's still my board -- is very cautious, and so we have Dave Norton (phonetic spelling) out of the

Atlanta offices, our chief actuary on the long-term care Program, and he is absolutely a genius when it comes to structuring self-funded--

ASSEMBLYMAN ROMANO: Madam Chair.

Do you see any possibility-- The way we have to Medicare -- we have the supplemental, which now goes beyond fee for service. You have many managed care plans. Do you see the Federal government or the state, on its own, coming up with some sort of plan where the state is paid by payroll deduction, the way one does for FICA and the Medicare supplement money? And people would have the option to choose that sort of program that they feel would be best suited for them in their needs so that you might have that insurance company and another one and another one and another one, just the same way that we have different HMOs.

MR. HARTUNG: You know, we-- The board wouldn't let me explore that area because they had a specific ruling on what they wanted me to design. That was a stand-alone program that they had complete control over. They didn't want to pass the control to the Federal government at all regarding the long-term because the last person that's going to buy a long-term care program in the state of California working for the state or a public entity-- The last program they're going to buy is anything that has anything to do with Federal regulation. There's no way we could sell it.

ASSEMBLYWOMAN MURPHY: You have no control over -- the Feds get into it.

MR. HARTUNG: You cannot sell anything in California to anybody where they don't think they have control over it somehow. And we have -- our entire financial condition of the Program is a public document that

goes out before the owners of the Program once a year. It's the only one in the United States where you can see what the investment pattern is, what the investment return is, what the benefit cost is, and the solvency of the Program. Those elements are not visible on any other plan that I know of except the self-funded plans.

Hewlett Packard has a self-funded plan. They went out in 1965, and they sold it to 15 percent of their employees the first year they were out.

ASSEMBLYWOMAN MURPHY: May I ask you a question?

Can these policies-- If I were buying a long-term care policy, am I buying it for a face amount?

MR. HARTUNG: Yes, that's a really good question, and I'd like to talk about that one because that is one of the most misunderstood.

Our Program is designed-- If you come in and buy your program at age 60, which would be at my cost -- a lifetime with inflation protection would be \$141. That would be \$141 until I went into benefit.

ASSEMBLYWOMAN MURPHY: Now, what would be--

MR. HARTUNG: Unless the premium was raised or lowered.

ASSEMBLYWOMAN MURPHY: I'm not speaking to the premium, I'm speaking to face -- the benefit. Am I buying benefits in an amount or am I--

MR. HARTUNG: With inflation protection, it compounds and doubles every 14 years.

ASSEMBLYWOMAN MURPHY: So I'm buying lifetime benefits -- whatever it costs me to get into this nursing home.

MR. HARTUNG: Right. Unless you think the cost of long-term care is going to be more than a 5 percent compound inflation, you're probably going to run a surplus in what you have in terms of value. If the surplus becomes a real surplus, as a self-funded program, some of the cost is going to be cut back, and I'm going to receive the benefit of that.

ASSEMBLYWOMAN MURPHY: Would it not make it less expensive for young people to buy if they could buy coverage in dollar amounts?

MR. HARTUNG: They have kind of an option to that. The younger they are, the more likely they're to buy lifetime with inflation protection. They're the highest purchaser -- is the person under age 50 years old for lifetime, which is a true lifetime, with compound inflation because they don't want to have to worry about the government. They don't want to have to worry about the cost. They can buy it at a premium then. They can never get it that cheap again. They're the ones that are going to buy the compound with inflation.

ASSEMBLYWOMAN MURPHY: And the premium for someone 25 years old, going into work now -- what would the premium be per month?

MR. HARTUNG: The age 25 is \$27, with compound inflation for a lifetime, a month.

ASSEMBLYWOMAN MURPHY: Could they buy if they didn't earn enough to pay \$27 a week-- Could they buy a policy?

ASSEMBLYMAN THOMPSON: A month.

ASSEMBLYWOMAN MURPHY: A month. Assuming that they are 25 years of age, would you sell them a policy that would allow them to buy in at \$13 a month?

MR. HARTUNG: Right, if they buy it without compound inflation, it is \$13 a month.

ASSEMBLYWOMAN MURPHY: Could they transfer it over in five years if their salary were increasing?

MR. HARTUNG: If you buy it without inflation, with our Program, which the other private programs are doing now-- I love these kinds of questions. We have, what we call, a ratcheting-up element. That means that without underwriting, if you ratchet it up every three years to the face value, then you just pay the additional amount that is added to the \$13.

ASSEMBLYWOMAN MURPHY: Right. There is no penalty -- no penalization of my--

MR. HARTUNG: Absolutely none. You can do that for the rest of your life. What I choose to do with mine is-- I bought mine when CalPERS first offered it in 1965. I don't remember what I paid for it. It was around 100 and something or less than 100. I bought it without inflation protection, and that's a financial gamble on my part. I have it ratcheted up automatically every three years. I'm assuming that just because of the way I do my investments and planning, which is probably not good-- That's the way I wanted to do it.

ASSEMBLYWOMAN MURPHY: Yes, but you have those options. Or I can just convert it to a compound inflation product. You can do that. You can offer those kinds of options without penalty if you're a self-

funded program, and those are the incentives that bring the young people, I would think, to the table.

MR. HARTUNG: You know, that's why we designed the Program that way. They're not buying it that way. They don't even want to look at anything other than lifetime with compound inflation.

We decided that we were going to go out and-- Just anybody under the age of 40 years old -- we were just going to offer them the lifetime with compound inflation. Just one strike down the middle. That was all they were buying anyway, but we got so many people complaining that it looked different than the one they had that we had to go back and give the spreadsheet to everybody. Because the son was going in and saying to the parents who were also (indiscernible) the Program, "This is what mine is," and they said, "Well, I got a different one." And they got confused, so we went back to this. But, yes, they have that option, and we do educate them on the differences.

ASSEMBLYWOMAN MURPHY: Now, if I'm a member of PERS now, in California, and in three years, I take a job somewhere else and I'm outside of the system, can I continue my PERS -- my long-term care insurance?

MR. HARTUNG: Yes, it's 100 percent portable. And if you are any kind of a public employee or the spouse or parent of an employee and you enroll in the Program and move anywhere in the 50 states--

ASSEMBLYWOMAN MURPHY: That was the next question.

MR. HARTUNG: We're not ready to offer benefits in foreign countries because we have no control over the quality yet.

ASSEMBLYWOMAN MURPHY: Right.

MR. HARTUNG: I think that's going to come, but how do you choose between Germany and Yugoslavia?

ASSEMBLYMAN THOMPSON: But you're saying that you can stay enrolled in the Program as long as you're in the U.S.

MR. HARTUNG: Yes, if you're a teacher in--

ASSEMBLYMAN THOMPSON: Even though you don't work in California?

MR. HARTUNG: If you're a teacher in southern California and you enroll in the Program and you're not a PERS member, you're just a teacher there who is eligible, and you decide to teach in Maine the next year, you simply unplug your Program and plug it into your banking account or your monthly payment or your quarterly payment and move to--

ASSEMBLYWOMAN MURPHY: Maine.

MR. HARTUNG: --Maine. And if you then decide to utilize benefits in Maine, you utilize benefits in Maine. So it's what we call 100 percent portable.

ASSEMBLYMAN THOMPSON: You mentioned if you are a parent or child or someone, etc. Are you saying-- I have a son out in California right now. He doesn't work for the state, but if he worked for the state, he could buy a policy on me living over here?

MR. HARTUNG: You would enroll, and it would be your policy. You could do whatever you want. You can enroll--

ASSEMBLYMAN THOMPSON: Even though I live over here and he works for the state of California.

ASSEMBLYWOMAN MURPHY: That's right.

MR. HARTUNG: Right. If you live in any state--

The only thing that we didn't do was include children. And the reason that we didn't include children was, when we were designing this Program in 1994, there were no real good actuarial figures on children. So we didn't know how to price it. We didn't know what to charge. And so we just, rather than holding this thing up until there is a body of actuarial evidence on children-- How do you underwrite them? Who do you eliminate? And there wasn't any information on that. That's coming, and some are already moving in that direction, but the people who are eligible on this Program are your spouse, regardless of the age, and your parents and your parents-in-law. The oldest person that we had enrolled in this was 103 years old. She bought a three-year Program without inflation protection.

ASSEMBLYMAN THOMPSON: When you say your parents--  
Based on your other statements--

MR. HARTUNG: I'm sorry, it was 101 years old. She bought the three-year period.

ASSEMBLYMAN THOMPSON: We won't argue over the difference.

An earlier speaker was suggesting that there might be cases where the kids want to buy for the parents. But you're saying that the parents themselves have to buy it, even though their child may be the one working for the state, or so on.

MR. HARTUNG: Right. And there are a lot of legal reasons for that because it's the beneficiary of the Program who is the person, and they

should be the one in control. Now, if the child wants to pay for it on behalf of the parents, that's easy, but the parent has to sign everything.

ASSEMBLYMAN THOMPSON: Oh, you're saying-- It's easier for you to collect from a state employee's paycheck, and so on.

MR. HARTUNG: They can't pay for it that way. They have to pay for it--

ASSEMBLYMAN THOMPSON: Oh, you don't have deductions out of their paychecks?

MR. HARTUNG: No, they can't have a deduction because of California law for something other than they benefit from. So it's that law book--

ASSEMBLYMAN THOMPSON: Well, if you have to mail the check--

MR. HARTUNG: They can mail the check in for them, or they can have it electronically transferred out of their banking account.

ASSEMBLYMAN THOMPSON: Sure.

ASSEMBLYWOMAN MURPHY: Susan.

DEPUTY COMMISSIONER REINHARD: Okay, now we've bought this insurance policy. What triggers the benefit?

MR. HARTUNG: Okay, all tax-qualified programs-- I don't talk about anything but tax-qualified programs because it has a lot of built-in protections and penalties there that are consumer protections. There is an argument on that, but that's a whole other afternoon. The argument is pretty flimsy. The tax qualifying gives you certain benefits that you can't get otherwise, and if there are future tax qualifications--

There are questions as to how you make that eligible. There's something called the six activities of daily living--

ASSEMBLYWOMAN MURPHY: Right.

MR. HARTUNG: --ADLs. And when you have two of those losses, which can be transferring, which is walking or bathing or eating, then this triggers the -- and makes you eligible. You have two triggers for home care. You have three triggers for nursing home care. Let me tell you that you can sometimes have four or five triggers before people who have comprehensive programs go into the nursing care because they can find some way within the Program to stay in a less-- There are not people beating down the door to get into nursing homes. That's sometimes the only solution.

ASSEMBLYWOMAN MURPHY: Yes.

MR. HARTUNG: There isn't anybody in a nursing home care facility that's there because they thought they were going to be there. They're there because they didn't think they were going to be there. We had been toying with the idea of having a home care only until we figured out that when they need the benefit the most, we'd be cutting them off.

ASSEMBLYWOMAN MURPHY: Yes.

MR. HARTUNG: And we don't want to be sitting there listening to that story and having -- and putting our board of administration through that kind of a sad story. So we don't sell that one. We think that one is full of all kinds of pitfalls.

DEPUTY COMMISSIONER REINHARD: And you mentioned going from home care to nursing home care or all these different options. How

do you do that? How do you manage that change? Is it this counselor you have?

MR. HARTUNG: It's the voluntary care advisor. Remember, it's not-- They come up with a program, and you can mix and match between the two, some of the nursing home care, some of the assisted-living facilities. You can do it anyway you want. We wanted that to be totally flexible. And the care manager assists you with this so that you're getting the right care. One of the things is the male wants to stay at home, no matter what his condition is, at the burden of the wife or the spouse. That's got to be managed because that puts her in nursing home care earlier. That's what happened to my mother. My dad had a series of strokes, and for four years she was getting him up. She's, like, 100 pounds. He should have gotten a different kind -- even if it was a day care facility or somebody coming in for home care, she would have had a higher quality of life, and that's just-- If I'm a little prejudiced on that, it's because it was my mother.

I didn't know what was going on. I didn't understand it. I thought she was doing the right thing, but she needed something else to help her because, within a year after his death -- and she was taking care of everything. I thought she was in the peak of health. She was in home care within a year after his death. She was eight or nine years younger than him.

ASSEMBLYMAN THOMPSON: Is there any discount for both spouses being enrolled?

MR. HARTUNG: You know, I saw one of those one time, and it's not a big, big figure until you get into your 90s.

ASSEMBLYWOMAN MURPHY: And that's not impossible.

Susan.

DEPUTY COMMISSIONER REINHARD: I'm very sorry for your experience. It sounds like that was very stressful for you and for your family. I know you bring that to the work you do, and that's helpful to have someone that can bring that.

MR. HARTUNG: Yes, it helped me understand the experience, and it helped me understand the need. It's not that I-- I'm not mad at anyone. I'm just upset that we didn't plan better.

DEPUTY COMMISSIONER REINHARD: Well, none of us seem to do much of that these days.

I just have one last technical question. You mentioned underwriting for a minute there a while ago. Can you explain underwriting and your process?

MR. HARTUNG: Underwriting in insurance is a predetermination of the risk associated with the cost. For example, on home insurance, if your home is relatively free from overhanging trees, shrubbery, bushes, weeds, and close to a fire hydrant, that's underwriting, making that determination. And your home can be anywhere from a three to a nine. If you live in the California hills that are -- you're surrounded by the beautiful scrub oaks, which can ignite by sneezing too hard on them, you're going to be a nine, and you're underwritten -- you're going to be paying three times the home insurance as the guy who lives down in the flatlands next to a fire hydrant.

The underwriting in long-term care insurance is-- There is eligibility and noneligibility, and so, if you're at high risk of long-term care in the next four to five years, you can't pass eligibility. However, in a self-funded

program, we decided to push the envelope in that. And so, when we went through our third-party administrator, we said, "I look at the standard underwriting, and there are people that are at risk of death but not at risk of long-term care that are being excluded. We want them included unless there is a high liability of risk." We were looking at things like AIDS and heart disease.

You know, if you have disabilities and you have AIDS, you're not going to pass the deductible period because you're already at a stage where you're going to die in six to eight weeks. So that did not become the risk to us. And so we wanted that envelope opened. AIDS was not going to be a risk of long-term care. If someone has AIDS, they're probably going to die. Most of the people who have AIDS aren't going to buy long-term care insurance either because they're not going to have that much utilization. They're not going to pass the deductible period, and the deductible period, in our Program, generally matches all of our hospital plans that have a deductible, 90 days of coverage.

DEPUTY COMMISSIONER REINHARD: So do you start doing this at a particular age, or everybody has to be assessed? If you're 40 years old and you sign on -- you have a medical--

MR. HARTUNG: When we first started, the question was, "Is the underwriting the same for everybody?" Today it is. It's just that the older you get, the more questions you have to answer that have detail related to it. When we started our Program in California, we had-- What we had was a modified guaranteed issue, which means there's underwriting there, but the risk wasn't there when we evaluated it with our actuaries from Towers and

Parents. That before people understood how to get in the Program that -- we could say-- If you're an active member and actively working for a public agency for the first two enrollments, we said, "If you haven't been in long-term care or have used long-term care in the last 12 months and you're not currently using it, you're automatically in." The spouse was underwritten, and then-- The older you get, the more detailed the questions are because the answers are different. And so it becomes a face-to-face interview almost automatically if you're over the age of 75.

We have built-in protection for Alzheimer's that if it's determined that you didn't make your premium payments because of an Alzheimer's involvement-- You know, there's six months where you can reenroll -- pay back your premiums, and during those six months, we're going to be chasing you to find out what happened, whether you're deceased or whether you voluntarily withdrew and just let it lapse. You can build those into self-funded programs. It's different.

But you look at the cost associated with it. Now you've got enrollees. You don't want to change the program that's going to make them subsidize someone else, but you can do all those things in a self-funded program. You probably can do it in a fully-funded program if you control the reserves and control certain things. So there are elements there but not to the same level.

ASSEMBLYWOMAN MURPHY: Questions?

MS. MICHELSEN: I have a question related to the one that Dr. Reinhard asked about triggers. I know about the ADL types of triggers. Is age ever a factor? Is it three ADL and you're over 60 also? What if you had --

what if you developed MS and you were 50 years old and you bought the policy when you were 30?

MR. HARTUNG: If you buy into this Program/a fully-funded program and you were age 30 and went out and had an automobile accident and lost two ADLs, you'd be eligible for home care for the rest of your life. So it's a good Program.

MS. MICHELSEN: So in a sense, you could sell it to younger people because it is really almost like a long-term disability policy.

MR. HARTUNG: Guess who's buying it the most and the youngest.

MS. MICHELSEN: Self-insured people?

MR. HARTUNG: Firemen, policemen, highway workers.

MS. MICHELSEN: People who are-- What about people who are self-employed and don't have a disability policy through their employer?

MR. HARTUNG: We don't have-- Ours are all public employees.

MS. MICHELSEN: Right, but they can go out and buy a banker's policy or a traveler's policy, and that would be a wise investment, wouldn't it?

MR. HARTUNG: Right, and if they're self-employed, they can structure it. They can write their premium off.

MS. MICHELSEN: That's right.

MR. HARTUNG: I couldn't let that one by. That's in the Kennedy-Katzenbaum. And they don't have to offer it to anybody else.

ASSEMBLYWOMAN MURPHY: Any more questions? (no response)

MR. HARTUNG: This was great. You guys got me back into my thinking realm on this. There are some questions there--

MS. MICHELSEN: You look pretty energized about it.

MR. HARTUNG: --I haven't heard for a year. I enjoyed this a lot.

DEPUTY COMMISSIONER REINHARD: We're delighted. Thank you for coming.

ASSEMBLYMAN THOMPSON: It was great information that you supplied us.

ASSEMBLYWOMAN MURPHY: We cannot thank you enough. It was a long trip, and we do appreciate your having made that -- and others for having encouraged you to come in.

Deputy Commissioner Reinhard, for your committee's work--

DEPUTY COMMISSIONER REINHARD: Thank you.

ASSEMBLYWOMAN MURPHY: The fact that so many of us are thinking about the same thing, we all benefitted from the information.

MR. HARTUNG: They-- I go all over, and they think I do more help than damage, so--

ASSEMBLYWOMAN MURPHY: Well, we do too, Craig. Thank you so very much for coming.

Does anyone in the audience, on the Long-term Care commission (*sic*), have any questions they wanted to ask?

If you'd identify yourself for the record and use the microphone, we'd appreciate it.

Craig, don't go yet. You have to sit at one of the microphones, Craig, because your answer needs to be recorded.

MR. HARTUNG: My flight's not in until 8:00 tonight.

ASSEMBLYWOMAN MURPHY: You need to sit back down because we need to record you on the tape. (witness complies)

MR. HARTUNG: Oh, I'm sorry.

MS. KIENZT: I don't know if the microphone is working. It's a question for you.

Carol Kientz from the Home Health Assembly.

ASSEMBLYWOMAN MURPHY: That's the recording microphone. (indicating)

MS. KIENZT: Thank you.

Two questions. First of all, is hospice one of the long-term care options -- hospice care in the community?

MR. HARTUNG: It really depends because it's not basically a care that's built into the Program, but if it's an alternative care, there are ways that it can be put into our Program. You can have it built into your program if you wanted, but it's-- There are ways of putting it in. We have that anything-you-want type of thing, but, remember, there are some hospices where you're going in there because you don't -- and you have all six of your activities of daily living, then you wouldn't be eligible. For example, you might have a cancer that-- It gets real jumbled there. Most of the hospital programs have something associated with this, and we haven't had a lot of experience in it.

I didn't have any experience in it whatsoever when I was working for CalPERS, but I noticed that when I was developing this Program, the major hospitals in California were standing right at my shoulder. I joined the

Alzheimer's program with them because they're starting to look and build platforms for that assisted-living level because some of that assisted-living level is a high utilizer of acute care, and these people generally have acute care policies and the long-term care policy. And there is a real interesting blending of services there that was very exciting to me. And I was working with some lobbyists in Sacramento that were representatives of the hospital associations, and it was just really exciting what we could get into.

And Sutter General Hospital, which is a huge hospital with a great mortality -- low mortality rate on (indiscernible), that's now-- And I only say that because they have 0.8 percent. They're trying to develop something that kind of blends where you kind of move into an intermediate and then to a long-term care depending on the disabilities. There are lots of interesting things going on there. And I think policy makers, such as yourselves, should be promoting those types of developments because what they result in is a lower-cost platform for the services that are offered today.

ASSEMBLYWOMAN MURPHY: But I think what you said, Craig, in terms of self-funding means that if hospice care for patients who are dying of cancer or terminal, which is usually what the definition is of hospice care--

MS. KIENZ: Right, palliative care.

ASSEMBLYWOMAN MURPHY: --X amount of time, that could be written in if that was what the group chose to put into the pool.

MR. HARTUNG: Sure.

MS. KIENZ: And that's exactly what-- I was thinking the palliative level, not treatment for cancer, but palliative for those individuals who are terminal.

ASSEMBLYWOMAN MURPHY: But if it is self-funded, you write your own conditions.

MR. HARTUNG: Yes, you write in your own -- you write your own chapters. And we didn't really understand-- When we were starting on this, there wasn't anything called a self-funded program out there. And every time I tried to punch something into the Program, the board says, "Well, are you sure?" I said, "No, I'm not sure." They said, "Well, stay closer to what you understand, and we, with a self-funded program, will let you develop those things later as you see them necessary." And that could even be a rider on a policy, for example.

MS. KIENZ: Could I just have one other clarification if I may. I happen to be an owner of a long-term care policy myself, which I, very happily, bought several years ago. It's lifetime and comprehensive, but it has a daily cap. Yours has no daily cap? If, for instance, I, at age 80, have arthritis and am very limited in my mobility, I may have had a small stroke, I may want a combination of some home care during the day to get me ready to go out to go to a day care center, I may live alone and want someone to live in with me in the evening or at night, can I have whatever, short of probably a Lincoln Continental to drive me to the day care center? Is there no cap, daily, to what I could opt for?

MR. HARTUNG: That's another good question. And I didn't get into plan design that much because we'd be here-- For the home care element

of it and because Craig had a hell of a time with his mother trying to figure out how to do this because one day it was \$90 and the next day it was nothing, then on Friday it was \$100, what we have is-- The plan that is designed right now -- again you can design this any way you wanted to, but we're trying to design it with what we understood and what we knew was out there -- that the daily benefit for home care and community care is 50 percent of the nursing home care benefit times 30. So you get to spend it however you want to spend it within that 30-day period.

MS. KIENTZ: Times 30. So if the daily cost in a nursing home was \$500, just to pick a number that I know how to divide, then it's \$250 times 30?

MR. HARTUNG: Let me talk about what our plans are.

MS. KIENTZ: Times 30 days.

MS. MICHELSEN: Yes.

MS. KIENTZ: I'm sorry.

MR. HARTUNG: Our Program is \$130 a day. The average cost of a nursing home care in California right now is about \$4600 or \$4700 a month. So ours is designed at \$130 a day, which covers that. So that's a design. Now, you take \$65 times 30. You can -- which is \$1900/\$2000 a month -- those who are quicker with numbers in their head. It's got to be right within a few dollars. Let's say, \$1900 to \$2000 a month. You spend it however you feel.

MS. KIENTZ: I see.

MR. HARTUNG: Now, you can design that differently, and I'm sure that the plan is going to change. We go into the future, we may want to

say, "Okay, for *X* number of bucks, you can ratchet up your home and community care from 50 percent to 70 percent or 100 percent." But again, remember, when we were designing the Program, we were looking at -- we had to look at programs that were out there. I had to go to my board and say, "Yes, this has worked, and this is something I can understand, and this is not something I'm guessing at." But because it's self-funded, I told them that if it comes that that's what the people want, then that's what we'll sell.

ASSEMBLYWOMAN MURPHY: And that's what they'll buy.

MR. HARTUNG: Right.

We found out that they're buying the products-- They wanted the simple choices because, when they look at 30 choices for home health care, you know what happens? They get into a position where they're unable to make a choice. They're so confused. They have a couple of choices with our Program.

DEPUTY COMMISSIONER REINHARD: You mentioned that you did a lot of education. I assume that some of this education fell on ears of people who weren't public employees.

MR. HARTUNG: Yes.

DEPUTY COMMISSIONER REINHARD: Did you find that other private insurance companies also increased their products -- they were selling more also?

MR. HARTUNG: To the tune of 65 percent increase that year. The first year--

DEPUTY COMMISSIONER REINHARD: So they're not threatened by you. You seem to be helping them.

MR. HARTUNG: It depends on who you're talking to. If you're talking to the company planner, they see this as an opportunity. And Tony (indiscernible), the vice president of Bankers, the largest in the nation, in a public meeting, sat up and -- stood up and thanked me for the Program because their sales had gone up 65 percent, and they learned a new way to put the program together.

Now, if you talked to the broker who only can count sales and not the overall impact to the program -- only sales in his office, he's not going to feel the same way about it because he sees it as something threatening his income. But I have, in my presentations-- I'm a broker, but I don't sell -- car, home, commercial insurance. I try to, at the conferences, explain to them that we can never sell to more than 10 percent of the people in California. I said that before we came on the market, there was only 1 percent in sales. There's over 2 percent now. I said, "Let's not fight over the 2 percent or the 10 percent that may be eligible. You can have all of the other 90 percent." And that went over with some of them, and some of them it didn't go over very well with.

ASSEMBLYWOMAN MURPHY: Well, thank you again.

DEPUTY COMMISSIONER REINHARD: I wanted, for the record, to acknowledge that Dr. Miriam Arronson is also on the Long-Term Care Insurance task force (*sic*). And also Rick--

ASSEMBLYWOMAN MURPHY: And this is Dr. Miriam Arronson.

DEPUTY COMMISSIONER REINHARD: And also Rick Abrams arrived.

ASSEMBLYWOMAN MURPHY: Thank you very much.

**MIRIAM ARRONSON, Ph.D.:** Thank you.

I have a question back to the ADLs.

MR. HARTUNG: Yes.

DR. ARRONSON: Who defines the ADL? Is it partially out, totally out? For instance, if you have an Alzheimer's patient who can technically dress themselves but can't really, they have to have their clothing selected, they have to be cued-- In some policy-- What do you do? In some policies, they'll consider cognitive impairment, in and of itself, as one ADL. Do you do that?

MR. HARTUNG: Yes, all tax-qualified programs have to have -- and thank you so much for bringing it up. There's so much that I've forgotten to tell you. And that is that there are six ADLs. In cognitive impairment, including Alzheimer's, you're already triggered for nursing home care, but again that's the wrong care for an Alzheimer's patient.

ASSEMBLYWOMAN MURPHY: Yes.

MR. HARTUNG: I even went through an Alzheimer's with my mother, and I didn't-- She wasn't in an Alzheimer's so that was the wrong setting, but I had to go through those things and figure them out myself at the time. But it was a nice apartment. She had supervision. As long as she could find out where the fire escape was-- It was just like a home, and she could wander around in controlled yards, and it wasn't too much different than the setting she was in when she was totally independent.

ASSEMBLYWOMAN MURPHY: Craig, again thank you so much.

Thank you all for being here. You have given us more time than we are really allowed.

MR. HARTUNG: Not as much as you deserve.

ASSEMBLYWOMAN MURPHY: Thank you very much.

Thank you all for being here.

The meeting is adjourned. You may turn the machine off.  
(referring to recorder)

**(MEETING CONCLUDED)**